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Dual diagnosis discourse and narratives in the State of Victoria 1985-2012

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Abstract

Health services are more effective if they are coordinated around the person, family or community. Frequently they operate in silos determined by diagnosis. Many people with mental health problems also have problems with alcohol and other drug (AOD) use, and vice versa. The coexistence of such problems has been variously termed 'dual diagnosis', 'co-occurring disorders' or 'comorbidity'. In recent decades attention has been drawn to the problem of fragmented services for people considered to have a 'dual diagnosis'. A dual diagnosis discourse has developed around the proposition that there should be 'no wrong door' when people seek treatment or support. Services specialising in either mental health or drug and alcohol treatment should recognise assess and respond to co-occurring problems. Little research attention has been paid to the historical and cultural impediments to the 'no wrong door' approach.

The thesis asks: Why did dual diagnosis discourse emerge? How did it evolve in the two specialist sectors? What are the implications for service users/consumers, services, professions and governments? How has the discourse played out in the context of an espoused vision of person-centred care, rather than care organised around disciplinary and service structures?

The research, focusing on the State of Victoria since 1985, involved a qualitative exploration comprising six stages: a review of research literatures; collection and analysis of government policy documents; in-depth interviews with key informants, purposively selected to offer varied perspectives from the level of policy development and service leadership; feedback of findings to these informants for validation and further comment; synthesis of findings into papers for peer review; and final refinement of conclusions in the submitted thesis.

I found that dual diagnosis discourse emerged in Victoria at a time of greater differentiation between services. Deinstitutionalisation was a part of this but further contributors were greater managerialism, the allocation of funds according to diagnosis, professional turf issues and a broadening of the scope of mental health and AOD strategies to encompass mild and moderate as well as severe conditions. 'Capacity-building' characterised the discourse and strategies through the 1990s and 2000s, entailing top down and bottom up change management that challenged over-specialisation and offered leadership, networks and a focus for achievement. The mental health and AOD sectors both made at best incremental progress towards a 'no wrong door' service culture. Still to be resolved are enduring therapeutic pessimism, particularly in the acute mental health sector, cultural clashes between sectors, and enduring social stigma.

The thesis contributes to the body of qualitative research on the history and course of efforts to develop appropriate care for patients who are considered to have alcohol and drug problems and other mental health disorders. More broadly, the thesis illuminates the development and implications of a medical construct over time in a particular context. It adds to the evidence for improving quality control and interdisciplinary, intersectoral workforce development with a focus on patient strengths and recovery within an integrated health and social support system.

List of publications contributing to this thesis

Published

Roberts, B. (2013) The seeds of dual diagnosis discourse in an Australian State. *Mental Health and Substance Use Dual Diagnosis, 6:4, pp 325-338.* DOI: 10.1080/17523281.2012.741611.

Roberts, B.M., Maybery, D. and Jones, R. (2013) Reflections on capacity-building initiatives in an Australian State. *Advances in Dual Diagnosis, 6:1,* pp. 24-33. DOI: 10.1108/17570971311309006.

Roberts, B. (2012) Interprofessional relationships in dual diagnosis discourse in an Australian State: Are we respecting each other yet? *Mental Health and Substance Use Dual Diagnosis, 5:2,* pp. 148-159. DOI: 10.1080/17523281.2011.618995.

Roberts, B. and Jones, R. (2013) Dual diagnosis narratives and their implications for the alcohol and other drug sector in Australia. *Contemporary Drug Problems, 30:4,* pp. 663-685.

Roberts, B.M. and Maybery, D. (2014) Dual Diagnosis Discourse in Victoria Australia: The Responsiveness of Mental Health Services. *Journal of Dual Diagnosis, 10:3*, pp. 139-144. DOI: 10.1080/15504263.2014.929332.

Monash University declaration for thesis based or partially based on conjointly published or unpublished work

In accordance with Monash University Doctorate Regulation 17.2 Doctor of Philosophy and Research Master's regulations the following declarations are made:

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 four original papers published in peer reviewed journals and one unpublished publication. The core theme of the thesis is dual diagnosis discourse. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the candidate, working within the Monash University Department of Rural and Indigenous Health under the supervision of Associate Professor Darryl Maybery and Dr Rebecca Jones (and, at various times, Associate Professor Priscilla Pyett, Associate Professor Janice Chesters, Associate Professor Deirdre O'Neill).

The inclusion of co-authors reflects the fact that the work came from active collaboration among researchers.

In the case of Chapter 4 my contribution to the work involved the following:

Thesis chapter	Publication title	Publication status*	Nature and extent of candidate's contribution
4	The seeds of dual diagnosis discourse in an Australian State	Published	100% authorship
4	Reflections on capacity-building initiatives in an Australian State	Published	90% authorship
4	Interprofessional relationships in dual diagnosis discourse in an Australian State: Are we respecting each other yet?	Published	100% authorship
4	Dual diagnosis narratives and their implications for the alcohol and other drug sector in Australia	Published	90% authorship
4	Dual diagnosis discourse in Victoria Australia: the responsiveness of mental health services	Published	90% authorship

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

Signed: Date: 11 February 2015

Acknowledgements

Acronyms

ABS	Australian Bureau of Statistics
ADIS	Alcohol and Drug Information System
AHA	Australian Healthcare Associates
AIHW	Australian Institute of Health and Welfare
AIPC	Australian Institute of Primary Care, La Trobe University
AMHS	Area Mental Health Service
AOD	Alcohol and other drug
CEP	Co-existing Problems
COAG	Council of Australian Governments
DD	Dual Diagnosis
DDCAT	Dual Diagnosis Capability in Addiction Treatment
DH	Department of Health (Victoria – merged with DHS 1994-2010)
DHS	Department of Human Services (Victoria)
DSM	Diagnostic and Statistical Manual of Mental Disorders
DOHA	Department of Health and Ageing (Commonwealth of Australia)
EBPP	Evidence based policy and practice
GP	General Practitioner
ICD-10	International Classification of Diseases, Tenth Edition (ICD-10)
ISI	Improved Services Initiative
MH	Mental Health
NDARC	National Drug and Alcohol Research Centre
NDSF	National Drug Strategic Framework (NDSF)
PDRSS	Psychiatric Disability Rehabilitation and Support Services
RANZCP	Royal Australian and New Zealand College of Psychiatry
SUMHNet	Substance Use and Mental Health Network
SUMITT	Substance Use and Mental Illness Treatment Team
VIC	Victoria
VDDI	Victorian Dual Diagnosis Initiative
VICSERV	Name of peak body representing community managed mental health services in Victoria
WHO	World Health Organisation

Chapter 1: Introduction

Many people experiencing problems with alcohol or other drugs also experience mental health problems, and vice versa. The co-occurrence of these problems, or 'dual diagnosis', can lead to greater difficulties, impairments and disability. Yet the service systems for mental health and alcohol and other drug problems are divided and attract criticism for not recognising the prevalence and needs of people experiencing dual diagnosis. This problem has been recognised internationally. The State of Victoria, Australia is a site of emergent responses. This study examines the development and progression of the dual diagnosis system of care that evolved in Victoria over the last 25 years. While Chapter Two outlines the often competing literatures and perspectives that are background to the service system's responsiveness or otherwise to people experiencing dual diagnosis, the thesis begins with an introduction to the field and the author's position in relation to it, and outlines the study's rationale and key questions.

Background

In recent decades the attention of governments, their health bureaucracies and health professionals has been drawn to the need for a better relationship between mental health services and services for people with alcohol and other drug problems, a relationship that will ensure more appropriate treatment for people experiencing dual diagnosis. The demand for this improvement is evident in the overarching vision of integrated health services expressed by the World Health Organisation, where health services are organised and managed so that 'people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money' (Waddington & Egger, 2008, p. 1). More specifically, the evidence suggests that people with mental health and alcohol and other drug problems fare better when treatment plans are integrated and treatment for both types of problem is undertaken at the same time (Horsfall, Cleary, Hunt, & Walter, 2009; Morisano, Babor, & Robaina, 2014).

Terminology

The focus of the study on contested concepts means that it is important to pause at the outset to acknowledge the problem of terminology in this domain. Dual diagnosis is one term for the co-occurrence of problematic use of alcohol or other drugs with the signs and symptoms of one or more other mental health problems. Common synonyms for dual diagnosis are 'co-occurring mental health and drug use disorders' (Drake et al., 1998), 'coexisting mental health and drug use problems' (Ministry of Health, 2010) or 'comorbidity of mental health and substance use disorders' (Teesson, Slade, & Mills, 2009).

I use the term 'dual diagnosis', as the chosen term in the policies of the State of Victoria, the location of my case study. The term has been criticised as inaccurate for two main reasons. First, there are frequently multiple, rather than two, problems, all of which require attention. Second, mental health and alcohol or other drug use may be problematic without formal diagnosis being appropriate or necessary.

Already these terms bring in questions of the use of 'diagnosis' 'disorder' 'comorbidity' or 'problem'. Use of the first three terms suggests a medical philosophy, defining the problem as a treatable illness, while 'problem' is used as an all-inclusive term (as in this thesis) or in the more limited sense of a negative but undiagnosable condition. I acknowledge the tendency for 'mental health' to become a euphemism for mental *ill*-health, and the changing and sometimes overlapping criteria for the clinical identification of problems, whether mild, moderate or severe. I use the term 'mental health problems' to include psychotic disorders, major depression and the more prevalent depression and anxiety disorders. I prefer the lengthy phrase 'alcohol and other drugs' to the simpler 'substances' or 'drugs', because it is common in Australian discourse(National Drugs Sector Information Service, 2013) and is a reminder of the high burden of disease of alcohol when compared with that of illicit drugs or legal pharmaceuticals. As for the problematic effects, in this thesis I refer to 'alcohol and other drug (or AOD) problems'. These span a continuum of adverse consequences arising from AOD use (Teesson et al., 2009),

whether in terms of individual health, education, work, the law or interpersonal relationships. The definition of 'addictive disorders', 'substance use disorders' (DSM-5) or 'dependence syndrome' (ICD-10), is an ongoing issue in the field, where addiction is constructed as a biopsychosocial disorder in which 'there are fluid and undetermined links' (Keane, 2002) between the physical, the psychological and the social.

Prevalence

The scale of the problem of dual diagnosis is significant, although measurement is challenging. Prevalence studies of mental disorders (including alcohol and other drug problems) suggest that an estimated 2‑3% of Australians live with severe disorders, including people living with psychotic disorders (about one third) and those (about two thirds) living with disabling forms of depression and anxiety. Another 4‑6% of the population have moderate disorders, and a further 9‑12% have mild disorders (National Mental Health Report 2013, DOHA). It is estimated, however, that only about 33-45% of people living with mental health problems receive care (ABS 2008, reporting on 2007 household survey; Evaluation of Better Access). It is not known to what extent this represents a lack of services, as other factors include lack of awareness of a problem or illness, and access issues such as lack of knowledge of treatment options, past negative experiences of treatment, fear of losing children to the state, and the stigma of mental ill-health (National Mental Health Report 2013). While many people affected by one issue do not necessarily have problems in the other, it is internationally acknowledged that the co-occurrence of AOD problems with other mental health problems is significant, although quantifying the overlap in the general population is problematic, owing to such reasons as lack of screening and the limits of self-report (Regier et al., 1990; Teesson et al., 2009). Local (Victorian) screening studies suggest that at least half of AOD and mental health clients 'meet the criteria' for dual diagnosis (Lambert et al., 2005; Lubman et al., 2007; Staiger, Ricciardelli, McCabe, Young, & Cross, 2008).

People experiencing dual diagnosis are at heightened risk of deteriorating mental illness and problematic AOD use, social isolation and relationship distress, homelessness, infections and other physical health problems. The minority with severe AOD problems and severe psychotic disorders are at particular risk of incarceration, violence, suicidal behaviour and suicide (Teesson, Slade, & Mills, 2009). They may encounter any of a wide range of services, none of which can directly meet all their needs, treatment may be unwelcoming and inadequate and they may give up or be given up on, leading to further complications and distress. If mental health and AOD services are well connected with each other and linked with support for physical health, housing, education, employment, legal issues and social relationships, people with dual diagnosis are considered (in this consensus) to be more likely to engage in appropriate and effective treatment and be in better health. If intersectoral relationships fail, it is argued, these people receive either no service or treatment that is inappropriate, ineffectual and ignores a significant aspect of their problems: hence the language of 'falling through the cracks' and calls for 'no wrong door' service systems that do not turn away people experiencing dual or multiple problems.

The prevalence of co-occurring addiction and mental health problems in Victoria and the lack of a coherent service response provide the background to this thesis and are further explored in Chapter 2. This study has sought to examine the issues, problems, solutions and tensions (the discourse) in the Victorian health sector as it sought to respond to the need for action in the dual diagnosis area.

Separate services in the local context

The public health services available to people experiencing AOD or other mental health problems have developed considerably in Victoria since the 1960s. In that era people with the more severe AOD problems might find themselves in the large psychiatric institutions, where there was a long and vexed history (still to be fully researched) of their being largely unwelcome: in brief, they were not seen as being mentally ill or deserving of

treatment (Lewis, 1992; White, 1998). The first public and specialist alcoholism treatment clinic of the time (i.e. since the 1930s) was set up in Melbourne's St Vincent's Hospital in 1964. Between the 1970s and the early 1990s the state government funded units for AOD treatment, education and research on the campuses of psychiatric hospitals and an outpatient clinic in inner Melbourne.[1] Psychiatrists, psychologists, psychiatric nurses and social workers staffed these specialist services. When they needed specialist psychiatric help it was not uncommon (according to key informants interviewed for this thesis) for a staff member to walk with them to the mental illness admission unit and stay with them to negotiate access and see a psychiatrist before returning with them to the AOD unit to continue treatment there. Meanwhile multiple voluntary non-government organisations developed, providing generalist, community-based treatment and support for people with alcohol problems or for those with drug problems[2] (the two groups of service users seeing themselves as culturally distinct). There was also a growing body of small non-government organisations providing care and support for people experiencing mental illness.[3]

In the late 1980s, for reasons including a government funding crisis, the advent of New Public Management and international research indicating the value of outpatient, community-based services, the psychiatric institutions began to close, and in 1990 the government AOD services were moved off their campuses. During the 1990s public mental health and AOD services were tendered out as two separate service systems. Services for people experiencing a severe mental illness were subdivided into clinical treatment (medically staffed) and psychiatric disability and support (staffed as rehabilitation and welfare services). This distinction was not as clear in the AOD services, however, reflecting the range of positions about what 'treatment' constituted and where it

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[1] Gresswell, Pleasant View, Heatherton (hospital sites) and Smith St, Fitzroy (community location)

[2] For example: Salvation Army in 1956, Buoyancy in 1967, Moreland Hall Alcoholism Treatment Centre in 1970.

[3] For example, Prahran Mission from 1946 and Richmond Fellowship, the Association of Relatives and Friends of the Mentally Ill (ARAFMI) during the 1970s (Meadows, Singh, & Grigg, 2007).

merged with psychosocial or generalist support for the whole range of a client's needs. Debates about specialist AOD treatment, the higher cost of medicalised treatment models, and the strength of the non-government sector's claims for an alternative (often anti-psychiatric) model, contributed to a greater separation of the sector from clinical mental health services.[4]

The two specialist service sectors – mental health (including clinical treatment and psychiatric disability rehabilitation) and AOD treatment – have encountered tensions concerning clients experiencing both types of problem. The workforce in each service sector has its own identity and culture, grounded in separate histories and philosophies, and its own assumptions about the other sector. They also have much in common, such as certain disciplinary and professional backgrounds, the policy environment, low status in medical hierarchies, and a context of complex societal attitudes to their work and to their clients. Both sectors are working with people who have chronic, relapsing conditions and behaviour that can at times be confronting. Both sectors are engaging with consumer/survivor movements and demands for a recovery orientation.

It is worth noting that treatment for people with alcohol and drug problems has varied historically: at times a sub-specialism of psychiatry, at times having no apparent place in the health system at all and at other times occupying a separate sector allied with health and community services. Second, another aspect of AOD work's shifting place in the health and social system is that it is arguably more intersectoral in its culture. From the first Australian drug strategy (NCADA, 1985) the pillars of harm minimisation (demand, supply, and harm reduction) have guided a multifaceted approach to AOD and society (Fitzgerald & Sewards, 2002). Government strategies for mental illness services, on the other hand, have started from an insular position with linkages always mentioned but with the emphasis less on integrated treatment (i.e., working directly with other services) than on stigma reduction and improving mental health patients' access to generalist health and

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[4] Professor Alison Ritter, Turning Point Oration 22/11/14; and thesis data.

community services, employment and housing. Other major differences lie in the degree of paternalism in mental health services, supported by mental health legislation (Pilgrim, 2009), whereby clinical mental health services have a coercive and custodial role.[5]

Aetiology and the treatment pathway

The causes of mental health or AOD problems are uncertain. Where these problems co-exist, there is often consideration of whether one caused the other, or whether they have arisen independently. As it is often difficult or impossible to determine which condition existed first there are grounds for considering both as 'primary' and treating them accordingly (Kavanagh, 2011).

Public specialist clinical services are funded and set up to admit people according to their primary presenting problem and to exclude those with other primary problems. For individuals, mental health problems may appear, or be detected, before or after alcohol and other drug use has become problematic. The relationship between problems may vary over time, with one more significant than the other at different times. In clinical terms people are diagnosed as experiencing a primary psychiatric disorder, a primary AOD use disorder or a dual primary disorder. The diagnosis chosen determines the service pathway. Patterns of treatment have been described as *sequential* or *serial*, where one problem is diagnosed as primary and is expected to be resolved before the secondary one is treated; *parallel*, where both conditions are treated at once, but independently, by different services and different professionals; and *integrated*, where specialists work together to the extent required by the complexity of the person's problems (Drake, Bartels, Teague, Noordsy, & Clark, 1993). The sequential model tends to see the more acute problem (acute psychosis or acute intoxication) treated first but is criticised in the case of non-acute problems when the service a person approaches does not accept responsibility (Ries, 1993). The parallel model may be effective if both services are of a high standard

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[5] Legislation for compulsory alcohol and other drug treatment has however existed in Victoria, with limited scope and uptake, for some time (Alcoholics and Drug-Dependent Persons Act 1968, The Severe Substance Dependence Treatment Act, 2010); and milder forms of coercion into treatment occur through court diversion programs.

but relies on inter-service coordination or the client's ability to manage both services and complete a coherent combination of treatments (Torrens, Rossi, Martinez-Riera, Martinez-Sanvisens, & Bulbena, 2012). Consensus has grown, in the absence of unequivocal evidence, that services that are better *integrated* are important if treatment for dual diagnosis is to be better matched, at the right times and places, to individual preferences and needs (Drake & Wallach, 2000; Minkoff & Cline, 2004; Morisano et al., 2014; Torrens et al., 2012; Torrey, Tepper, & Greenwold, 2011).

Various models of integration are developing, with common principles such as multidisciplinary teamwork, co-ordination across types of treatment, continuity of care, adequate length of care, and systemic support for integration. There is a spectrum of models, from fully merged mental health and AOD services, usually for people with severe mental illness and AOD problems (Torrey et al., 2011) to frameworks that do not dictate infrastructure mergers but describe a service system approach with a nuanced definition of service integration based on problem severity (Rush, 2010). The guiding principles of the systems approach emphasise a person's ability to move within the system as required, and with an appropriate level of support, without being owned by any one organisation or service. Cautions about embedding integrated dual diagnosis services as the norm include the fact that many people affected by one issue do not necessarily have problems in the other. Further, there is a need to respect consumer choice and motivation, both because of the principle of taking an integrated view of the whole person and their wellbeing, and because of evidence that to do otherwise is likely to affect help seeking, engagement in treatment and outcomes (Minkoff & Cline, 2004). Finally, work on service integration is not the whole answer to better care, and is not a substitute for developing intrinsically better treatment services that are adequately resourced, accessible, efficient and provide a continuum of care options (Morisano et al., 2014).

Current dual diagnosis policy in Australia describes an increasingly close relationship of between the mental health and AOD sectors, and administratively in Victoria the two are

directed from within a single 'mental health and drugs' unit. Policy documents can be interpreted as having a shared holistic vision: the language of 'Because Mental Health Matters' (DHS, 2009, p. 9) is of 'whole-of-person care', and the reform of AOD and psychiatric rehabilitation and support services alike is towards 'person-centred' care, (Department of Health, 2012, 2013; Department of Human Services, 2008).

For a health system organised around the treatment of single conditions, dual diagnosis is a challenge. The professed goals of a quality dual diagnosis approach are a social model of health, person centred care, seamless integration of services and collaborative partnerships. In practice health systems struggle to adapt to the needs of people considered to be experiencing dual diagnosis. This thesis focuses on why and how a movement towards better responses emerged, and its significance for the health system and those who use and provide it.

Why I started this thesis

The personal background of my study lies in the three professional roles I have undertaken in Victoria. I have been a leader of outdoor adventure-based psychosocial rehabilitation with people with mental illness; a committee member and policy officer with the peak body for non-government psychiatric disability rehabilitation and support services (PDRS); and a research and evaluation practitioner in the alcohol and other drugs sector. In my seven years of leading adventure-based programs I found that some of the participants were open about being in treatment for alcohol and other drug problems. Many, it turned out, were hiding problematic use, evidenced only by Monday absences from the program, late arrivals because of a need to buy heroin on the way, and empty spirits bottles hidden at a campsite. It was only when I entered the alcohol and other drug (AOD) treatment field as an evaluator that my eyes were really opened to these and other signs of drug related activities that I had missed or misunderstood among the people I had worked with in the outdoors. Similarly, on joining an AOD organisation, I noticed a

corresponding lack of awareness of mental health problems. Yet the experience of both sets of difficulties was clearly seen as prevalent and not well addressed.

I wondered what was new about this emphasis on 'dual diagnosis'. The term 'dual diagnosis', in my experience, ignited strong feelings, often of frustration but also of a passion for change, among service providers. I realised that there were significant players in policy and service provision who, now in senior positions, had a story to tell. It seemed that I would be well-placed to explore it from a critical perspective – with my experience in system and program evaluation I would not only ensure that the perspectives and interests of multiple stakeholders were considered but could be a 'critical friend' who would be respected by the key informants in the field. This was confirmed by my experience of evaluating the Victorian Dual Diagnosis Initiative in its early years.

Further, I saw a role for a researcher who was outside the principle disciplines and service cultures which respond to people experiencing dual diagnosis. The problem of dual diagnosis calls for an interdisciplinary approach which can integrate knowledge for translation into policy and practice. The study of mental health and illness and, separately, of alcohol and drug issues, embraces the fields of psychiatry, psychology, public health, community medicine and medical science, social sciences, sociology, criminology and history (e.g., Meadows, Singh & Grigg, 2007, O'Brien, 2011). In dual diagnosis, however, there is as yet relatively little interdisciplinary research.

Summary of issues and research questions

The emergence of the idea of dual diagnosis as a focus for improving health services for people with both mental health and AOD problems occurred during the 1980s. In the western world this has been a significant event in the development of health services as it sought to integrate two separate service systems with different cultures, foci, histories and training.

Much academic literature has focused on the need for services that are capable of treating and supporting people experiencing dual diagnosis, considering the experience of the consumer as well as clinical and biomedical issues relating to the co-existence of problems. An important knowledge gap however, is that there has been little systematic analysis of the concept of dual diagnosis – the narratives and discourses which surround the services – nor of its application in the different service realms and systems of mental health and alcohol and other drug treatment, care and support. This thesis aims to examine the evolution of a dual diagnosis system of care as it developed over a 25 year period and explore its significance. The research focuses on the State of Victoria since 1985 during a time of significant change including the closure of large psychiatric hospitals, the growth of community-based care and the evolution of national and state mental health and drug strategies. The specific research questions this thesis will address are:

1. Why did 'dual diagnosis' emerge?
2. How did it evolve in the two specialist sectors and what were the implications for each sector?
3. What are the implications for service users/consumers, services, professions and governments of the emergence and evolution of dual diagnosis as a concept?

The story of the emergence of the concept of dual diagnosis and the discourse surrounding it, in the State of Victoria in recent decades offers a valuable case study which has implications not only for the immediate service systems but for the development of intersectoral relationships in health. The choice of a case study design enabled in-depth contextualised examination of the phenomenon.

Summary of methodology

The thesis adopts an interpretive approach in order to illuminate the complex social reality of the research topic and the chosen case. For all three research questions, three lines of inquiry were pursued. The first two questions, on the emergence and development of dual diagnosis policy, practice and discourse, required a comprehensive examination of the

clinical and health services research literature, focusing on US, Canadian, European and Australasian sources. The next step was analysis of the chain of relevant policy documents emanating from federal and state health departments, to explore their interpretation of the research evidence, the evolution of the discourse, and the policy directions for service systems and practice. The third step entailed a two-stage consultation with key informants who had experience of delivering relevant services in Victoria from 1985 to the present. This step was necessary in order to gain multiple, nuanced and grounded perspectives on why and how the discourse had emerged and grown – perspectives that are not necessarily explored in the literature or in policy documents.

The third research question, on the implications of dual diagnosis policy, practice and discourse, suggested a need to expand the review of literatures to add sociological and philosophical texts and studies of system and organisational change. The reflections of key informants at the meso-level of policy and service development were particularly essential for exploration of the benefits and drawbacks of a focus on dual diagnosis for different actors – service users, service organisations, professionals and government.

Format and chapter outline

This thesis has been undertaken and produced as a 'thesis by publication', that is, the core of the thesis is a series of five peer-reviewed journal publications. These publications are set within the context of the research literature, methodology and methods and implications of the findings. This chapter (Chapter One) has provided an overview of the study and introduced its rationale, research questions, methods and findings.

Chapter Two is a narrative review of relevant literatures. It highlights debates in the field of dual diagnosis, concentrating on high-level issues and expanding on the necessarily constrained and partial consideration of research literature in the publications. Chapter Three describes and discusses the study's methodology, tracing its influences in

constructivism, discourse analysis and narrative analysis. I outline and reflect on aspects of the method such as the warrant for a single case study and the focus on meso-level informants. Both of these chapters provide a more comprehensive, detailed and reflective consideration of the research literature and methods than can be encapsulated in a journal publication.

Chapter Four begins with a discussion of the contextual material from the study as an introduction to the five publications that emerged from the research questions. Each publication has a different focus, addressing in turn the three research questions. The first explores why dual diagnosis discourse began. The second traces its evolution in Victoria, the development of a discourse and its associated initiatives. The third, fourth and fifth examine implications in relation to different groups: the professions, the alcohol and other drug sector, and the acute mental health sector. Together these contribute to the field a rich picture of the work that 'dual diagnosis' has done in the development of responses to complicated and complex problems of health and health service delivery. These overarching findings and conclusions are discussed in Chapter Five, the final chapter, drawing together the findings and considering the overall relevance of the study to health service improvement and to future research.

Chapter 2: Concepts of dual diagnosis in the research literatures

Introduction

The landscape of this study includes elements of social science, sociology and health services research. Reference to the research literatures in the five journal publications (Chapter Four, below) is necessarily brief. The 'scene-setting' references are also similar in each publication. This chapter therefore complements the published papers with a higher-level synthesis and greater emphasis on the social construction of dual diagnosis. The review's approach is narrative rather than systematic, following threads relevant to dual diagnosis, as they connect overtly 'dual diagnosis' studies with generic texts that illuminate salient themes.

The chapter begins with a commentary on the body of dual diagnosis research. I then explore dual diagnosis as a problematic concept with multiple dimensions. This leads to discussion of guiding images that help understanding of complex issues, images that are important to keep in mind when reading research literature emanating from particular and traditional disciplines or professions. I then move to a brief review of dual diagnosis as seen from epidemiological, clinical and health services research perspectives. Reflections on inquiry into health service integration takes the argument back to guiding images and future directions for dual diagnosis research.

'Dual diagnosis' as a research topic

Relative importance

Dual diagnosis research has burgeoned since its first appearance in the 1980s. In relation to research on its constituent topics, however, it has a modest presence. For example, Figure 1 indicates the relative growth in the number of publications per year that have the terms 'depression', 'schizophrenia', 'addiction' or 'dual diagnosis' in the title or key words.

It shows the number of results retrieved when separate, single-word searches of PubMed[6] are carried out for these four topics. We would expect all to increase, in the era when publication became easier with the aid of the internet and worldwide growth in academic institutions and the number of peer-reviewed journals. Results for 'depression' and 'schizophrenia' in 2012 were four times those of 1985, addiction results 17 times greater and dual diagnosis 28 times greater. Interest in the latter two concepts greatly increased, but from a low base (171 and 34 respectively), and if the trends on this graph continue, dual diagnosis research will not catch up.
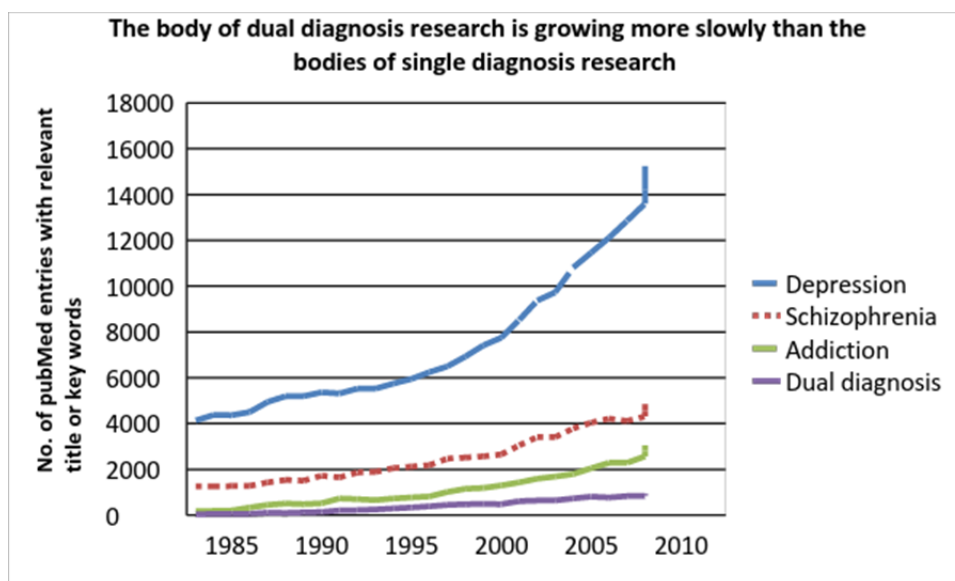
Figure 1: Frequency of the terms depression, schizophrenia, addiction and dual diagnosis in PubMed, 1985-2012

This graph, indicative as it is, demonstrates three major points. First, that publication reflects neither relative prevalence nor relative harms: in terms of prevalence and harms, schizophrenia would arguably lie fourth on the list and would not increase through the period (ABS, 2008; AIHW, 2011). Second, that publications are more likely to focus on single diagnoses. Third, that interest in addiction and in dual diagnosis intensified at around the same time but dual diagnosis studies remain a minority research pursuit.

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[6] Citation database of biomedical literature, National Center for Biotechnology Information, U.S. National Library of Medicine, located at the National Institutes of Health.

Overview of a developing field

The year 1989 saw the first of many publications by influential authors in the dual diagnosis field. The research questions were predominantly about the prevalence of the problems and the improvement of clinical treatment. Kenneth Minkoff published his first paper on integrated dual diagnosis treatment in 1989 (Minkoff, 1989). With Christie Cline he has subsequently developed and focused on supporting the implementation of a model of integrated treatment known as the Comprehensive Continuous Integrated System of Care Model (Minkoff & Cline, 2006). Similarly a multidisciplinary medical team in Dartmouth, New Hampshire, now known as the Dartmouth Dual Diagnosis Center, began to make their work known (for example, Drake & Wallach, 1989; Osher & Kofoed, 1989; Teague, Mercer-McFadden, & Drake, 1989). These authors have principally focused on improving responses to substance use and misuse among people with severe mental disorders. In 2002 they widened their focus to take in responses to the detection of a wide range of mental health disorders among people presenting to AOD treatment, and began to publish in alcohol and drug journals, in a shift that is relevant to tensions in the field and confusions about the most meaningful definition of dual diagnosis and whether this included the milder and more moderate mental health problems.

Australian research was in step with these US teams. Notably, Helen Herrman, Patrick McGorry and colleagues (1989) surveyed homeless people in Melbourne, finding almost half the people interviewed received diagnoses of current psychiatric or substance use disorders and there was considerable comorbidity.

There has been little sociologically informed research into how dual diagnosis is constituted by government policy-making, social and professional attitudes and personal lived experience. I am with Drake and Wallach (2000) in regretting an over-emphasis on medical and moral perspectives, which typically focus on deficits and the interests of treatment providers. Taking stock in 2000 of 15 years of dual diagnosis literature published in the US they note that highlighting the presence of illnesses, through the term

'dual diagnosis', leads to a focus on individuals and their responsibility to engage in and benefit from treatment, while changes in policy and the environment receive less attention. They call for a more positive approach involving psychosocial models that take into account the social risk factors for the poverty, homelessness and crime that frequently attend dual diagnosis, and phenomenological models that privilege sufferers' own insights, preferences and visions of recovery. I would add to Drake and Wallach's list the need for the development and use of models of system and organisational change, to aid inquiry into the barriers to and facilitators for effective treatment and recovery.

Heeding the call for attention to lived experience, the next section introduces first hand stories of people with lived experience of dual diagnosis. These are supplemented by selected accounts from qualitative research studies.

Insights from lived experience

The voices of people considered to have a dual diagnosis do not appear extensively in the research literature. Two text books are exceptional in placing first-hand writing in early chapters (Allsop, 2008; Phillips, McKeown, & Sandford, 2010). Rosco Woods (2008) recalls his transition from the role of drug and alcohol service user to involuntary patient in an Australian psychiatric hospital, homeless, depressed, alcohol-intoxicated and in heroin withdrawal. While the staff were 'compassionate and caring',

> *they really had no idea of how to work with me in a personalised manner, due mainly to their lack of knowledge of the complexities and nuances of drug dependence. There seemed to be a desire to attribute some primary illness to me, and my doctors gave me the impression that they were in a dilemma trying to find a label to fit me* (Woods, 2008, pp. 18-19).

After discharge, AOD services lost interest in him at first because he had become a mental health services patient. He saw his main problem as a lack of self-esteem, not 'dual diagnosis'. Stereotyping, tradition, policies and protocols were a barrier to providing an individually tailored response. Clinicians in both mental health and AOD

services did have a positive role when they offered 'hope, optimism, and a belief in me' (Woods, 2008, p. 20).

Another Australian, David Webb (2009), author of a doctoral thesis and a book about suicide, describes the 'two worlds' he encountered as a service user:

> *At drug and alcohol services I was always greeted warmly with a big effort made to make me feel as welcome as possible….The psych wards were so very different. First, the admission formalities are so cold and clinical as you wait for judgement – like in a courtroom or being dragged before the headmaster – on whether you will be admitted or not* (Webb, 2009, p. 29).

Webb lists ten contrasting characteristics of psychiatric wards as compared with alcohol and drug services. He experienced the latter as holistic and strengths based, operating a psychosocial recovery-focused model that considered the social context. The services enabled strong peer support and the active participation of service users. Staff were mostly non-clinical. A feature he considers underplayed in dual diagnosis discourse is that attendance is usually voluntary. This latter point leads to his main criticism of moves towards a No Wrong Door policy, namely that people may be deterred from approaching AOD services if this might lead to being locked up in a mental health service. He urges the AOD sector not be 'colonised' by psychiatry: rather, the AOD approach should be applied to the mental health sector in the interests of providing a 'safe space' for healing. For Webb, the challenge is to put into practice the rhetoric of a biopsychosocial, recovery-based theory as opposed to the currently dominant biological model.

These first-hand messages are echoed in the small body of literature that privileges the stories of service users. Holt and Treloar (2008) interviewed 77 service users seeking help for illicit drug use problems. They found them to be unfamiliar with the language of mental health problems and advocated improving mental health literacy. People needed to be more able to seek appropriate help and understand contradictory service provider attitudes and advice, for example about the nature of their problems or about antidepressant use. Only the small number who had engaged in peer-education activities

or accessed drug-user organisations understood the terms comorbidity or dual diagnosis. In another example from the qualitative literature, six people interviewed in the UK (Lawrence-Jones, 2010) told of their experience of parallel treatment services, exclusion and stigma in spite of dual diagnosis policies having been in place for several years. Service users were treated as undeserving and existing service provision frequently compounded their disadvantage. As in the Holt and Treloar study, peer support was seen as a major aid to recovery.

Other studies highlight the role of caring workers: in New York, 39 formerly homeless people, when asked what engaged them in treatment, cited pleasant surroundings, acts of kindness and access to housing, as opposed to the system's rules and restrictions (Padgett, Henwood, Abrams, & Davis, 2008). In a report of interviews with 23 young people in Victoria, Australia, entitled 'Dual diagnosis: young people speak out', Sarah Russell (2009), records these young people's attitudes to services and the way they used services not just to fix the problems but for the support given by contact workers. Their relationship with a worker often determined whether they thought the service was good or bad. They told of having 'a million different types of workers', contradicting some arguments that mental health and AOD clientele did not significantly overlap. They used mental health services for medication and talking therapies, although finding them formal and impersonal, and the AOD sector, about which they spoke more favourably, for social and support activities. They described persistent problems with a dual system, such as conflicting advice from different workers and a lack of communication and cohesion among services. Similar stories have arisen from in-depth interviews with young people in New Zealand (Barnett & Lapsley, 2006).

Important points about these stories are both positive and negative. First, they include acknowledgement of compassionate and caring staff and peers who foster self-esteem and hope, and of individual survivorship. On the other hand, even after the introduction of dual diagnosis policies and initiatives, recent accounts of experience of the service system

continue to record unwelcoming attitudes and processes. It is also worth noting the warning that some potential beneficiaries of separate services may fear the possible consequences of being identified as having the other disorder. This means that a service that welcomes people experiencing dual diagnosis may, without due care in their design and delivery, deter others from seeking or staying in treatment. Further, some AOD clients, in seeking help with AOD problems, do not identify with the medical language of diagnosis or disorder.

Next I consider some of the contested issues contained in the term dual diagnosis. This aims to expand consideration of issues alluded to in the five publications (Chapter Four) that make up the focus of this thesis.

Problematising dual diagnosis

The above sources attest that the label 'dual diagnosis' is often far from a passport to service. The needs expressed are material (secure housing), psychological (self-esteem), social ('acts of kindness') as well as medical. What appears to be offered is confusing and fragmentary, and falls short of what a reasonable citizen of a developed country would expect from the health system if diagnosed with, say, breast cancer or heart disease, or comorbidity of the two conditions. 'Dual diagnosis' as explored in this thesis is not only a medical term for the lived experience of people experiencing a range of problems. It is a nexus of ideas, institutions and systems. The 'reality' of lived experience interacts with institutionalised notions of dual diagnosis. To explore the dynamics of dual diagnosis discourse and begin to address the question of why dual diagnosis discourse emerged and what it meant for treatment care and support, I now turn to readings in the social construction of mental illness and of alcohol and other drug problems. Beginning with the nature of diagnosis, I highlight key considerations for research on dual diagnosis discourse. The position I take is one of both acceptance and critical questioning: acceptance, that is, of the material reality of the human problems that cluster around 'dual diagnosis' and critical questioning of hegemonic beliefs about them.

Diagnosis is both the process of determining the nature and identity of a disease, and the formal classification of a condition. Diagnosis does not name an essential, value-free entity. Authors such as Annemarie Mol (1998), Charles Rosenberg (2002) and Owsei Temkin (2002) illuminate the problem of expecting the natural sciences to understand the realities of the living world and, through diagnostic classification, to carve nature at its joints and thence make unbiased progress towards containment or cure. Moral, social and economic factors are involved in the naming of disease, and the naming in turn has moral, social and economic implications, such as social inclusion, the development of professions and the rise and fall of institutions. Temkin argues that all diagnosis has moral implications, carrying its own potential for praise and blame: as he points out, mental illness and AOD misuse are among the particularly obvious cases where people's 'abnormal' behaviour is at times valued and at times condemned.

Psychiatric classifications are consensus based and change over time. Sand is a common metaphor: in critical comments on the concept of dual diagnosis, Frederick Glaser questions the wisdom of erecting an extensive foundation on the 'shifting sands' of diagnoses. (Glaser, 1993, p. 53); and McLaren, writing on DSM 5[7], claims that:

> *we are simply engaged in a vastly expensive exercise of drawing boxes in the*
> *sand and then watching impotently as the social winds blow them away*
> (McLaren, 2010, p. 194).

Philosopher Ian Hacking analyses these social winds that hamper the drive in the social and psychological sciences to emulate the natural sciences, and to produce 'true natural kinds of people' (Hacking, 1999, p. 104). Through a looping effect,

> *what was known about people of a kind may become false because people of*
> *that kind have changed in virtue of how they have been classified, what they*
> *believe about themselves, or because of how they have been treated as so*
> *classified (Hacking, 1999, p. 104).*

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[7] Fifth edition of Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association. In this edition Roman numerals (as in DSM-I through IV) have been abandoned.

Mental disorders are thus culturally bound. Psychiatric diagnosis is a hugely contested area: attempts to reach a new consensus on how to classify mental disorders in DSM 5 have taken more than a decade and continue after the manual's publication. Diagnosis seeks to establish natural, scientific distinctions but mental disorders defy categorisation (McLaren, 2010). The criteria for schizophrenia have changed since the term was first used, with 'flat affect' a fundamental feature for Eugen Bleuler in 1908, later replaced by delusions and hallucinations, and becoming prominent again more recently. The concept of addiction changes in relation to the place of a drug in society and the way it is used. For example it is now axiomatic in AOD theory that AOD problems are a product of the drug, the set and the setting (Zinberg, 1984) – a classic example is the case of US soldiers using heroin in Vietnam to the point of addiction and in many cases ceasing use and addiction without treatment intervention, after returning home to a different setting with different demands on the mind and body (Robins, Davis, & Nurco, 1974).

Drawing diagnostic boxes, albeit in sand, serves many purposes. As both a process and a classification, diagnosis plays an active part in creating structures and serving professional and political interests (Rosenberg, 2002). In the 'Seeds of Dual Diagnosis' paper (Roberts, 2013) I contemplated why a focus on dual diagnosis had emerged. Was it simply, as Glaser (1993) and Room (1998) suggested, an artefact of an increase in the number of possible diagnoses and changes to diagnostic thresholds?[8] At the time of writing the diagnostic classifications have undergone further change. DSM 5 now lists over 400 disorders (compared to 22 in DSM I in 1952). Among the changes to the criteria for diagnosing substance use disorder, DSM 5 has replaced the dichotomy between abuse and dependence with a spectrum including moderate problems, thus apparently lowering the threshold for diagnosis. Preliminary analysis (Teesson, Slade, & Mewton, 2011) indicates the prevalence of alcohol use disorders could increase by more than 60%

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[8] The diagnostic categories that make up 'dual diagnosis' are defined in the DSM and the ICD-10. The former, a product of the American Psychiatric Association, guides funding allocation in the US and well beyond. The latter emanates from the World Health Organisation. There are attempts to reconcile the two, as both undergo revision.

under DSM 5 when compared with the numbers diagnosed under DSM IV. Increasing the number of diagnoses and lowering the thresholds for diagnosis will clearly, in line with Glaser and Room's claims, lead to more people with multiple diagnoses.

Many authors draw on metaphor to capture the complexity of dual diagnosis. Ian Hacking (1999) uses the metaphor of a matrix: applied to dual diagnosis, the 'idea' or classification of dual diagnosis inhabits a matrix formed by a complex of institutions, decisions and infrastructure. Grant Gillett evokes a multidimensional metaphor: the 'quilting point' is a node,

> *where multiple discourses or ways of thinking of things intersect or are locked together, vertically, as it were, because they concern an entity (such as the human being, or a disease event like a gastric ulcer). Necessarily there is no specialist discourse that completely or exhaustively delineates the quilting point because the node participates in multiple cross-grained networks of signification (a human being = a neural network, a psychological being well or ill adapted to a human context, a participant in a set of relationships, a moral agent responsible for certain events; a gastric ulcer = an inflammatory process, a response to stress, an epidemiological occurrence, and so on) (Gillett, 2012, p. 60).*

The quilting point idea suggests that we need to apply different ways of knowing and accommodate multiple discourses that surround but do not capture the problem or situation of concern: science cannot embrace the necessary complexity. Gillett reflects on being asked as a psychiatrist for an opinion on a person's danger to society. He considers himself 'unfitted by anything that would qualify as science for the role that has to be enacted', as it involves 'history, singularity and discontinuity' (Gillett, 2012, p. 60). Others, such as Alan Beattie go to cultural and urban studies to find, after Edward Soja and others, the concept of 'third space'. This is the interliminal space of constant change, beyond the safety of our traditional borders, where we replace stereotypes with new shared meanings (Beattie, 2003).

'Dual diagnosis' discourse is about complex reality. While the condition may be packaged and headlined as 'the rule not the exception' in the business of mental illness and alcohol and other drug services, the metaphors – nexus, sands, matrix, quilting point, the space between borders – serve as a reminder that one discipline or approach or perspective will not be sufficient to make sense of, still less resolve, human problems. Mental illness on the one hand and AOD problems on the other are themselves complex quilting points: when the two are combined, little wonder that people, whether sufferers, carers or service providers, lose hope of recovery.

Although in many ways unknowable as a nexus of human problems 'dual diagnosis' has become, I suggest, a recognised 'discursive ensemble' (Cresswell & Spandler, 2009) that can be used to draw political attention to the need for resources. In 'Psychopolitics' Peter Sedgwick (1982), critical of the nihilism of 1960s antipsychiatry, harnessed the concept of mental illness in order to legitimise demands on health services. Nearly thirty years later, Cresswell and Spandler (2009) argue that trauma, abuse and distress, as framed particularly by the service user/consumer movement, form a new discursive ensemble that may provide similar leverage. The common psychopolitical theme here is the claim for state investment in matters of mental health, as a complement to the current public health emphasis on individual responsibility. State involvement, these authors remind us, is particularly important when professionals lack interest in or hope for people with enduring AOD problems and mental illness. Dual diagnosis may well work as a discursive ensemble that can be used to attract funding.

'Dual diagnosis' also works as a professional sub-specialism. After Foucault, we are alert to the way specialist disciplines carry twin connotations, standing both for institutions for production of bodies of knowledge and for instances of the exercise of power. Dual diagnosis discourse entails creation of specialists in its field. While the degree of their power is questionable, given that their work is frequently low status and marginalised in relation to its component specialisms, the specialism does carry the risks of disciplinary

power: as Paulo Freire writes of 'miseducated' professionals, 'whatever the specialty that brings them into contact with the people, they are almost unshakeably convinced that it is their mission to "give" the latter their knowledge and techniques. … they do not listen to the people' (Freire, 1972, pp. 124-125). In reflecting on the meaning of dual diagnosis discourse, then, it is worth asking how it interacts with psychiatric and addiction specialisms and whether the power of a new specialism is used well. As suggested in discussion of the lived experience literature, for the person seeking or needing help, the power of 'dual diagnosis' can work for or against engaging and continuing in treatment, if the person is not listened to: they may resent or fear being labelled as having the 'other' issue when seeking help for AOD problems or mental health problems.

The influences of these and other theorists can be seen in some of the more applied thought about mental health and AOD problems. A team of researchers into drug policy in NSW has a long term project to bring together a wide range of thinkers to address drug and associated issues in policy and society. Gabriel Bammer (2008) advocates a return to awareness of ignorance and uncertainty: this stimulates creative adaptation in dealing with the unforeseen, taking opportunities for exploration and discovery, crafting good outcomes in a 'partially learnable world'. All of this also means 'dealing intelligently and sociably with other people', which in turn means negotiating often incompatible interests of politicians, researchers and entrepreneurs. Adaptation does not necessarily mean rejecting reductionist science. Alison Ritter (in Bammer & Smithson, 2008), referring to evidence that actuarial methods for clinical decision making are better than clinical judgement, claims that the problem of uncertainties is not that they cannot be resolved or that values conflict or that there is a lack of information, it is resistance to taking up a better way of dealing with uncertainty. She cites an approach to the prediction of suicidality that combines clinical judgement with algorithms and actuarial tools. This means being aware and adaptive, able to use tools appropriately and know they are not the end of the story, to be alive to uncertainty and not let the tools hide the task.

This section has touched on the uncertainties surrounding the term 'dual diagnosis' and introduced the dynamics of the discourse in preparation for examining the rationale and significance of its growth. Reference to post-structural philosophy has suggested its value in prompting new perspectives on day-to-day rationalist discourse. I now move from the philosophical context to the hegemonic health research literature, before returning to two of the themes from this section: specialisation and what counts as evidence.

Health research

This section provides an overview of three branches of health research – epidemiology, clinical research, and health services research – and how these areas relate to the dual diagnosis concept. I argue that epidemiological and clinical research points to the need for integrated dual diagnosis treatment and early 'no wrong door' intervention for people presenting to primary care or specialist services, and that, although still somewhat contested, the evidence base has strengthened. There are twin implications for improving services: the challenge of interpreting what the evidence base means for unique people, times and places and the inherent difficulty of translating knowledge into real-world practice. The section therefore concludes with reflections on the evidence-based policy and practice discourse and the growing field of implementation science.

Prevalence and patterns of dual diagnosis – the epidemiological lens

Epidemiologists tell us that according to successive Australian household surveys, one in five adults had experienced depression, anxiety or a substance use disorder in the previous year. Of those with substance use disorders, 35% were likely to have symptoms of anxiety and 21.4% to have symptoms of depression (AIHW, 2011; Teesson & Proudfoot, 2003; Teesson et al., 2009, p. 607). Psychotic disorders (schizophrenia, bipolar affective disorder, major depression) are less prevalent but when alcohol and other drug problems co-occur, the harms are likely to be severe (Lambert et al., 2005). According to the clinical and epidemiological research, dual diagnosis brings with it increased risks. These include more severe illness and likelihood of relapse, social isolation and relationship

distress, homelessness, infections and other physical health problems. The minority suffering severe AOD problems and psychotic disorders are more prone to incarceration, violence, suicidal behaviour and suicide (Teesson & Proudfoot, 2003).

For young people the impact of having both a mental health problem and difficulties with alcohol or other drugs is particularly telling. They are likely to be held back in their education, training, employment, maturing of social relationships and establishment of independent housing (Kenny, Kidd, Tuena, Jarvis, & Robertson, 2006; Lubman, Hides, Yücel, & Toumbourou, 2007). The young person's brain is particularly susceptible to the physical effects of alcohol and other drugs.

Local (Victorian) screening studies suggest that at least half of AOD and mental health clients 'meet the criteria' for dual diagnosis (Lambert et al., 2005; Lubman et al., 2007; Staiger, Ricciardelli, McCabe, Young, & Cross, 2008). An important point is that a majority of those who could benefit from treatment for 'dual diagnosis' either do not present to or are excluded from services, although the limitations of household and other population surveys mean that actual treatment rates are unknown (Australian Institute of Health and Welfare, 2012; National Mental Health Report 2013). The 2007 Australian National Survey of Mental Health and Well-being found, for example, that two thirds of people with a mental disorder did not consult a health service (Burgess et al., 2009). Potentially, a greater proportion of clients would meet the criteria for dual diagnosis, if the barriers to treatment were removed.

Aetiology – causal pathways

The question of causes is omnipresent in the biomedical literature, in line with the premise that if a root cause can be found, a cure can follow. Why do a large proportion of people with mental health problems use alcohol or other drugs to a harmful extent? Why do people with alcohol and drug problems experience high levels of depression, anxiety or psychosis? Is there a causal link? Are the problems sometimes causally independent? The many patterns of dual diagnosis are well described in the literature (for example,

Hickie, Koschera, Davenport, Naismith, & Scott, 2001; Room, 1998; Rush & Koegl, 2008; Teesson & Proudfoot, 2003). Explanations proposed for co-occurring problems are multiple, varied and not mutually exclusive (Mueser, Drake, & Wallach, 1998). The 'common factor' explanation suggests that both types of problem arise from a genetic or biological predisposition or from environmental or family trauma. Trauma, especially experienced at a young age, is increasingly the subject of research studies (Dore, Mills, Murray, Teesson, & Farrugia, 2012; Rees et al., 2011, Teesson, Degenhardt, Proudfoot, Hall, & Lynskey, 2005). Alternatively, one set of problems has led directly to the other. For example, amphetamine use may induce psychosis, or alcohol and other drugs are sought after a mental health problem has developed. Theories of indirect causal relationships include intermediary risk factors, as when early AOD use (or a mental health problem) affects education, leading to unemployment and, because of the unemployment, to depression (or AOD problems, respectively).

In the shifting sands of diagnosis and the variety and complexity of sufferers' individual experience and preferences, dual diagnosis practitioners take a pragmatic position. In my view this position helpfully overrides enduring (perhaps insoluble) arguments about causes, which can lead researchers to underemphasise the realities of multiple interactions among problems. For example, David Kavanagh, after warning against 'superficial interpretations' of causal pathways, recommends initially treating both the mental illness and the AOD problems as primary and adapting the response based on ongoing observation:

> *The complexity of potential causal connections requires that we initially approach co-occurring disorders as primary and having potential for mutual interaction, providing integrated treatment for both, while observing the apparent strength of specific causal associations over time. This approach does not guarantee success, but it may allow delivery of a treatment that is better suited to an individual's situation, than if practitioners routinely focus on a single disorder* (Kavanagh, 2011).

This approach assumes the capacity of the individual and the practitioner for ongoing contact in a system that can provide integrated treatment and is not skewed towards basing treatment (or exclusion from treatment) on the disorder that is the 'primary' business of the organisation or the practitioner.

Treatment – who is treated where and how?

Dual diagnosis presentations to the two specialist sectors differ. In Victoria, alcohol and drug services are more likely to be working with people with the high prevalence disorders – anxiety, depression and personality disorders; specialist mental health services principally treat – and psychiatric disability rehabilitation and support services support people who are experiencing psychotic disorders or major depression with concurrent AOD problems (DHS, 2007). An additional diagnosis of a personality disorder raises questions of clinical responsibility, and treatability – a vexed issue in the field which further complicates discussion of dual diagnosis (DHS, 2007; Teesson & Proudfoot, 2003). Primary care services, delivered by GPs, allied health and community health, are the site of early detection of problems, and treatment of less severe dual diagnosis (such as less intensive, highly accessible interventions that focus on anxiety and/or depression coupled with alcohol, nicotine and cannabis use) (DHS, 2007). Early detection and an appropriate response to mental health and/or alcohol and drug problems reduce the likelihood of short and long term harms.

Peer support, using the knowledge and skills derived from lived experience, is recognised as an important adjunct to professional treatment and care. Providing the right conditions for it to work with young people with dual diagnosis was a challenge taken on by Kenny and others (2006), who successfully built peer education into a group intervention.

An integrated, or at least a coordinated, response reduces deterioration in health and improves outcomes (Minkoff, 2000). Integrated treatment is generally accepted as the standard (Ziedonis et al., 2005) and was endorsed as the goal by US experts meeting to confer about bipolar disorder and AOD use (O'Brien and others, 2004). Their 'call to

action' details the strategies that should be in place, embraces harm reduction and acknowledges systems issues, including the low status of addiction research and practice, as a barrier to progress.

Systems issues - rival specialisms, contested evidence and system change

Systems issues proliferate in studies of dual diagnosis treatment. A growing body of research explores effective integration of health and social services into a system that offers the citizen a smooth pathway, whatever the complications and complexities of their needs. I discuss three of these systems issues: first, specialisation and consequent interprofessional challenges, second, the question of evidence-based policy and practice, and finally the mechanisms of system and practice change.

Specialisation

There is a trend towards specialisation in health services, a trend which dual diagnosis discourse counters. The mantra that 'dual diagnosis is core business' directly challenges the specialist, single-diagnosis preoccupation that is built into mental illness and AOD service systems. It sits within a wider push for closer inter-service relationships, which have been identified on a ladder of intensity from information-sharing and coordination to full integration. As described by the Australian Ministerial Council on Drug Strategy,

> *Strong partnerships and integrated service approaches with alcohol and other drug treatment, social welfare, income support and job services, housing and homelessness services, mental health care providers and correctional services are needed if people with multiple and complex needs are to be assisted to stabilise their lives, reintegrate with the community and recover from alcohol and other drug-related problems* (Ministerial Council on Drug Strategy, 2011, p. 15).

A major text book 'Mental Health in Australia: collaborative community practice' places partnerships and integration at the front and centre of the issue (Meadows et al., 2007). In a chapter on working collaboratively, Noel Renouf and Graham Meadows discuss the basics of teamwork and of intersectoral working. They validate the anxiety and

defensiveness that arises when professionals are asked to enter another's working world and the fear of the erosion of their own speciality. Boundaries tend to become walls instead of spaces for negotiation. Success entails shifting the focus away from the anxiety about boundaries and towards working with and for the clients. I explore this theme further in the paper 'Interprofessional relationships in dual diagnosis discourse in an Australian State' (Chapter Four), drawing on a typology of boundary issues (Hudson, Hardy, Henwood, & Wistow, 1997), literature on interprofessionalism (Leathard, 2003) and evaluative work on dual diagnosis service frameworks (Brousselle, Lamothe, Sylvain, Foro, & Perreault, 2010; Rush, 2010).

Specialist disciplines and professions are based on shared beliefs, including beliefs about the evidence for what they do, and the type of client or patient they should work with. Next I consider the implications of the evidence-based policy movement in dual diagnosis discourse.

Evidence-based policy and practice
Dual diagnosis discourse has developed in the same period as the evidence-based policy and practice (EBPP) movements, the dominance of which has particular implications for people with complex or complicated needs. The requirement of EBPP is that approaches to prevention or treatment are based in theory and have undergone scientific evaluation. The movement emerged in the UK in the 1990s (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996) in an era when politicians had grown openly dismissive of evidence (Nutley, Davies, & Walter, 2002).

The term 'evidence' is often mistakenly equated with the findings of experimental study designs, rather than the findings of the most appropriate study design for the question at hand. While many public sectors are eclectic in their definition of evidence, medicine adopted a hierarchy of evidence, with systematic reviews of randomised controlled trials as the gold standard (Nutley et al., 2002). This has meant the prioritisation of research designs that seek as narrow a focus as possible, such that research subjects with

complicating characteristics are excluded. These include half the population, in the case of women and psychopharmacology (Chaves & Seeman, 2006), or a possibly larger proportion in the case of people with dual diagnosis (Humphreys, Weingardt, Horst, Joshi, & Finney, 2005; Zetin & Hoepner, 2007). This hierarchy has arguably limited research on the way forward for people with dual diagnosis. Sackett and colleagues were, however, clear in their understanding that 'evidence based' meant that clinicians also took into account individual patient circumstances and preferences and were not 'tyrannised by evidence'. Dual diagnosis is a prime illustration of the need to engage with the individual and base decision-making on multiple forms of evidence – biological, psychological and social/environmental. Further, as Denzin reminds us, we need to be aware of the way in which the bodies of evidence are influenced, through funding and other mechanisms, by politics (Denzin, 2009).

System change

The demand for faithful implementation of proven interventions has fuelled the new field of implementation science (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Translation of knowledge into practice is especially challenging in work that is furthest from controllable experimental conditions – which covers most of dual diagnosis treatment and support. An extensive literature on capacity-building has developed, recognising that new practices cannot be introduced simply through skills training and educational courses for front line staff. Improvement entails multifaceted workforce and organisational development activities that affect culture and attitudes (Allsop & Stevens, 2009; Rapp et al., 2008). Real-world complexity is a challenge for implementation and its evaluation: a variety of qualitative and mixed methods research designs are used, with extra impetus provided by the consumer recovery movement's demand for different ways of creating and interpreting evidence. Realistic evaluation (Pawson & Tilley, 1997) promises to satisfy multiple audiences in an approach that maps causal pathways from context, through contextual factors (or 'mechanisms') to intermediate and longer-term outcomes. The aim is to synthesise evidence and discover what works, for whom, in which circumstances,

and why. O'Campo and colleagues (2009) drew on Pawson's later work (2002) to conduct a realist synthesis of the quantitative and qualitative evidence in research and grey literature concerning homeless people with dual diagnosis. They identified promising strategies included an emphasis on client choice in making decisions on treatment, positive interpersonal relationships between client and provider, Acceptance and Commitment Therapy (ACT) approaches, providing independent housing along with other services, providing services beyond mental health and substance use treatment, and non-restrictive program approaches. They concluded that several of these strategies worked by promoting client autonomy; as such, these strategies were likely to lead to longer-term positive health changes. While they confess to vagueness about exactly how the mechanisms leading to outcomes should be identified (suggesting that the approach has more art and less science than may sometimes be claimed) their conclusions are persuasive. The approach goes beyond the narrow focus dictated by experimental methods to a way of working with the shifting sands and quilting points of dual diagnosis that is plausible for those seeking to be informed by evidence.

Other authors have drawn on research on system and organisational change or innovation to propose a way forward for mental health and AOD service systems. For example, Minkoff and Cline (2000) propose systemic measures to develop dual diagnosis capability across the multiple service types. Capability assessment tools are in use to support such change (McGovern, Matzkin, & Giard, 2007). More recently, Rush and colleagues (2010) have applied a systems approach to the design of alcohol and other drug-related health promotion, early intervention and specialist treatment. This further develops the idea of integrated services for people experiencing dual diagnosis, by capturing the idea of treatment pathways that move into and out of intense, specialist treatment ('stepped care') and enable long term support across a continuum of care. Another research team (Novotná, 2013) has applied institutional theory to a study of progress towards integrated treatment in Canada, highlighting the range of factors in the

political and professional environment that influence practice change. In the UK, a study of innovations in mental health services applied innovation theory to the micro level, to surface the factors enabling and impeding new ideas (Brooks, Pilgrim, & Rogers, 2011).

The literature review in the thesis publications

To conclude this discussion of the literatures relevant to dual diagnosis discourse, I offer a brief summary of the ways in which these literatures appear in the publications presented in Chapter Four. First it is worth noting that all the papers required at least a brief orientation of the reader to the field, as expressed in the international literatures. Common points are: the principal understandings of the meaning of 'dual diagnosis', its prevalence and associated harms; the problem of fragmented health systems; and the warrant for a focus on the system in the Australian State of Victoria as a case study.

The first paper, addressing the research question of why dual discourse emerged, pays most attention to the research published in the late 1980s and early 1990s. Writings on the political and professional changes of the time joined those on deinstitutionalisation and dual diagnosis. The second paper, focusing on the research question of how the discourse evolved, reviews 20 years of developments in responses to dual diagnosis. It builds on international implementation research and its insights into theories of change facilitation and capacity-building in complex systems. The remaining three papers enlarge upon the implications of the discourse for the relevant professions, for the AOD sector and for the mental health sector respectively. The third paper draws on a burgeoning body of research on interprofessionalism, for its focus on 'turf' issues in the meanings of and responses to dual diagnosis. The implications of dual diagnosis discourse for the AOD sector and its service users are the fourth paper's focus. A thematic analysis of international qualitative literature on dual diagnosis was able to highlight the experience of living or working with complex problems for which solutions are unclear, unavailable or simply of low political status. The fifth paper, on the uncomfortable relationship of psychiatrists and other mental health workers to addiction, made further space for works

on attitudes and stigma, and reference to a Foucauldian perspective on the complex challenges facing psychiatry.

Marshalling the range of perspectives in the literature that may be helpful in studying dual diagnosis discourse is a challenge and there is no perfect synthesis. My approach was to aim for an orientation to others' work that would, within the limitations of each paper and the target journal, introduce and sharpen analysis of the primary data (stakeholder interviews) and support, contrast with or otherwise stimulate the discussion and conclusions.

Conclusion

Dual diagnosis has multiple meanings, formed by people's experience and values. This chapter's exploration of relevant literatures highlights important issues for improving policy and practice. Tracing the history of dual diagnosis research revealed a developing literature from 1985 onwards that is not keeping pace with growth in 'single diagnosis' research and that there is a need for more psychosocial content and more phenomenological, consumer-focused research. Exploring how the perspectives of those with lived experience are expressed in the literature highlighted the need for consumers to receive a compassion and care in medical treatment and support, as well as the importance of creating service options that do not deter consumers who identify as having only a mental illness or only an AOD problem. The consumer view that people are not being well served led to an exploration of the complexities in dual diagnosis discourse and the need for creative ways of working with uncertainty that embrace a range of ontologies and epistemologies. I argue for dual diagnosis as a discursive concept that may leverage much-needed government resources.

Epidemiological and clinical perspectives on dual diagnosis throw systems issues into relief, in particular specialisation, with the need to negotiate boundaries, and the importance of research and dialogue about effective approaches to system change.

Research will continue towards making sense of dual diagnosis and finding ways forward towards better treatment, care and support. Clinical treatment research has made advances in recent decades concerning specific interventions for dual diagnosis but there are calls for more 'real-world' research: more sociological research (for example, Drake et al., 2001; Drake & Wallach, 2000), more attention to the processes of behaviour change (Orford, 2008), more implementation research and service evaluation (for example, Jorm, Griffiths, Christensen, & Medway, 2002; Sacks, Chandler, & Gonzales, 2008) and more evaluation of outcomes (for example, Crosbie, 2009). Greater involvement, in all aspects of research, of people with first-hand experience of dual diagnosis will improve consumer empowerment and greatly enrich the relevance and usefulness of findings (Bastian, 1996; Hanley, 2005; NHMRC and Consumers' Health Forum, 2002).

This chapter has explored the research landscape behind my research questions about the emergence of dual diagnosis discourse in the mental health and AOD sectors and the implications for service users/consumers, services, professions and governments. I turn in the next chapter to methodology and a detailed review of my study methods.

Chapter 3: Methodology and method

Introduction

This chapter presents and discusses the approach taken to answer the research questions. I begin by reviewing my research influences, with a focus on the interpretive frames of narrative and discourse analysis. The second subsection is a reflection on the research design and methods, expanding on the brief summaries that appear in the publications (Chapter Four) and including discussion of the strengths and limitations of the design. The methods described flow from the research questions concerning how 'dual diagnosis' discourse has evolved and what this means for the future of treatment, care and support for those affected.

Research influences

This research has been conducted from an interpretive perspective that assumes multiple constructed realities and embraces the value of exploring these. This perspective suits the research questions because 'dual diagnosis', as I have indicated earlier, is not a homogeneous or coherent entity and as such invites interdisciplinary exploration of multiple meanings. I believe that understanding drug use and mental health/illness depends on 'situated knowledges' or partial locatable, critical perspectives and shared conversations (Haraway, 2003, p. 30).

The two 'parent' fields, mental health or illness studies and alcohol and other drug studies, are not owned by any one academic discipline. While neuroscience and pharmacology illuminate the brain, and clinical psychology and psychiatry the cognitive-behavioural patterns of our lives, their respective visions are partial. In my view, solutions to the distress experienced by people struggling with mental illness and AOD-related problems require multidimensional approaches. The body of dual diagnosis research to which this thesis contributesmust encompass different epistemologies if it is to make sense to the widest possible range of interested audiences and enable understanding of the multiple social, biophysical and professional dimensions of dual diagnosis. It is called upon to take

account of beliefs about the human condition – the brain, mind and body, our rights and responsibilities; to grapple with the way social, political, health and welfare systems work; to consider the meaning of whole-of-population data and the distribution of health problems; to measure and understand risk and protective factors; to inquire into illness, causes, cures, and what works for whom in which circumstances, and the role of coercion or containment. With its focus on service systems, as expressed in the research question 'What are the implications of dual diagnosis discourse for service users, services, professions and governments, this study sits in the applied domain of 'health services research'. My aim is for the research to make sense to diverse players and to be a resource to support improvements in health and welfare. The research questions indicate the need for open, interpretive inquiry about the meanings of 'dual diagnosis' in the health service system.

Narrative and discourse analysis are inclusive concepts that enable consideration of dual diagnosis as seen through multiple epistemological lenses, whether philosophical, systems-oriented, epidemiological or clinical. I now discuss these two concepts in turn.

Narrative analysis – an aid to sense-making

Humans share an inclination to make sense of the world by constructing stories or narratives. Out of a perhaps random concatenation of events we construct beginnings, middles and ends, plots and protagonists. The word narrative has etymological roots in the Greek 'gnarus', meaning 'knowing':[9] story-making is a way of knowing. A story teller knows not merely certain events (actual or fictitious) but how to choose and organise them to *interest, instruct, or amuse the hearer or reader'.*[10]

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[9] The Chambers Dictionary 1993.
[10] Macquarie Concise Dictionary, 4th Edn, 2006.

Narrative analysts, put simply, build on this human propensity and use stories as an analytical frame for understanding how the teller is creating meaning. While this can be understood as an ancient way of knowing, 'narrative analysis' has become a distinct methodology in the contemporary era. It encourages explicit attention to context 'in the round' as opposed to disembodied content and themes. Arthur Frank (1995) uses patient narratives to disrupt medical perspectives; evaluative story collection and analysis are evident in nursing education, as in 'Critical Incident Technique' (Fisher, 2002; Koskinen, Mikkonen, & Jokinen, 2011), and in program evaluation's Most Significant Change Technique (Dart, 1999). As Catherine Riessman describes the process (Riessman, 1993, 2008), layers of interpretation are developed, building from the story-telling or written text, to the researcher's interpretive account and finally to the narratives that readers construct. In dialogic narrative analysis (informed by literary theory) the researcher explores how and why stories are constructed, reading them closely for context, assumptions, cultural traits, the teller's 'stake' (Silverman, 2001) and indications of what might be preferred or alternative narratives.

The argument for adopting narrative analysis as a methodological position is that it allows reflection on changes over time and, by elucidating the stories that exist at different levels and times, provides a rich framework for sense-making in a multifaceted and contested field. My interest was in development over time, from the inception of dual diagnosis studies in the 1980s, so there was potential for the informants, whose careers spanned the period, to construct their story of dual diagnosis from then to the present, and potential for the analysis to undertand the way people have made sense of dual diagnosis over the period and perhaps to shape an overarching story. Second, there were conflicts in the field that, it seemed, needed unpacking: clearly there were multiple stories to be told, with contrasting realities and varying themes and structures, both explicit and implicit. Together, the stories promised a richness that could illuminate and instruct.

Discourse analysis – analysing talk and text

Discourse analysis offers a focus on how people use language to construct identities and activities, encourages a close look at how words are used, how shared meaning is created, the role of various actors, and policy itself as an agent. Building on Foucault's insights Phillips and Hardy (2002) argue that discourse analysis has promise for the study of the fluid and contradictory dynamics of contemporary service systems. Its unique contribution is to 'insert the discursive level to understand how structured sets of texts and the practices of their production, dissemination and reception together constitute the social' (Phillips & Hardy, 2002, p. 86). Discourse analysis pays close attention to terminology and categorisation. An example of the way it can challenge the 'taken for granted' is Norman Fairclough's substitution of the term 'social wrongs' for 'social problems', because:

> *use of 'problems' is part of the self-justifying (and one might say ideological)*
> *discourse of contemporary social systems in countries like Britain. The*
> *objection to it is that some wrongs are produced by systems and are not*
> *resolvable within them.* (Fairclough, 2009, p. 186).

In other words, words that at first glance are innocuous can mask reality: in this case, that social 'problems' are not all naturally occurring but may be caused by the social system. In a similar vein, Richard Lakeman (2013) writes of the need to challenge scientific (or 'scientistic') discourse in the psychiatric field: he claims that the language of psychiatry evokes wonder, in order to maintain 'compliance' and faith in treatment in the absence of biological markers of disease and known aetiologies. Discourse analysis can thus offer a fresh and provocative view that challenges the dominant messages that suffuse our language.

In the present research, discourse analysis offered an approach to understanding the ways in which the coexistence of substance and mental health problems (not a new phenomenon) became constructed as 'dual diagnosis' by professionals and policy makers. I have construed 'dual diagnosis discourse' as the language associated with dual

diagnosis policy and practice, a language that serves social, ideological or political interests.

This study has balanced an eye for text with an eye for context, in applying discourse analysis to policy document review and the analysis of interview transcripts. At the micro level, the text of metaphors has demanded attention – as in 'no wrong door', 'the blind men and the elephant' – and nuances of terminology (such as 'mental health person', in the first story quoted above, standing for a 'worker in a mental illness service'). The broader view of discourse,considering contextual dnamics, has been prominent when informants describe power relations. I use this lens when considering how a document or the content of an interview expresses social or moral positions and views of the world (Perakyla, 2005).

Narrative and discourse analysis complement each other. Both narrative and discourse analysis have been useful and complementary frames of reference for this study. As I have illustrated, a narrative brings together events, moods, environments, undertones and overtones into a rich whole that is appreciable on multiple levels at once and which may provoke thought, dialogue and action. Discourse analysis includes but does not emphasise distinct narratives in its exploration of how language works in society. The two approaches work together, in that narrative analysis provides understanding of broad themes and change over time, and discourse analysis takes the focus to issues of terminology and social relations. Both were used to compare and contrast informant perspectives.

Thus a bricolage of schools and authors has contributed significantly to my understanding of this study, the design of the overall research project, my understanding, reflections and interpretations of participant interviews and the bringing together of findings from this study with the larger body of knowledge. This section has indicated the research territories of the papers that form Chapter Four.

Design and methods

This section of the chapter expands on the published articles' necessarily brief account of my methods. In particular I present the design rationale, finer detail of the processes of data collection and analysis, and some dilemmas and criticisms that arose. I summarise the general quality of the study's design and conduct.

Overview of design

The study adopted a case study design (depicted in Figure 2) including a review of sociological and clinical research literatures, policy document analysis, observation of dual diagnosis forums and conferences, and interviews with key informants. Qualitative analysis considered narrative and discourse. Key informants validated preliminary findings by means of an online questionnaire.

The case: 'Dual diagnosis' in the State of Victoria

Literature review

Policy document analysis

Key informant interviews

Online informant questionnaire

Iterative analysis

Peer-reviewed papers

Thesis by publication
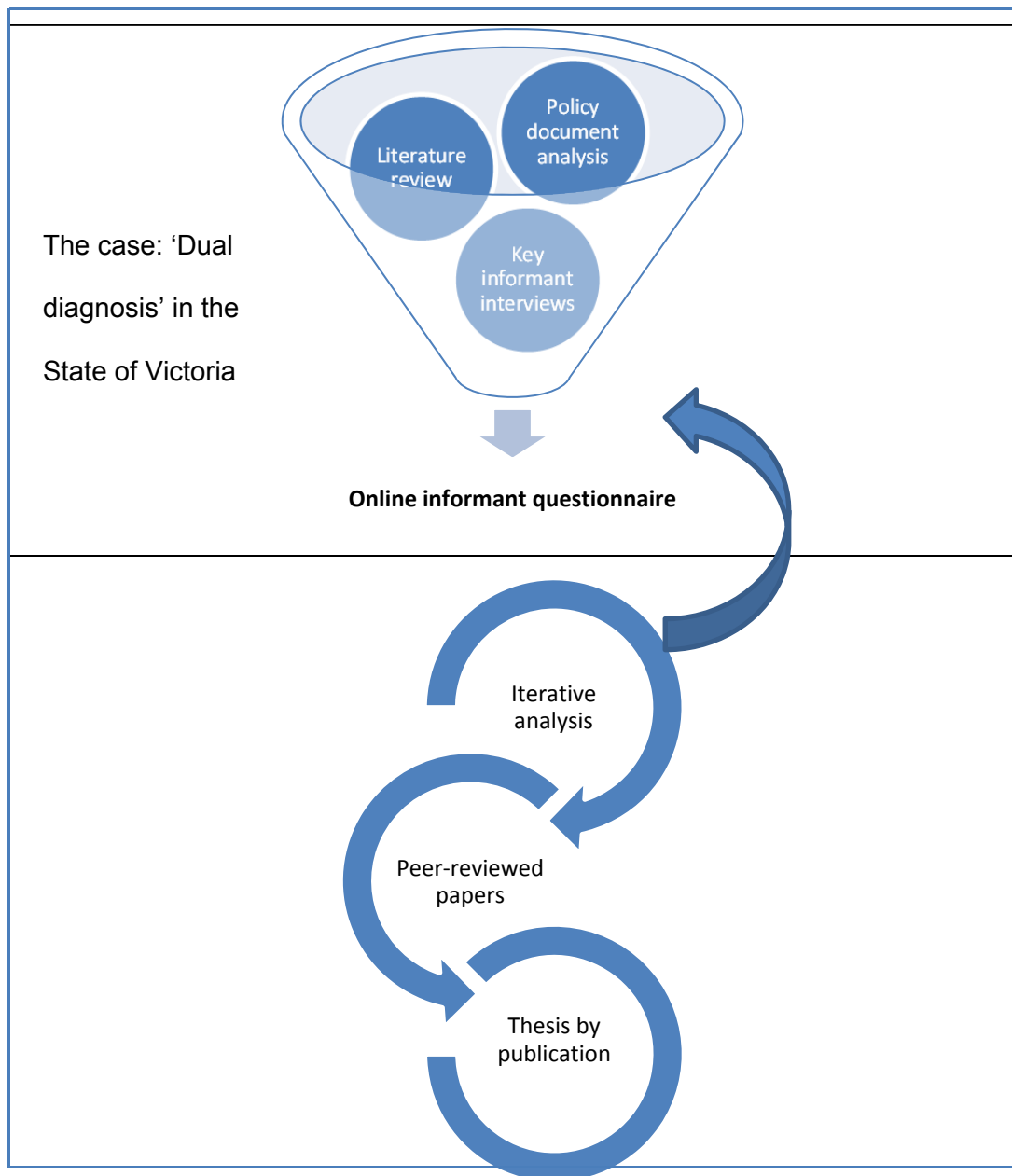
Figure 2: Diagram of case study design showing the input of four sources of data (including informant online questionnaire) and iterative analysis leading to published outcomes.

Case study

Describing my project as a case study has been useful in a number of ways: it has given the study a geographical and institutional boundary (the State of Victoria) that has enabled energy to be focused and experientially grounded, when the complications and complexities of the topic of dual diagnosis exert a strong pull towards universally imponderable questions. This was the promise offered from the beginning by methodological scholars (Gillham, 2000; Stake, 2005; Yin, 2008). Robert Stake writes of making 'the realities of the particular landscape' the primary focus for consideration of

complex social phenomena (Stake, 2005): the approach allows for description, exploration and explanation of contemporary events and their contexts, and the explanatory logic is developed from analysis of rich and unique detail.

Case study purposes and associated designs occur along two continua – the number of cases may be one or many, and the purpose ranges from understanding uniqueness (the 'intrinsic' case study) to generalisation or theory-building (Stake's 'instrumental use' of case study). In Stake's view, the researcher in a good intrinsic case study asks what is important about the case within its own world (Stake, 2005, p. 450). In other words, it works inductively towards generalisations, rather than deductively beginning with preconceived theories and coding frameworks. An intrinsic case study, in Stake's terms (2005, p. 450). includes rich detail presented in a way that allows the reader to understand the researcher's interpretation and also to reach his or her own interpretations:

The particular problems or challenges of framing my project as a case study are fourfold: managing expectations; boundary-setting; partiality; and lack of data. First, there were twin risks in terms of expectations: raising expectations of a richness and comprehensiveness that were beyond the study (not everything can be described, so the ultimate picture reflects the information received from participants, and the researcher's judgement) and on the other hand I needed to manage the more positivist social scientific expectations of the instrumental purpose and use of the case study, that is to build theory, at the possible expense of exploring and understanding the important intrinsic features of the case. Second, the case study literature warns of the risk of expanding the boundaries of the case beyond a single researcher's comprehension, so that it is not experientially knowable. The third, and related, challenge was exposure to the charge of bias in the selection and presentation of detail. For example, the case of Victorian dual diagnosis has numerous potential sub-cases – individual service users, the acute mental health sector, the AOD sector, the psychiatric disability sector, the dual diagnosis teams and the health professions – and within these categories there are multiple perspectives and realities. To

ensure a fair account, data collection, management and analysis had to be transparent and disciplined in order to present 'experiential knowledge' rather than opinion and preference (Stake, 2005, p. 455), and the researcher's standpoint had to be made clear (Lincoln and Guba, 1985; Malterud, 2001). Finally, case studies frequently draw on quantitative as well as qualitative data. Hopes of being able to present and critique outcome data were soon abandoned: there are no trustworthy estimates of changes in the service system's responsiveness to dual diagnosis through the period of the study.

In summary, this study takes as its case the gradual emergence and early implementation of dual diagnosis policy in the State of Victoria from the years of the first national mental health and drug strategies to the present – a period of some 25 years. It is thus bound in space and time and forms a case for the description and analysis of intersectoral differences. Conducting the study posed significant challenges.

Data collection and analysis

Turning now to the details of the study's data collection, I briefly address the purpose, rationale and process of literature review, policy documentanalysis, and semi-structured interviews.

Literatures

A range of literatures was explored to inform answers to the research questions, 'Why did dual diagnosis discourse emerge in Victoria', 'How did it evolve in the two specialist sectors?, and 'What are the implications for service users, services, professions and governments?' Systematic searches of the medical and health services research literature were helpful in charting the history, rationale and context of dual diagnosis initiatives. Sociological and philosophical texts informed conclusions about the meaning of the emergence of the discourse for the future of treatment, care and support for those affected. Literature searches of multiple databases used key terms relevant to the overarching topic and then to particular issues arising from key informant interviews, such

as managerialism, specialisation, and interprofessionalism. 11 Iterative literature searching and reading occurred throughout the study since its inception in 2009. Wide reading around the subject of dual diagnosis is reflected in a coded and annotated EndNote library.

Policy documents

The purpose of reviewing policy documents was to create a narrative of the emergence of 'dual diagnosis' policy discourse over about two decades and to reflect on their role in constructing 'dual diagnosis' and their representation of change or progress. The rationale was that policy documents would describe principles and plans, evaluation reports and policy commentaries would reflect actual high-level achievements and debates; all would demonstrate changes in the discourse over time.

I assembled a library of national and state MH and AOD policies, strategies and related evaluation reports (listed in Appendix 4). After a preliminary scan of their content I systematically searched them for references to dual diagnosis (and related terms) and developed spreadsheets for ease of analysis. These included a chronology of relevant events and publications, including those from the international discourse. I noted references to dual diagnosis (or synonyms) over the years, their density, and the models that were explicit or implicit. Other initial variables of interest were references to the evidence base, and policy statements on coordination or integration of services and on the concept of whole-person care.. Later I tabulated the frequency of references to the 'other' condition (that is, references in mental health policy to alcohol and other drugs, and to alcohol and other drugs in mental health policy). In a 'softly' quantitative exercise, I calculated the proportion of relevant paragraphs per page of each document, in order to chart the relative intensity of references to dual diagnosis.

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[11] See Appendix 2 for further detail

Interviews

Choice of informants

The method of selection was 'purposeful', also known as 'purposive' (Patton, 1990, 1997). The main criteria for selection of participants in semi-structured interviews were that, first, they were of a certain generation of mental health or alcohol and drug practitioners who had experienced the many changes in the Victorian service system over the 25-year period and second, they had reached positions of authority, as leaders in policy development, service management and/or clinical expertise. These people had stayed with the challenges of a field where innovation and research continue but problems remain vexed and efforts attract little prestige, if not active stigma. I wanted to find out what such people said when invited to take a step back and reflect on the changes they had seen.

With these principles in mind I began with maximum variation sampling. Based on my direct knowledge of the field as an evaluator and my reading of published and grey literature I developed a list of 52 potential participants, cross-referenced by gender, discipline, experience in one or more relevant roles, and by degree of involvement with specific dual diagnosis initiatives (some had been,for example, in designated dual diagnosis roles for many years, while others were positioned in either of the specialist sectors). I ranked them in order of priority for interviewing based on the intensity of their involvement with dual diagnosis ('high', 'medium' and 'low') and to maximise diversity of perspectives, with the aim of achieving a variety of well-informed perspectives from different sub-sectors of the field in the State of Victoria.

The second and minor sampling method was snowballing. At the end of each interview I asked the informant to suggest three other people I should invite to interview. Their answers expanded the database to 60 and confirmed that the sample was basically well-founded, as many interviewees suggested informants who were already on my shortlist. Two interviewees were added as a result of recommendations by participants. Others (six)

suggested by interviewees either felt they did not have enough direct experience of my topic (which I established by approaching them), or had retired and I was unsuccessful in locating them.

Table 1: Characteristics and number of key informants

	Candidates identified (n=60)	**Sample interviewed (n=19)**
Public servants/politicians, State of Victoria	17	3
Health and welfare service providers	36	14
Consumer advocate/researcher	7	2
Major focus on dual diagnosis	21	4
Major focus on AOD services or policy	16	6
Major focus on mental health services or policy	23	7
Gender	29 f, 31 m	10 f, 9 m

After preliminary analysis of 19 interviews I determined that the transcripts contained enough varied insights to enable interpretation and illuminate answers to the research questions. On balance, I determined that further interviews would not add substantial material and thus not warrant the burden placed on informants.

The 19 participants included senior policy executives (3), service providers (14) and consumer researchers (2) from a range of professional backgrounds. All the service managers had a background in a health profession: social work, occupational therapy, psychiatry, psychology, and general, psychiatric or drug and alcohol nursing. Seven could be described as speaking mainly from experience in the MH sector and six from an AOD sector perspective, with four additional participants experienced in both. Of the five

currently or recently employed in positions funded by the Victorian Dual Diagnosis Initiative, four had moved from a mental health service position and one from the alcohol and other drug sector: this reflected the relative size of the two workforces.

Table 2: Professions and recent positions of informants

Profession	Number of informants (n=19)
Psychiatric nursing	6
Social Work	4
Psychology	2
Psychiatry	2
Occupational therapy	1
Physiotherapy	1
Nursing	1
Other	2
Most recent position related to mental health or alcohol and other drugs	
Policy executive, State government	3
Service manager (MH or AOD)	7
Dual diagnosis clinician	7
Consumer researcher	2

A reader may question why consumers/service users were not informants in this study. Were their views on service systems and professional interests not relevant? I remain convinced that their views are paramount but the principal focus of the study was policy and professional discourse. The scope and resources of the study did not provide for authentic and ethical consumer involvement, which entails a participatory research approach, power sharing and adequate resources, including time, education, training, psychological and other support. I also took the view that my study did not warrant

intrusion into their experiences with the service system. I therefore chose to focus on experienced workers in the sector and documentary evidence from the last 25 years.

Consent

Invitations to participate in interviews were sent to a purposeful sample of potential key informants. Informed written consent was sought for voluntary participation in a 30-60 minute interview (in person or by telephone) and optionally for each subsequent activity: audio recording, review of the interview transcript, a follow-up interview, review of preliminary findings and identification as a participant in publications. (See Appendix 4: Information sheet and consent form.)

Interview format and structure

A key informant to this study commented on ways of conducting clinical assessment interviews:

> *Some people sit with the assessment form on their knees and it might take two hours but they'll write it down verbatim, go through page by page – and then you don't get the narrative and you miss so much! … … When people stick rigidly to a questionnaire - I know myself, if someone asks me a question, my mindset's there... but if you're telling a story it all comes up* (Key informant 19).

This description is equally applicable to the preferred approach for this study, namely to encourage reflection and story-telling. I used a degree of structure: an interview guide (Appendix 2), developed in the initial stages for the submission to the Human Research Ethics Committee, remained relevant and useful throughout. It notes that the researcher will have informed herself of the participant's career and published views, will pose open-ended questions to invite recall of key events in the history of the period, followed by reflections on the meaning of key concepts (such as 'dual diagnosis' and 'integration') and commentary on the benefits, limitations and future of dual diagnosis policy, including the question 'Who are the winners and losers in dual diagnosis discourse?' Generally the informants covered these topics naturally without prompting, with the exception of the 'winners and losers' question, which proved useful as a summing-up question.

The assumption in the interview process was that each participant had an unique story and the authority of special knowledge. The interview approach was relatively open so that the informants' own structure, based on extensive knowledge and experience, could dominate (Stephens, 2007; Zuckerman, 1972). The length of the interview, between half an hour and two hours, was determined by the informant. All informants, whatever the length of the interview, appeared intrigued by the research topic and expressed considerable interest in wherever it might lead.

To give some further context for the interviews, it is worth noting when and where they were conducted. I arranged and conducted the interviews myself, meeting the informants at a mutually convenient time and place or by phone. The interviews took place between February 2010 and November 2011, with most clustered in mid-2010. The locations of interviews included the offices of an alcohol and other drug service, a community mental health centre, a national office, a back office in a suburban general hospital, a city hospital administration wing, a public health research centre, the Department of Health, and the rooms of two private practices – all in various parts of Melbourne, Victoria.

Transcription and checking

I transcribed the interviews rather than using a transcription service. While this was a relatively slow process it had the advantage of making sure I became completely familiar with the content of each interview. The rules I adopted for transcribing were to (a) exclude most hesitations and 'ums and errs' (b) note such traits when they seemed to indicate stronger feelings, or doubt about the 'facts', and (c) 'correct' some words when the intended meaning was obvious from the context, the most common example being contradictory negatives. I edited the participant's exact words only after listening and replaying the section several times. This approach to transcription was a layperson's, in relation to the field of conversation analysis, discursive psychology and critical or historical discourse analysis, where the way the interviewee speaks (for exmaple their pauses,

pitch, emphasis, breathing, and tone) is indicated by symbols in the text (Neufeld, Marchessault, & Dean, 2006; Oliver, Serovich, & Mason, 2005; Perakyla, 2005).

In taking this approach I was applying the first steps in interpretation and risked erasing the performance of the interview. Theoretically, a transcript by another person could have produced different knowledge and insights (Fairclough, 2009). Indeed, a transcript by a trained Hansard writer would have been a polished version and may have been preferable for the participants: when they read their transcript, several felt the need to apologise for their rambling thoughts, or for their incomplete sentences. Nevertheless, each endorsed his or her verbatim interview transcript, with four providing minor amendments for clarity and accuracy. Based on this feedback, the transcripts were ethically acceptable and fit for purpose.

Analysis with informant participation

Analysis of the primary and secondary data was incremental and iterative. For example, a close reading of an interview would lead on to relevant research sources to further illuminate a theme or idea. The understanding gained then informed a re-reading of that and other interviews. Developing my thoughts through writing papers also led me back to the interviews and the literature. An important part of the analytical cycle was reflective sharing with others, whether supervisors, peer reviewers, conference delegates or peers. The linear form of the process was however to move from preliminary coding to an online survey of informants and thence to testing findings and conclusions with peer reviewers and completing publications.

Preliminary analysis - interviews

Analysis of interview material entailed reading and re-reading the 172 pages of transcript to distil the key themes, common and contrasting narratives and use of key terms. Both manual and computer software (QSR NVivo) data management techniques proved helpful.

Initial inductive manual coding resulted in a hard-copy matrix of informants against the following themes: the history of the mental health service system, professionalisation, trends in relevant disciplines and sectors, mental health practitioners' attitudes to alcohol and other drugs, alcohol and other drugs practitioners' attitudes to mental health problems, relationships between mental health and AOD practitioners, 'what works' and, finally, the metaphors used to describe the dynamics of dual diagnosis discourse. A further step was colour-coding to explore sub-themes and any differences among sub-groups of informants. This analysis contributed to findings on why, when and how dual diagnosis discourse had evolved and to understanding of the background to the attitudes of practitioners to other service sectors.

A second coding exercise (conducted in NVivo) focused on the question of the implications of dual diagnosis discourse for service users, governments and the relevant service providers in the mental health, psychiatric disability and AOD sectors. Responses were mainly but not exclusively elicited by the question 'Who do you think has benefited from a focus on dual diagnosis, and who has missed out?' (Appendix 2, Page A-19) summarises findings from this exercise.

Third, in order to develop a historical account of the evolution of dual diagnosis discourse, interview texts were coded by the approximate date of incidents recalled and stories told. Further coding distinguished negative experiences of the system from stories of positive change.

After synthesis with the literature review and policy document analysis, this analysis produced interpretations and outstanding questions in a form which could be offered to participants for feedback and further comment.

Feedback loop – an online survey

An adaptation of the classical Delphi process (Rowe & Wright, 1999) facilitated further responses from key informants and confirmed areas of consensus and contradiction. From the preliminary analysis I developed deidentified key propositions relating to the

reasons for and implications of the emergence of dual diagnosis discourse. Multiple-choice and open questions included 'Why did "dual diagnosis" emerge in Victoria as an issue in the early 1990s?' and a series on benefits and concerns in relation to dual diagnosis discourse in Victoria. The questionnaire (reproduced in Appendix 2) was designed for online completion and all informants received an email invitation with an appropriate link. Thirteen informants (68%) responded. Follow-up inquiries established that two of the six non-respondents had moved to a different health sector and one had retired.

Results are shown in Appendix 2.

Writing

In consultation with my supervisors I made an early decision to write papers for publication rather than a single thesis dissertation or monograph. This suited my preference for prompt application of the learning as it emerged, and for testing ideas with peers, through the review process.

The most striking issue in the interviews was, it seemed, that of interprofessional hierarchies and turf issues, and the notion that dual diagnosis discourse might be serving institutional interests before those of service users. This then formed the core of the first article. Thereafter I formed a plan to write about the discourse's origins and development, and the implications for the two sectors. The process of writing was thus inductive, building on analysis and reanalysis of the material and following lines of inquiry as they arose and resonated with my knowledge and experience.

Conclusion

The above account of the research design and methods has outlined throughout the techniques used to enhance quality. In undertaking the project, I was aware of debates about the criteria for evaluating qualitative research. The approach adopted is guided by criteria developed by Yvonna Lincoln and Egon Guba (1985) and, along with similar proposals (Patton 1990, Malterud, 2001) widely accepted in health services research. The assumption is that the trustworthiness and value of the findings is supported by

techniques to enhance their credibility (as in 'do they make sense?'), transferability (is the learning applicable to other contexts?), dependability (is there enough description of the context and method?) and confirmability (is the researcher's standpoint clear and is there an audit trail?).

Taking these criteria in turn:

- Credibility of findings was enhanced through: my reflective engagement with the field and the study over a number of years; interpretation that drew on multiple perspectives or voices as well as literature and document review; the checking of preliminary findings with key informants ('member-checking'); and consideration of competing plausible narratives. The choice of a purposeful sampling process yielded a partial set of observations: the sampling frame's narrow focus on mid-level management of the community based treatment system excluded many perspectives that are also important, such as those of consumers and those around them, those of current front-line staff and those of offenders in the forensic mental health system and the professionals who work with them.

- Transferability was aided by describing the unique context of the study, to enable readers to make their own judgements. Framing the project as a single intrinsic case study of dual diagnosis discourse in one jurisdiction and in the community based services set obvious limitations but also allowed depth.

- I have aided confirmability and dependability through a reasoned outline of the research process and provision of supporting working documents.

This chapter has described the influences on this qualitative social inquiry. It has detailed and reflected on the research design and methods, to make as transparent as possible the source of the study's claims about dual diagnosis discourse and its implications. Findings are consistent with and add to other work on organisational and system change

in this field e.g. (Mitchell, 2009; Novotná, 2013; Padwa, Larkins, Crevecoeur-Macphail, & Grella, 2013; Sacks et al., 2013). I argue that the deliberate boundaries of the case study allowed for rich exploration that is appropriate given the sparsity of critical research on the emergence of dual diagnosis discourse.

Chapter 4: Findings

Introduction

The study's results are developed in the five journal publications that form the body of this chapter. They are organised in a sequence that unfolds a story of dual diagnosis discourse in Victoria from its beginnings to the present. Each paper is briefly introduced below.

This narrative of dual diagnosis begins with *The seeds of dual diagnosis discourse (*Roberts, 2013), in which I examine the emergence of the concept of dual diagnosis, the context in which it emerged and the motivations for its development. The paper explores the years of extensive structural and political change affecting the mental health and AOD sectors in the late 1980s and early 1990s in Victoria, including deinstitutionalisation, mainstreaming, tendering out of health and human services and attendant issues of competition. I argue that multiple factors beyond the often-cited closure of psychiatric hospitals were bringing dual diagnosis gradually towards the front of the stage.

I then take the narrative through the next 20 years: the second paper, *Reflections on capacity-building initiatives* (Roberts, Maybery, & Jones, 2013), considers the way dual diagnosis discourse has evolved and developed. I analyse developments aimed at improving the ability of specialist services to apply a 'no wrong door' policy to their practice and identify the principal helping and hindering factors which have influenced the policy's implementation, briefly reaching beyond the dual diagnosis sector to reflect on the implications of these findings for other health sectors.

The findings then move from the development and temporal implementation and progression of dual diagnosis to focus on interprofessional relationships within the sector. *Interprofessional relationships in dual diagnosis discourse in an Australian State: are we respecting each other yet?* (Roberts, 2012) addresses the earliest and most prominent

theme to emerge from my research, exploring the relationships between the different practitioners in the sector.

In the fourth and longest publication *Dual diagnosis narratives and their implications for the alcohol and other drug sector in Australia* (Roberts & Jones, 2012) I focus specifically on one side of the dual diagnosis treatment divide to identify three narratives of dual diagnosis at play in this sector, each portraying a different trajectory for dual diagnosis work. I argue for a combination of the strengths of the differing narratives in a metanarrative that has strong potential to influence structural reform.

In the final publication, *Dual diagnosis discourse in Victoria Australia: The responsiveness of mental health services* (Roberts & Maybery, 2014), I focus on the other side of the dual diagnosis divide and the efforts to develop appropriate practice in acute mental health services. The paper adds to the evidence for improving quality control and interdisciplinary, intersectoral workforce development with a focus on patient strengths and recovery within an integrated health and social support system.

The findings in the publications derive from analysis of relevant literature, policy documents and interviews. Supporting information is included in the thesis appendices. As an introduction to the publications a summary of the key policy milestones in the period appears below. This is drawn from my analysis of the treatment of the dual diagnosis question in government policy documents and policy evaluations released since 1985 (listed in Appendix 2). It offers a temporal context for the developments I discuss in the papers and indicates the evolution of the different sectors in relation to each other and the emergence of dual diagnosis-oriented policy.

The year 1986 in Victoria saw the Mental Health Act formalise the deinstitutionalisation of psychiatric hospitals and the expansion of care in the community for a greater number of people. In the same period, the national and state governments increasingly shared in the development of health and human services. In 1985 the first national drug strategy was launched and in 1992 the first national mental health policy and plan. In successive

policies, plans, strategies, frameworks, service standards and initiatives since 1985, the espoused vision becomes more explicitly of a social model of health, incorporating health promotion, prevention and early intervention, continuity of care and the idea of joined-up, whole-of-government strategies. As highlighted in Table 3, the issue of service coordination is omnipresent and solutions are variously seen to lie in linkages, case management, partnerships, capacity-building and networks. It is clear from early in this period governments were challenged by the problem of service fragmentation. Another main message from the body of policy documents is that people experiencing dual diagnosis, ignored in the early years, became a priority group for service expansion and improvement.

Table 3: The theme of coordination and integration in Australian and Victorian mental health and alcohol and drug policy 1985-2011

Year	Policy/Strategy	Relevant priorities	Reference to 'the other'
1985-86	Victorian Mental Health Act (1986) and 'New Directions for Psychiatric Services in Victoria' policy	From institutional care to community care, citizenship and human rights for the seriously mentally ill. Service **coordination**	None
	National Campaign Against Drug Abuse, later 'National Drug Strategy' (NDS); Victorian Drug Strategy	Harm minimisation, population health	None
1992	First National Mental Health Policy and Plan (1992-1997)	Mainstreaming into general hospitals to improve quality and reduce stigma	None

Year	Policy/Strategy	Relevant priorities	Reference to 'the other'
1993	NDS 1993-97 'The Drug Offensive' Victorian Drug Strategy 1993-1998	**Intersectoral** action	'People with psychiatric problems' are a priority group,
1994	Victoria's Mental Health Services - Framework for service delivery	'To put people first, rather than institutions or systems.' **Formal links** re disability, AOD and child welfare	'Substance abuse' now 'more common'. Services will be provided for DD but 'Mental health services on their own have neither the skills nor the facilities to treat, manage or rehabilitate people with drug or alcohol dependence. Intervention for serious mental illness cannot reasonably commence until the dependence is being suitably managed.' (p. 41)
1996	National Mental Health Standards	Quality improvement	'The mental health service ensures access to a comprehensive range of treatment and support services which are, wherever possible, specialised in regard to dual diagnosis.' (p. 24) Notes and Examples: **Dual case management** with alcohol and other drug services.
1997	Victoria's Drug Treatment Services: The Framework for Service Delivery	Define the components of the specialist drug and alcohol service system (competitively tendered)	Effective **case management** processes will be critical to achieving and maintaining continuity of care for clients, including cases where clients have **linkages** with other services such as accommodation, child welfare, disability or mental health services. (p. 3) 'Dual disability' is 'well recognised'. (p. 24)
1998	Second National Mental Health Plan	Promotion and prevention, **partnerships** in service reform and delivery, and quality and effectiveness	People with complex needs – a priority group.
1998	National Drug Strategic Framework 1998-1999 to 2002-2003	'Building **partnerships**'	'Specific strategies to meet the needs of individuals with co-existing mental health and drug problems – through the coordination of drug treatment services, mental health services and mainstream health services'. (p. 7)

Year	Policy/Strategy	Relevant priorities	Reference to 'the other'
1998	Victorian 'Working Together Strategy'	Quality improvement in MH, AOD, Youth, Justice sectors – youth focus	'**...** attention has been increasingly drawn to the frequent coexistence of mental illness, child abuse, juvenile crime, substance abuse (and other) problems and the need for an official plan to respond to clients who need two or more such services'. (Sec 5)
2001	Victorian Dual Diagnosis Initiative. National Comorbidity Collaboration	**Capacity-building**	State and national initiatives – education, training, research, local change agents (**dual diagnosis teams**).
2002	Victorian Mental Health 'New Directions'	Respond to 'increasingly complex consumer needs'	Expansion of existing **dual diagnosis programs** for young people. (p. 18)
2003	Third National Mental Health Plan	Adopting a population health framework	Framework recognises the effect of mental illnesses occurring comorbidly with drug and alcohol problems and other conditions, and need for **collaboration and linkages.** (p. 9)
2006	Victorian 'Dual Diagnosis: Key Directions & Priorities for Service Development'	**DD capability** across MH and AOD	Formalises and consolidates the approaches adopted by the Victorian Dual Diagnosis Initiative, mandates MH and AOD sectors to become dual diagnosis capable.
2006	National Action Plan on Mental Health	Comorbidity	Funding for the Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative, January 2008 – December 2010 - Local **capacity-building** projects in the non-government AOD sector.
2008	National Mental Health Policy revised	**Whole-of-government** focus	Is explicit about dual diagnosis and complexity

Year	Policy/Strategy	Relevant priorities	Reference to 'the other'
2008	Victorian Mental Health reform strategy 'Because Mental Health Matters 2009-2019	'mental health and mental illness as everyone's business' 'prevention, early intervention – in life, illness and episode – recovery and social inclusion' (p. 7)	Outlines an **integrated, networked vision**. Contains many more paragraphs where AOD problems are mentioned and solutions proposed (over 100 in 11 pages compared with 23 in the 90-page Fourth National Mental Health Plan, and less than 12 in other mental health or AOD policies).
2009	4th National Mental Health Plan: *An agenda for collaborative government action in mental health 2009-2014*	Service access, **coordination** and continuity of care	Outcome: There is greater recognition and response to co-occurring alcohol and other drug problems, Expand community based youth mental health services which are accessible and combine primary health care, mental health and alcohol and other drug services (page v). Improve **linkages and coordination** between mental health, alcohol and other drug and primary care services (page vi).
2010	National Mental Health Standards	Quality improvement	'The Standards apply to ATOD services that are part of a mental health service. For stand-alone ATOD services, mental health services should be able to demonstrate that they are developing or have **collaborative /partnership** arrangements in place to ensure **integration and coordination** of care for consumers.' (p. 3)
2011	National Drug Strategy 2010-2015	Building **partnerships** across sectors	Those who are most at risk are people with multiple and complex needs. (p. 14) One of four structural priorities: 'Continued work is needed with the mental health sector to improve **links**'. (p. 12)

The seeds of dual diagnosis discourse in an Australian State (publication)

Monash University Declaration for Thesis Chapter Four

Declaration by candidate

In the case of Chapter Four publication *The seeds of dual diagnosis discourse*, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Concept, research, all drafts, revisions after peer review	100%

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate's and co-authors' contributions to this work.

Candidate's Signature	██████████████	Date

Main Supervisor's Signature	██████████████████	Date

The seeds of dual diagnosis discourse in an Australian state

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The problem of 'dual diagnosis', the co-occurrence of mental health and substance use problems, while far from new in human experience, has become in recent decades a focus for research, policy and practice internationally. This article inquires into the emergence of dual diagnosis discourse in a particular place and time, the State of Victoria, Australia in the early 1990s, and reflects on implications for current health service practice and administration. An interpretive approach draws upon the research literatures, analysis of policy and related documents and interviews with a purposive sample of 19 stakeholders, conducted during 2010 and 2011. Qualitative analysis indicated that the main initial impetus was a perceived increase in the exclusion of people with severe concurrent mental illness and substance use problems from specialist services. Contributing factors included deinstitutionalization, the restructuring of government funding and professional interests. We conclude that 'dual diagnosis' offered a scientifically and politically acceptable window of opportunity to lobby for better support for a stigmatized, marginalized population. Reflecting on the emergence of the concept of dual diagnosis resonates with today's concerns about person-centred care and highlights enduring systemic challenges in providing continuity of care among services divided by diagnosis and fragmented funding.

Keywords: Australia; comorbidity; deinstitutionalization; managerialism; dual diagnosis; qualitative health systems research and evaluation

Introduction

This paper is an interpretive analysis of the beginnings of dual diagnosis discourse in Victoria. It explores the social and political landscape in the late 1980s and early 1990s to illuminate the features that gave dual diagnosis a toehold on the health policy agenda. Analysing the emergence of dual diagnosis as a concept provides a rich and nuanced understanding of a powerful and still-current concept which reflects social, economic and health system trends and highlights the unrealized potential of service provision in mental health (MH) and alcohol and other drug (AOD) treatment in Australia. The paper first outlines the appearance of the term 'dual diagnosis' in research literature and policy and introduces a significant moment of its emergence in Victoria. I then describe the research method, which draws on a range of literatures, policy documents and interviews with key professionals. In presenting results, I link informants' accounts, based on early- to mid-career

recollections of the period, with relevant literature and policy and proceed to the discussion of the relative meaning of several proposed antecedents of dual diagnosis discourse: a general increase in prevalence, deinstitutionalization, New Public Management (NPM) and biomedical professional trends. The paper ends with questions about the pertinence of these explanations to today's needs.

What is 'dual diagnosis'?

'Dual diagnosis' began to appear in the US literature from the later 1980s (Kofoed, Friedman, & Peck, 1993; Lehman, Myers, & Corty, 1989; Minkoff, 1989) as a shorthand term for coexisting severe psychiatric and substance use problems. In Australia, the term 'dual diagnosis' was adopted and retained in Victorian state discourse (Department of Health and Community Services, 1994) while the preferred national-level terms have been 'comorbidity' and the more explanatory 'co-occurring substance use and mental health disorders' (Teesson & Burns, 2001). There is general agreement in the Anglophone literature that the phenomenon was not in fact new in the 1980s, that the conditions referred to are diverse and significant and that they are associated with complex physical, psychological and social difficulties for a wide range of sufferers and those around them (Rush, Fogg, Nadeau, & Furlong, 2008; Staiger, Long, & Baker, 2010; Teesson, Slade, & Mills, 2009).

A major facet of the problem of dual diagnosis is the fragmentation of relevant services and principally the separate organization of services for people with severe mental illness from those for people with AOD problems. Kenneth Rice (1989) was an early author and Dan Lubman a more recent one (Lubman, Hides & Elkins, 2009) to argue that the issue is one of 'dual programme' rather than 'dual diagnosis' as there are many co-occurring disorders (such as anxiety with depression) that do not raise the question of exclusion from services. Concern about coordinating or integrating services through better screening, assessment and case management has been a theme of the dual diagnosis literature from an early stage (Carey, 1989; Lehman et al., 1989; Minkoff, 1989) and continues today (Brousselle, Lamothe, Sylvain, Foro, & Perreault, 2010). More broadly, better integration between physical and MH care is advocated (Kathol & Clarke, 2005), coordination with the justice system makes sense (Osher, 2008) and primary health care needs to be supported to respond to the many people who present with dual diagnosis or other complex needs (Swerissen, 2002).

The beginning in Victoria of concerted action by political, professional and service user networks to prevent people with dual diagnosis from falling through gaps between services was marked by a two-year state-funded action research project and report, entitled 'Not Welcome Anywhere' (McDermott & Pyett, 1993, 1994). In their 1993 report, the project authors considered several factors to be at play in bringing to a crisis point the difficulty of treating and caring for people with dual diagnosis. These were deinstitutionalization, lack of adequate support in the community, the separation of MH and AOD services, lack of clarity about which sector should deal with clients with these dual problems and the current economic recession and consequent budget restrictions (McDermott & Pyett, 1993, 1994).

This paper explores perspectives on these and other possible factors in the development of dual diagnosis discourse and policy in Victoria. Reflections on the

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situated 'talk and text' of dual diagnosis suggest conclusions on the meaning of dual diagnosis discourse 20 years on and ways in which the findings may apply to general questions of health service fragmentation.

Methods

This article takes an interpretive, historical approach, drawing on analysis of sociological and clinical research literature, policy documents and the perspectives of key informants in a case study of dual diagnosis policy in Victoria, Australia. The methodology recognizes the situated knowledge of researcher and informants. The informants were purposively selected, based on my knowledge of the local context, to offer insights into threads in the discourse. The primary data for this paper comprises 19 in-depth interviews conducted by the researcher during 2010 and 2011 with senior bureaucrats (3), service providers (14) and consumer researchers (2) with expert knowledge and experience of relevant developments in the field of dual diagnosis in Victoria throughout recent decades. From a range of professional backgrounds, seven could be described as speaking mainly from experience in the MH sector and six from an AOD sector perspective, with four experienced in both. Of the five currently or recently employed in VDDI positions, four had moved from a MH position and one from AOD. Each participant validated his or her interview transcript. Thirteen also provided written answers to a follow-up consultation on the question 'Why did "dual diagnosis" emerge in Victoria as an issue in the early 1990s?' The responses were then analysed with further reference to the literatures. Qualitative analysis was both manual and aided by a computer software package (QSR International NVivo). Thematic, discourse and narrative analysis (Perakyla, 2005; Riessman, 1993; Silverman, 2001) proved useful in iterative study of the text and relevant literatures. Literature searches focused on analyses of deinstitutionalization, mainstreaming, managerialism, specialization and integration. The study was approved by Monash University Human Research Ethics Committee.

Results

This section introduces informants' perceptions of the early influences leading to a dual diagnosis movement. It draws on the literature and policy perspectives to discuss each proposed influence, working from the most commonly discussed influences, namely that people with dual problems were more visible, particularly during deinstitutionalization, to those less noticed, namely public sector reform and trends in the treatment sphere.

People with dual diagnosis were more visible

Key informants recalled that there was, in the early 1990s, a perceived increase in the number of people with severe concurrent mental illness and substance use problems who were excluded from specialist services. Government health department officers were receiving service users' and carers' complaints about 'lack of access, poor integration, and differing responses' (Key informant [KI] 16). Clinicians based their views on observation, as in [the problem] was 'staring us in the face' (KI 12) and dramatic, publicized events raised the profile of drugs and psychosis:

> You had a lot of psychotic *pe*ople living out on the streets and in poor accommodation
> where there was a lot of substance use happening, so they became even sicker...which
> was only the tip of the iceberg regarding dual diagnosis, and which got people's
> attention (KI 5, clinician).

Experiencing more clients with dual diagnosis, clinicians sought help – 'the practical
reality...led me to seek more information' (KI 11, clinician). The epidemiological
and clinical literatures in the main confirmed their observations. Seminal US
research in the late 1980s and early 1990s highlighted the prevalence of dual
diagnosis (Regier et al., 1990); the implications of dual diagnosis for quality of life
and the need for a more integrated response (Carey, 1989; Drake & Wallach, 1989;
Minkoff, 1989); and the emerging evidence on the association of cannabis use with
psychosis (Andreasson, Engstrom, Allebeck, & Rydberg, 1987; Castle & Ames,
1996). Some suggested that the greater visibility of people with dual diagnosis
reflected a rise in AOD use among the general population, particularly among young
adults (Phillips & Johnson, 2010; Schmetzer, 2007).

Local Victorian research on the prevalence of psychotic, affective and
substance-related disorders in homeless people in inner-city Melbourne (Herrman,
McGorry, Bennett, & Singh, 1990; Herrman et al., 1989) was also influential in
providing 'a local context and argument for rethinking service delivery' (KI 11,
clinician). This work highlighted that almost half of the residents of shelters for the
homeless and cheap single-room accommodations had a current mental disorder
and that 10–12% had a dual diagnosis. In addition, the action research project
'Not Welcome Anywhere' (McDermott & Pyett, 1993) highlighted a significant
number of people who were falling into gaps between services and explored
explanations and solutions, taking a strongly biopsychosocial (Engel, 1977) rather
than a biomedical perspective.

Amid this proliferation of publications on dual diagnosis, there were very few
sceptical voices (then as now). Glaser (1993) suggested that the increased prevalence
of dual diagnosis was an artefact of the overlap of diagnostic criteria. Others (e.g.
Rice, 1989) argued that, rather than focus on dual diagnosis, it would be more
productive to improve case management, as most clients had multiple issues which
required a planned and integrated approach.

Collection and interpretation of data on AOD consumption and harms is an
ongoing challenge and there are many contested definitions and measures. The
same is true of MH problems. The best available evidence on prevalence and
harms in the late 1980s and early 1990s in Australia was that overall alcohol
consumption was declining but there were signs of an increase among women and
young people; heroin use may have been declining; benzodiazepine use among
women was of concern (Heather, Tebbutt, Batey, Saunders, & Wodak, 1989).
Contemporary community perceptions of mortality from alcohol and illicit drugs
were greater than actual mortality (Australian Institute of Health and Welfare
[AIHW], 1996). Trends in severe mental illness are unclear, owing to the
limitations of and changes in household survey methodology and limited data
on prevalence among the homeless and imprisoned, but mortality from mental
disorders was found to be increasing (AIHW, 1999). There was certainly enough
political concern to launch and coordinate national and state plans for mental
illness services and, separately, social, health and law enforcement responses to
AOD problems (Australian Health Ministers Advisory Council, 1992; Second Task
Force on Evaluation, 1992).

Deinstitutionalization

Key informants all considered that closure of the state's public psychiatric hospitals and a shift to care in the community was associated with the growth in concern about dual diagnosis. Alcohol and other drugs were more readily obtained in the community than in hospital:

> The increase in dual diagnosis is huge now, because people are not in hospital for many years, or for long admissions – that used to be the saving grace from their substance use. That no longer happens and they are now at higher risk from substance use than they ever were before (KI 14, Clinician/manager).

While acknowledging a possible increase in the objective risk of people with severe mental illnesses developing AOD problems, some informants felt, however, that the turning of the spotlight onto people with dual diagnosis was a token gesture towards much broader problems with the closure of psychiatric hospitals:

> It was one way, I think, to address the failure of deinstitutionalization without calling it a failure (KI5, clinician).

Many commentators identify deinstitutionalization and inadequate increases in community care as major factors in the increased prevalence of dual diagnosis. A review of American studies conducted over a period of 30 years (Cuffel, 1992) detected an increase in AOD use among people diagnosed with schizophrenia that was thought to be associated with greater ease of access to substances with the advent of more community based treatment. One premise of deinstitutionalization, psychiatrists Singh and Castle (2007) argue, was that patients would learn the effects of, and how to modulate, intake of substances, while 'in reality' people with illnesses such as schizophrenia are 'at much greater risk of ongoing use of substances'.

In the early 1990s in Victoria, deinstitutionalization was under way and accelerated from 1993 onwards. The 1986 Mental Health Act enshrined the principle of 'normalization' and the move to shorter stays, if any, in bed-based psychiatric services (McDermott and Meadows in Meadows, Singh, & Grigg, 2007). The first national mental health plan (Australian Health Ministers Advisory Council, 1992) emphasized the growth of community based services and 'mainstreaming' of acute beds into general hospitals. Meanwhile treatment for people with AOD problems was separately organized and until the 1990s was somewhat 'in the shadows' of the health system (Webster, 1995), even compared to MH services. National drug strategy took an intersectoral, population health approach (Single & Rohl, 1997). The contemporary Victorian AOD sector grew from the 1950s onwards with the opening of diverse non-government services and a small number of specialist clinics on the campuses of psychiatric hospitals or in general hospitals. Major restructuring, designed to integrate services with community health, was on the agenda in the early 1990s and about to be radically accelerated by an incoming neo-liberal state government (Costar & Economou, 1999). Some authors focus on deinstitutionaliza-tion as a rehousing process, arguing that health reform neglected the housing issue. There was a failure to provide housing with necessary supports, in place of the total institutions (Krupinski, 1995; Room, 2005; Room, Rehm, Trotter, Paglia, & Ustun, 2001). 'Transinstitutionalization' was observed, where people were bypassing treatment and support and appearing in prisons and accommodation for the homeless. Many saw a clear need for better coordination of government action

across health, community care, disability and housing: in the same year as 'Not Welcome Anywhere' was published, the 'Burdekin Inquiry' (Human Rights and Equal Opportunity Commission, 1993) found that 'in general, the savings resulting from deinstitutionalization have not been redirected to mental health services in the community' (Vol. 2, p. 908) and recommended that 'disability, mental health and drug and alcohol services should assume joint or collective responsibility, as appropriate, for the assessment, treatment and rehabilitation of people with dual or multiple disabilities' (Vol. 2, p. 935).

Contemporary research, public inquiries and this project's key informants thus claim that deinstitutionalization and the simultaneous rise of dual diagnosis discourse were not merely coincidental. While deinstitutionalization was seen by informants as crucial in the rise of dual diagnosis discourse, other factors were also seen to be at play.

Greater differentiation between services

Deinstitutionalization coincided with the adoption of corporate management principles in government. Several key informants were strongly of the view that the leverage exerted by narrow funding criteria was a major influence on the emergence of dual diagnosis discourse. Gatekeeping became tighter:

> Services would take the "easier" clients – i.e. those who did not also have other problems. So [we] got a much more differentiated and separated set of clients through the 80's and early 90's – that ultimately meant that lots with both [problems] in the middle were presenting elsewhere... and being noticed (KI 1, clinician, manager).

Mental health and AOD services had developed separately in Victoria. This separation in itself has been seen as a critical barrier to treatment for people with dual diagnosis (McDermott & Pyett, 1994). Key informants recalled, however, that before the 1986 Mental Health Act came into force, the psychiatric services they worked in were more willing to admit people with AOD problems, and to some extent took 'dual diagnosis' as a normal condition:

> Before the Act, we used to look after drug and alcohol people. With the new Act, there were exclusion criteria – part of that was people using alcohol and drugs – that was a big change (KI 17, clinician).

Similarly, informants recalled that AOD services would treat people with co-occurring moderate MH problems and expect such problems to be present, without formally acknowledging 'dual diagnosis' (KI 7).

Mental health services also became more likely to exclude people suffering from what were seen as less serious illnesses or problems:

> The mainstreaming shift pretty much meant that state-funded services... became more or less 'serious mental illness', howsoever defined.... where there had been an overlap of understanding around drug and alcohol, anxiety disorders, post-traumatic stress disorders, eating – that whole 'mush' in the middle - it really fell through (KI 16, public servant).

Funding was in any case highly constrained (Australia was sharing in an international recession after expansion in the 1980s) and both MH and AOD

services were competing near the bottom of the health funding ladder. In the words of one informant:

> 'mental health is low on the pecking order and alcohol and drugs is even lower on the pecking order' (KI 14, clinician manager).

Mental health and AOD policy rhetoric in the early 1990s recognized the risk of excluding people with dual diagnosis. The 1994 Victorian Framework for Mental Health Service delivery was the first prescriptive document introduced to the hitherto 'voluntaristic' and professionally led sector (Gerrand, 2005). It stated strongly that work with AOD agencies should be 'built in as core business' and services must not engage in 'buck-passing'. Similarly, although without specifying people with dual diagnosis, national and state drug strategy documents emphasized the need for an intersectoral approach. As key informants implied, however, funding levers were more influential than policy statements, and they tended to operate against the interests of people with dual diagnosis.

This turn to specialization can be seen in the wider context of the adoption into health services of corporate management principles, or 'managerialism' was the term preferred by two key informants. For key psychiatrists of the time (Meadows et al., 2007, p. 80), 'the approach resembled component specification in product management.' New Public Management entailed the major themes of disaggregation, competition and incentivization (Dunleavy, Margetts, Bastow, & Tinkler, 2005) with the main economic rationalist objectives of less public expenditure, smaller government and greater efficiency, economy and effectiveness (Germov, 2005; Rhodes, 1998). Australian managerialism in health was characterized, according to Germov (2005), by an emphasis on programme structures, programme budgeting and performance measurement. A key dimension was decentralization to agencies and the separation of operational management from policy-making. Government's role in funding according to performance raised concerns about unintended consequences for service users. 'Managerialism' appeared in Victoria in the late 1980s, following the economic rationalism of Reaganomics in the United States and Thatcherism in Britain (Considine & Costar, 1992; Costar & Economou, 1999). The contemporary recession hit Victoria hard, and its government lost power in 1992 to a neoliberal party under Kennett, committed among other things to major cuts in public expenditure.

The relevance of this history to the beginnings of dual diagnosis discourse is that there was considerable social concern about the fragmentation of services and shortages in government support – for example, 10% of hospital staff were cut in 1993 (Costar & Economou, 1999). What would be the impact on those already poorly served by the health and social system? Through this lens, deinstitutionalization was only part of the picture. The problem was about meeting performance targets related to narrowly defined client or patient needs and the ideal of comprehensive, coordinated community care was subsumed. Medical trends of the time, however, were also understood as influential in creating dual diagnosis discourse.

Professional trends

While political, economic and system changes were stark in the early nineties, there were slow but influential changes under way among MH and AOD service providers.

Informants recalled trends in diagnosis and psychiatry's renewed interest in AOD problems. Several informants were sceptical of claims that dual diagnosis had become more prevalent in the early 1990s: rather, the language and other tools were available to put the issue on the agenda.

> In the last 25 years...there's been a push from the community sectors to be more evidence-driven and, particularly in AOD to adopt a more clinical approach based on evidence.... Within that clinical framework, then, the fact that someone has both an AOD problem and they are clinically depressed becomes significant (KI 7, manager).

This informant notes the growth of an interest in clinical evidence for AOD treatment. Several publications in the late 1980s and early 1990s indicate a distinct surge in research on treatment effectiveness (for example, Heather et al., 1989). In the same period, the third Diagnostic and Statistical Manual of the Mental Disorders, published in 1980 and revised in 1987 (American Psychiatric Association DSM-III 3rd ed., DSM-III-R 3rd ed., revised) listed many new diagnoses and, as Charles Rosenberg (2002) and Herman van Praag (1996) have observed, more diagnoses mean more likelihood of comorbidity. The publication of DSM III heralded a growth in dual diagnosis research and treatment pilots. Screening and assessment began to be more forensic and, as another informant noted, more comorbidities were recorded:

> Often some research happens that identifies problems that have been there for a long time...and the more you screen people...the more evidence you will find that these people need to be treated for both conditions (KI 6, clinician).

Once conditions were recorded, an obligation to offer specific treatments arose.

While psychiatry was bringing more diagnoses to the table, public health practitioners were highlighting broader population needs, and the value of prevention and early intervention. This increased the number of potential patients. AOD thinking was moving from the extremes of 'addiction' and 'alcoholism' to the concept of a spectrum of problematic use (Room, 2012); mild and moderate MH problems with AOD use were also gaining more attention (Pols, 1994). In 1993, however, the dominant concept of 'dual diagnosis' seems to have been of the most severe mental illness and dependence.

Psychiatrists appear to have been both attracted by 'dual diagnosis' as a new field of specialism and confronted by associated calls for multidisciplinary working.

> There are all these political agendas between psychiatric services and drug and alcohol services and it turned out that the people in the psychiatric services that were involved saw an opportunity for psychiatric services to take over drug and alcohol. Their rationalization of that was that it shouldn't have been separated in the first place and it's the natural way to do it. I didn't agree because they had a very psychocentric view of dual diagnosis (KI 5, clinician).

This informant's view is shared. For example, according to Glaser, the practical advantage of the dual diagnosis movement appears to be to 'establish the legitimacy of psychiatric hegemony over alcohol and drug problems.' Dual diagnosis, he claims somewhat cynically, 'has become the battle cry for a takeover of the alcohol and drug treatment system by psychiatry' (Glaser, 1993, p. 55). There is further support for this claim in a detailed and thoughtful analysis of the deinstitutionalization

process in Victoria: Gerrand (2005) found that one of the factors encouraging deinstitutionalization was that psychiatrists were seeking to move closer to other medical specialties – to treatment rather than custodial care. In the late 1990s, the AOD field was becoming better resourced with evidence of cost-effective, cognitive-behavioural treatments and the promise of improving pharmacological treatments (Heather et al., 1989), thus offering psychiatrists more hope of retaining an authoritative role in acute care. The Royal Australian and New Zealand College of Psychiatrists formed in 1987, a special interest group on substance misuse (Lubman, Jurd, Baigent, & Krabman, 2008), noted locally as significant 'since it follows a long period of apparent indifference to a specialty which, in some other countries, is seen as falling firmly within the ambit of psychiatric medicine' (Holman & Brown, 1989).

Psychiatrists' authority was challenged in this period by moves towards more multidisciplinary working and the diffusion of responsibility that came with community MH work. Holman and Brown (senior doctors in Pleasant View, a state government AOD clinic and training facility) preface their manual of addiction by welcoming psychiatrists and other medical practitioners to the field as major and needed resources. They gently warn them, however, 'that substance abuse is a multidisciplinary area par excellence, and one in which health and welfare professionals cannot afford to become isolated or narrow'(Holman & Brown, 1989). Gerrand (2005) also notes that, in the early 1990s, psychiatrists resisted arguments for better case management (i.e. the tailoring of services to individual needs, and a focus on better continuity and coordination). They sought to retain their status as gatekeepers of access to acute, specialist beds.

Discussion

The most frequently mentioned reason for the emergence of diagnosis discourse in Victoria is that clinicians and the community became aware of an increase in the number of people who were excluded from health services. Specifically, people with AOD problems did not 'fit' in clinical MH services and people with severe mental illness were excluded from specialist AOD treatment services. This greater visibility of people with dual diagnosis is generally attributed to the shortcomings of the major deinstitutionalization of public psychiatric hospitals and the (attempted, at least) mainstreaming of MH and AOD into general health. A further contemporary influence receives less attention: the 1980s was an era of growing managerialism and performance management in health services and this is thought to have led to greater differentiation among services and a greater risk of people becoming 'misfits'. At the same time, classifications of mental disorders were multiplying and professionals were formally recognizing the frequency and harms of their coexistence. Underlying all these influences are historically uneasy professional relationships in a system that separates mental illness from AOD drug problems and specialist treatment from primary health and social support.

How does this analysis of the beginnings of dual diagnosis compare with that of McDermott and Pyett? It echoes to a large extent their findings on the impediments to service provision – the lack of adequate services after deinstitutionalization, budget restrictions, the longstanding separation of services and lack of clarity about where clients should be treated. It adds corporate management and trends in professional interests, influences which may be more evident in hindsight than at the time.

Clearly deinstitutionalization was not the sole cause of 'dual diagnosis' emerging onto the agenda: many contemporary shifts were interacting. It was, however, a significant jolt, from which the health and welfare system is still recovering, and can be a convenient single frame of reference, into which managerialism, a search for cost savings and professional issues can be folded. Alternatively, by considering influences separately, we can gain insights into their independent strength:

- Is deinstitutionalization alone sufficient explanation? If psychiatric hospitals had been retained, patients may have had less access to alcohol and other drugs, at least during periods of acute illness. High security prisons, however, are unable to exclude drugs and the hospitals were relatively open institutions, so are unlikely to have been drug free. One key driver of deinstitutionalization may be the rights movement and campaigns against the stigmatization of mental illness and AOD use alike: discrimination was being named and confronted.
- Were corporate management regimes and their drive for economy, effectiveness and efficiency creating a visible population of people with dual diagnosis? With the NPM came increasing specialization of services, as noted by informants, and a greater likelihood of a person presenting to a service and being told that their problem was not that service's 'core business'.
- We can also ask whether the discoveries of science are sufficient explanation for the emergence of dual diagnosis discourse. Comorbidity was not new but newly described and measured. Medicine's interest may have grown irrespective of health reorganizations and tightly constrained budgets.

In the event, all these antecedents or influences, and no doubt some that this inquiry has missed, coincided in the early years of dual diagnosis discourse. Kingdon's theory of policy action (1995) helps to capture the essential dynamics at play when an issue appears on the policy agenda. Using Kingdon's multiple streams theory, we can argue that

- A 'problem stream' existed – practitioners, researchers and community members (consumers, carers and the public) were drawing attention to concerns about increasing AOD consumption; it was clear that, for reasons including the way they were housed (or not) and the market for substances, people with a serious mental illness were now more easily able to acquire substances; and an economic recession was heightening poverty and distress. There was a desire to close the gaps between services. People with severe dual diagnosis problems would be particularly in need of strong, equitable community support and specialist professionals were powerless to provide collaborative community care.
- In terms of a 'policy stream', there was new confidence in clinical solutions in association with the more nuanced understanding of dimensions of AOD problems (as expressed in the National Drug Strategy) and refinement of an intersectoral harm minimization philosophy. Studies of AOD treatment effectiveness were fuelling optimism about a suite of responses including pharmacotherapies and CBT and related counselling approaches. The policy *language* was at least available, if not the *resources*, to promote intersectoral work by MH and AOD services.

- As for the 'politics stream' publicity around deinstitutionalization and disturbed people being visible on the streets meant that politicians on all sides, looking for ways to complete the goals of deinstitutionalization, were beginning to be ready to support measures specifically for people with dual diagnosis and to frame this as an issue of both social control and human rights.

Conclusion

The 'Not Welcome Anywhere' report's recommendations have been to some extent realized in the last 20 years, through state and federally funded cross-sector capacity building initiatives and a government policy prescribing 'dual diagnosis capability'(Department of Human Services, 2007). Seminal Australian research has added to knowledge of the role of attitudes, beliefs and role perception in building collaborative work into practice. Currently, the need for dual diagnosis responsiveness in MH and AOD services is close to being taken for granted and substantial guidance is available (e.g. Cleary, Hunt, Matheson, Siegfried, & Walter, 2007); there are active networks of practitioners and champions; dual diagnosis modules are built into training and academic courses. The concept of dual diagnosis has thus been incorporated into current health discourse.

Two decades after the cause of dual diagnosis was taken up, there is scant reassurance, however, that the first intended beneficiaries, those people with the severest disorders, many of whom were homeless, are consistently finding a better welcome. Of the conditions in the policy environment that nurtured the seeds of dual diagnosis discourse, what endures today? Mental health funding has increased as a proportion of health expenditure but AOD treatment funding for Victoria has remained static for a decade. There is a continuing need to modify service systems so that they are more welcoming of, and effective for, 'difficult' clients. This is only in part a workforce development matter (Munro & Edward, 2008). Policy makers and planners have the challenge of funding services in a way which rewards excellence not only in their specialism but in their ability to collaborate. If dual diagnosis discourse is seen to have arisen simply from deinstitutionalization, the logical prediction is that, if the shortcomings of that process become addressed by realizing the original policy goals of coordination, cooperation and community access to housing and a range of services, there will be no need to distinguish people with dual diagnosis from the general body of MH and AOD service users: they will be part of core business. Twenty years on (and in another economic crisis) perhaps other more current and persistent factors in the genesis of dual diagnosis discourse explain why it still has currency: further policy development in the MH and AOD sectors, aided by study of multiple, interacting influencing factors, should take into account the unintended ways in which corporate management and the dynamics of professional interests become a problem for person-centred care.

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Reflections on capacity-building initiatives in an Australian State (publication)

Monash University Declaration for Thesis Chapter Four

Declaration by candidate

In the case of Chapter Four publication *Reflections on capacity-building initiatives*, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Concept, research, all drafts, revisions after peer review	90%

The following co-authors contributed to the work. If co-authors are students at Monash University, the extent of their contribution in percentage terms must be stated:

Name	Nature of contribution	Extent of contribution (%) for student co-authors only
Rebecca Jones	Reviewing drafts, suggestions on language and structure	n/a
Darryl Maybery	Reviewing drafts, suggestions on language and structure	n/a

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate's and co-authors' contributions to this work.

Candidate's Signature		Date

Main Supervisor's Signature		Date

Reflections on capacity-building initiatives in an Australian state

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Abstract

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

Design/methodology/approach – *Interpretive, case study analysis of policy documents and key informant interviews (19) illuminates the experience of dual diagnosis initiatives.*

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

Originality/value – *The paper presents a unique and independent view of a 20-year period and indicates progress in attitudinal change that merits wider acknowledgement and application to other settings throughout health and social care.*

Keywords *Mental health services, Social services, Substance misuse, Dual diagnosis, Australia, Qualitative research, Capacity-building, Service provision*

Paper type *Case study*

Introduction

This paper inquires into the implementation of dual diagnosis (DD) initiatives in the State of Victoria, Australia, which have adopted a ''no wrong door'' approach. Identifying barriers and enablers to integration at a case study level highlights the importance of attitudinal change and proper investment in systems improvement. Ideas tested in one of the more difficult fields for integration should be effective in any setting.

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

International research on building DD responsiveness into routine practice emphasises the need to focus on systems and attitudes. Implementation can be lengthy and complex, requiring wider system support (Torrey *et al.*, 2011; Carra and Clerici, 2006; Hintz and Mann, 2006; Todd *et al.*, 2002) and MH and AOD treatment providers may have considerable difficulties with intersectoral liaison (Kavanagh *et al.*, 2000). Integrated service models

(Minkoff, 1989) and tools for assessing progress on building DD capability (McGovern *et al.*, 2007; Minkoff and Cline, 2001) suggest that ''wider system'' support entails role clarification and change management at every level. Tiered frameworks can help to clarify roles (Rush, 2010; National Collaborating Centre for Mental Health, 2011) and support critically important personal relationships that avoid turf conflict (Brousselle *et al.*, 2010; Roberts, 2012). Common success factors in the literature are leadership and system-wide support.

Victorian research on building DD pathways (Staiger *et al.*, 2010; Edward *et al.*, 2012) highlights continuing challenges, including the need for a cultural shift in both MH and AOD sectors. Involving service users in improving DD treatment and systems is integral to a person-centred approach and a number of Australian projects (Macdonald *et al.*, 2002; Kenny *et al.*, 2006; Holt and Treloar, 2008) have provided valuable insights into the way assumptions about professional status and the capacities of consumers can affect service integration.

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

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

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

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

Methodology and method

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

The 19 informants were purposively selected to offer insights into threads in the discourse. The first author conducted the interviews during 2010 and 2011, with senior policy executives (3), service providers (14) and consumer researchers (2) with expert knowledge and experience of relevant developments in the field of DD in Victoria throughout recent decades. Interviews were semi-structured, focusing on experiences of DD discourse and perceptions of its function in service provision. They were conducted at the informant's choice of venue (their workplace or the researcher's workplace). One was conducted by telephone. Informants each validated their interview transcript and 13 later chose to respond to an online questionnaire based on analysis of the interviews. Multiple-choice and open questions included a series on benefits and concerns in relation to DD discourse in Victoria.

National and State MH and AOD policies, strategies and evaluation publications were reviewed. Qualitative analysis of interview and policy data was both manual and aided by a computer software package (QSR International NVivo). Thematic, discourse and narrative analysis (Perakyla, 2005; Riessman, 1993; Silverman, 2001) proved useful in iterative study of the texts and relevant literature. The study was approved by Monash University Human Research Ethics Committee.

Findings

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

Evolving initiatives

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

Thus, a narrative of DD capacity-building can be traced, emerging from the concern and work of early champions, challenged by siloed MH and drug strategies but slowly accruing support in a variety of forms: specialist workers in the role of change agents, training, policy directives,

research and dissemination of screening tools and clinical guidelines, outcome measurement and program or strategy evaluations. This narrative reflects the capacity-building theory of the period and arguably demonstrates the tendency for a greater emphasis on worker knowledge and skills than on organisational, system and socio-cultural factors (Allsop and Stevens, 2009; Hawe *et al.*, 1999).

Barriers

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

Difficulty of practice change

Several informants dwelled on the intrinsic difficulty of changing practice that has been established early in a career with a particular focus. People are considered ''too set in their ways'' (KI 12, KI 17) and services seem to become ''sheltered workshops'' (KI 18) where ''whatever has been going on in that location and in that service tends to be perpetuated'' (KI 1). In this respect many informants chose to reflect on their own early experiences as practitioners and the ways in which these remained influential.

In relation to clinical MH services, informants recognised the pressures in a crisis-oriented system, identifying the workforce as ''change weary and change wary'' (KI 2) and describing the challenge of facilitating a cultural and discursive shift as ''like turning round the Queen Mary''. The AHA (2011, p. 47) evaluation and this study's informants (KI 5, 6) highlighted independent stories of conflicts between acute MH services staff and staff in withdrawal units (residential detoxification facilities), where clients were exhibiting signs of acute mental illness and MH services were unresponsive.

Weak perception of need to collaborate

A weak perception of the need for DD capacity-building was seen as a further barrier to change. Informants (particularly from the MH services perspective) thought the need to share the care of the people needing both MH and AOD services was minor, given the low number of people with severe mental illnesses presenting to AOD services (KI 14). A contrasting view pointed to undetected psychoses in the community and to the over-specialisation of MH services on people experiencing psychosis: there was a clear need to collaborate, as ''mental health services don't provide a service to a lot of people who need it'' (KI 5). Informants generally acknowledged that legal and structural changes in the 1980s had narrowed the focus of MH services.

Interprofessional issues

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

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

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

Resources

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

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

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

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

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

Lack of data

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

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

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

Planning and coordination

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

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

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

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

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

Enablers

Champions. When asked about significant factors in the development of DD responsiveness, informants named champions of the cause: international researcher-practitioners, others with a national public profile, particular policy executives in state government departments, and long-serving clinicians in DD initiatives, all of whom were generally seen as providing

leadership and a focus for achievement amid complexity. Champions were considered important at every level – as ''it's only people within who actually change practice'' (KI 1).

Policy direction. A second enabling factor was the Key Directions policy (DHS, 2007) requiring that people be seen as ''clients of the whole system rather than one type of service'' (p. 28). Between 2007 and 2011, AOD and MH services were expected to build DD into core business by becoming ''dual diagnosis capable'', establishing effective partnerships and mechanisms to support integrated practice, monitoring progress and involving consumers and carers in planning and evaluation. Key informants were somewhat divided in their responses to this policy (as indicated above) although none classed it as a barrier. DD clinicians thought it lent considerable weight to their capacity-building efforts:

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

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

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

Injections of funding

Independent, government-funded evaluation of the VDDI was ''a real trigger point'' (KI 3) for later developments. The 2011 evaluation found that the additional funding prompted by the first evaluation in 2003-2004 had been effective, notably a state-wide education and training unit and greater psychiatrist involvement. National capacity-building funding for AOD agencies, although only for those who won grants, is reported to have had significant outcomes. Outcomes reported at a national evaluative forum (Australian State and Territory Peak AOD NGOs, 2011) include generic quality improvements: complete policy and procedure reviews, service accreditation, stronger linkages not only with MH but with other health and community welfare services, greater diversity awareness, access to clinical supervision, mentoring and networking, and better data collection systems. National and state funding was sometimes combined, through an integrated DD protocol that overcame some of the disadvantages of separate funding streams and priorities (AHA, 2011). The 2011 evaluators, however, warn that ''the remaining window for change is narrowing as the change agenda for organisations becomes increasingly crowded, by seemingly competing interests''.

Discussion

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

What are the insights from this study that may be of general use for health system integration? DD work is perceived as deeply connected with dominant issues in health:

individualised care, workforce development in its multidimensional sense and the sustainability of change. Projects aimed at up-skilling AOD services to manage DD have been recognised as extending to generic quality improvement for *all* clients whatever their co-occurring conditions. Ongoing resourcing for sustainably integrated treatment and care may be hard to come by when new funding has to have a diagnosis-specific label, a time limit of three years at most and, like many of the improvements we have mentioned, a selective grants process. Further improvement may have to come from the next new initiative, such as family-sensitive practice or as one informant reminded us, the neglected area of dental health. This process calls upon service providers to take a positive view of the latest quality improvement initiatives, seeing them as building on rather than subsuming or competing with the previous initiative. A major contribution of the years of DD work is the hope that when champions offer vision and leadership and collaborative personal relationships are a central focus, integrated, inclusive policy and structures must follow.

This unique study is valuable in considering a 20-year period and engaging key players and observers in personal, confidential reflection that is independent of current initiatives and their evaluation. Further study of the history of DD could build on the work of Russell (2009); Schulte *et al.* (2011) and others who privilege the voices of consumers. Related avenues of inquiry should address the shortcomings in data to inform decision-making that have been noted throughout DD research and evaluation; this may entail challenges to the limitations of traditional outcome measurement in matters of the mind.

Conclusion

A final observation from this study is the extent and complexity of efforts to improve services in a single jurisdiction over a period of 20 years. The longer view highlights the persistence of stigma and a (related) lack of resources. Yet DD work has arguably pulled above its weight, real progress in changing attitudes is claimed and merits wider acknowledgement. Status issues and moralistic attitudes bring particular challenges to the task of integrating MH and AOD services: if methods of bringing services into harmony are effective in the contested context of DD, then they should be effective in any setting throughout health and social care:

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

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Interprofessional relationships in dual diagnosis discourse in an Australian State: Are we respecting each other yet? (publication)

Monash University Declaration for Thesis Chapter Four

Roberts, B. (2012) Interprofessional relationships in dual diagnosis discourse in an Australian State: Are we respecting each other yet? *Mental Health and Substance Use Dual Diagnosis, 5:2, pp. 148-159.* DOI: 10.1080/17523281.2011.618995

Declaration by candidate

In the case of Chapter Four publication, *Interprofessional relationships in dual diagnosis discourse*, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Concept, research, all drafts, revisions after peer review	100%

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate's and co-authors' contributions to this work.

Candidate's Signature		**Date**

Main Supervisor's Signature		**Date**

Interprofessional relationships in dual diagnosis discourse in an Australian State: are we respecting each other yet?

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'Dual diagnosis' discourse has emerged since the 1980s, with the dominant message of ensuring people with both mental health (MH) and alcohol and other drug problems receive coordinated or integrated treatment for both types of problem. In a climate of rapprochement (required or voluntary) between service sectors, mutual understanding and respect are essential. While the literatures refer to interprofessional and intersectoral tensions, there is little thorough contemporary exploration of these as barriers to effective treatment and support. This article discusses the implications of a 'no wrong door' policy for the staff of acute MH services in an Australian State. The nature of interprofessional and intersectoral contestations is explored and it is argued that addressing these is a necessary step in discovery of better approaches to the complexities of people's experience of what is considered to be 'dual diagnosis'. The article draws on findings from a single case study of the emergence of dual diagnosis policy in the State of Victoria, Australia, following major reorganisation in the late 1980s and early 1990s. The research literatures, policy documents and key informant interviews (18) are thematically analysed. Dual diagnosis capacity building is generally welcomed but there is a need for system change that prioritises a networking model for intersectoral and interprofessional interactions, a person-centred approach to the individual seeking treatment and care and a similarly strength-based approach to working relationships.

Keywords: coexisting problems; comorbidity; dual diagnosis; service provision

Background

'Dual diagnosis' discourse is an international phenomenon that can be traced back to the 1980s in the work of Minkoff (1989) and Drake and Wallach (1989) in the US. The prevalence and harms of coexisting mental health (MH) and alcohol and other drug (AOD) problems are well known (Teesson, Slade, & Mills, 2009). 'Dual diagnosis' is a medical term of deceptive simplicity. People considered to be experiencing dual diagnosis are living with extremely diverse problems and sets of problems. How health practitioners understand and use the term depends very much on their work context: those in acute MH services work with people experiencing schizophrenia or psychosis, bipolar disorder or severe depression (often called 'serious mental illness'), where any alcohol or other drug use may be a severely complicating factor; those in AOD services are more likely to see the co-occurrence

of AOD problems with problems that are considered to be depression, anxiety and personality disorders, which are common in the general population but not, unless severe, the focus of psychiatric treatment and care. Beliefs and attitudes about what should be done about 'dual diagnosis' are formed by experience – 'the way we see things is affected by what we know or what we believe' (Berger, 1972); differing understandings are therefore unsurprising. This paper considers the discursive position of staff in the acute mental illness services, whose primary focus is people with the most severe mental illnesses.

The study's focus is the State of Victoria, Australia. Psychiatric services in Australia, as internationally, have a history of an uneasy relationship with alcohol and drug problems. In Victoria, the public MH services and those for alcohol and drug problems are funded and organised as separate systems, with different types of governance, organisation and workforce. Since the early 1990s there have been consistent calls for better relationships between the two service systems. Current Australian policy is moving towards a goal recommended by an international review to 'eliminate barriers between mental health and substance abuse agencies and services at Commonwealth, State, Territory and local levels leading toward full integration of these two health services. ... [and] ... build a seamless system for consumers with elimination of silos of care, financing and structure' (Thornicroft & Betts, 2002, p. 21). 'Dual diagnosis' has grown as a subject of inquiry and action in Victoria from small initiatives in the early 1990s led by concerned non-government organisations and individuals to the point where the term (or its synonyms) is ubiquitous. The report 'Not Welcome Anywhere' (McDermott & Pyett, 1993) was locally influential in representing the experiences of those who were falling into the gaps between services. Coalitions of service providers undertook local pioneering work to overcome the barriers to support and treatment. They shared their learning through a statewide network and lobbied government for a stronger response. In 2000 the state government funded the Victorian Dual Diagnosis Initiative, which introduced teams of dual diagnosis workers to act as catalysts of change (Roberts et al., 2004). After some years of this relatively soft approach, in 2006 the state mandated service outcomes in relation to dual diagnosis (Department of Human Services – DHS, 2007). MH and AOD services must now demonstrate 'dual diagnosis capability'. In theory, and expressed very eloquently in the language of the current 'Because mental health matters' policy (DHS, 2009), all the partners in the care of people who present to MH services and AOD services are united by the social model of health, described here as 'acknowledging that mental wellbeing is determined by social and psychosocial as well as biological and medical factors' (DHS, 2009, p. 23).

Major barriers to seamless care remain, however (Cleary, Hunt, Matheson, & Walter, 2009). What is standing in the way of better care and support? Most of the international literature on dual diagnosis attends to the prevalence of dual diagnosis and to clinical approaches to treatment and support and is building valuable evidence around screening, assessment, referral pathways, consultation and joint care planning, with varying degrees and types of integration between MH and AOD services (e.g. Baker, Kay-Lambkin, & Lee, 2009; Drake, O'Neal, & Wallach, 2008; Minkoff & Cline, 2006; Staiger, Long, & Baker, 2010). The more sociological and systemic concerns, however, receive scant examination. A team of Canadian authors led by Rush (Rush, Fogg, Nadeau, & Furlong, 2008) are an exception in developing an informed critique of the 'integration movement' (where the term integration is

used for the whole spectrum of 'joining-up' activities). They aim to understand the movement's influencing factors, including power struggles between disciplines and models of treatment and support, to reduce the risk of 'pseudo-integration' and to develop a more nuanced foundation for integration than the 'phenomenon' of dual diagnosis itself. Fellow Canadians Brousselle, Lamothe, Sylvain, Foro, and Perreault (2010) take up the challenge with an in-depth process evaluation of two types of service integration, identifying success factors and proposing that integration must be based not on debates about care models but on the patient's experience of care.

The integration question is encountered in other areas of health and finds no speedy solutions, as systems try to adapt to the tension between increasing specialisation on the one hand (with its biomedical tendency) and on the other the demand for person-centred care which holds the whole range of biopsychosocial concerns in its gaze. For help with understanding the systemic issues in dual diagnosis, it is therefore worth turning to the wider literatures on systemic intersectoral and interprofessional issues. Leathard (2003) explore the ways in which most contemporary health and wellbeing workers must navigate the boundaries of their spheres of practice: while formal mechanisms to ease the process provide a framework, a central issue is usually interpersonal relationships and trust. A typology of boundary issues described by Hudson, Hardy, Henwood, and Wistow (1997) in a study of working alliances between primary health care and social care in the UK distinguishes organisational, operational, professional and cultural issues and forms a useful aid to analysis of the Gordian knot of difficulties facing MH and AOD services.

Aims

This paper focuses on one aspect of a case study of the development of the dual diagnosis movement in Victoria in the last two decades: the attitudes of the specialist MH workforce to AOD problems, service users and staff and how these play out in developing effective services for people with 'dual diagnosis'. It could argued that, notwithstanding considerable advances in reducing the barriers between services for mental illness sufferers and those for people with AOD problems, there are enduring issues which need ongoing dialogue and thoughtful work on interprofessional culture, which should ultimately improve the experience of treatment and care.

Method

The principal data beyond relevant research and policy literatures (which were sourced through database and website searches) are key informant interviews with a purposeful sample of 18 government policy advisors (3), consumer researchers (2) and clinicians in service management roles (13) with experience of changes in the MH and AOD service systems in the State of Victoria since the 1980s. From the researcher's knowledge of the Victorian sector, informants were selected to offer a range of views and the best 'opportunity to learn' (Stake, 2005) about the research topic. Each was asked to suggest other informants, which led to a small number of new contacts. Interviews have yielded views from inside and outside the MH system, and from different positions in regard to dual diagnosis initiatives. Thematic qualitative analysis is based on the premise that an understanding of multiple situated perspectives will illuminate the space of 'dual diagnosis'. Semi-structured

interviews were transcribed for validation by the interviewee before analysis. The text was manually coded for this paper under the headings:

- history of system changes
- responses to change
- MH attitudes towards AOD use
- attitudes towards treatment and treatment providers
- 'where next?'

The researcher has 'insider–outsider' status, recognised by key informants on the basis of her local experience since 1992 in psychosocial rehabilitation work and then as a health services evaluator. The research has been approved by Monash University Human Research Ethics Committee.

Results: narratives from policy and practice

The MH treatment system is still a work in progress

The era of deinstitutionalisation, which started in Victoria in the 1980s and is arguably still unfinished, brought enormous change that was part of a larger picture in health and social/community services wherein the emergence of the 'new public health' – the vision of population based strategies to improve health by tackling social and economic inequalities (Baum, 1998) – coincided with the grip of neoliberal market-based policies. Development of new community based service systems was and continues to be a slow process, with governments feeling their way towards frameworks that satisfy political, social, industrial and medical concerns (KI 16).[1] People with AOD problems used to be admitted to the government asylums, although their treatment has historically been a vexed issue. Separate facilities opened in the 1970s within the psychiatric hospital campuses. Deinstitutionalisation saw the administrative and physical separation of AOD services from MH services (AOD funds in Victoria were devolved to a plethora of non-government organisations) and the separation of rehabilitation from acute (or 'clinical') MH services. Acute MH services were to focus on those with 'serious mental illness' – understood as a diagnosis of schizophrenia, bipolar disorder or major depression. While the large psychiatric hospitals were gradually closed between 1988 and 1998 their workforce was spread more thinly across 22 area MH services within general hospitals across the state, mainly in inpatient wards and community MH centres. Rehabilitation was devolved to the non-government sector and the MH professionals' role became almost exclusively with people in crisis (Australian Health Ministers, 1992; Department of Health and Community Services, 1994; Meadows, Singh, & Grigg, 2007).

With every aspect of the new system emergent and unsettled, and arguably under-funded, the Burdekin inquiry in 1993 (Human Rights and Equal Opportunity Commission, 1993) and again in 2005 reported a workforce with limited resources and under extreme pressure, leading to a culture of exclusion: care for people in mental distress (with or without complicating AOD problems) was barely accessible. For people considered to have multiple problems, dissatisfaction with access to quality care persists (Cleary et al., 2009). Key informants observed that the system was still being incrementally 'cobbled together' (KI 16) and had 'lost the notion of asylum' (KI 13). The acute mental illness workforce had become 'change-weary and

change-wary' (KI 2) and 'they are under siege constantly and they have a fortress mentality. . . . we have a highly qualified workforce in the acute mental health sector, but they are quite deskilled' (KI 13). They were in other words describing a culture that, for understandable reasons, was perceived to have a defensive, inward-looking stance. The move towards dual diagnosis capability and exhortations to end the culture of exclusion and build better working partnerships with the AOD treatment specialists looked like extra work and were not, therefore, universally welcomed.

Attitudes towards AOD problems and treatment expertise

What are the prevailing attitudes of MH professionals towards AOD use, treatment and the treatment sector? Hudson et al.'s (1997) typology of boundary issues (organisational, operational, professional and cultural) forms a useful tool for analysis of key informant narratives and can be seen to contribute to generally negative attitudes towards the AOD sector. Interpersonal professional and cultural issues are centre stage. Table 1 summarises the issues arising in the current study.

Organisational mismatches pertain in Victoria with, on the one hand, large, fairly uniform formal mental health structures in regional hospital-centred organisations and on the other an AOD sector described by two informants as 'a thousand flowers blooming' (KI 3, KI 10) – a wide range of organisations, ranging from small independent voluntary bodies to services within community health and finally to those recently amalgamated with hospital based area MH services. One of the many clashes at this structural level is a lack of pay parity, with social and community services lagging well behind health.

Operational concerns, the second type of boundary issue, include questions of how treatment is funded, and in particular how shared work is accounted for. Informants pointed to the difficulty of funding shared work (joint planning, secondary consultation), to a short-term crisis timescale in MH services, to language differences (such as in definitions of 'assertive' and 'access') and there are practical problems concerning risk management and confidentiality. AOD organisations may

Table 1. Selected boundary issues between public MH and alcohol and drug services, State of Victoria.

	Acute/clinical mental health	Alcohol and other drugs
Organisational	Uniform across state Hospital-centred Health sector	Diverse – NGO, community health, general health On borders of health and community services sectors
Operational	Powers and duties under Mental Health Act 1986 – risk management, hierarchies	Very limited powers of coercion
Professional	'Diagnosis' Medical and allied health specialists	'Needs' 'Deprofessionalised' (growing number with AOD qualifications)
Cultural	'Taboo questions Moralising; pessimism 'Disdain' for AOD	Resistance to 'medical model'

Sources: Hudson et al. (1997); key informant data collected by the author.

lack (and in fact not aspire to) the hierarchical clinical governance structures that MH staff regard as essential.

Turning to professional boundary issues, self-interest and competition for domains come into play, along with different views on the breadth of the professional's role. Under pressure, professionals narrow the perceived limits of their role and increase their specialisation (Hudson et al., 1997). The dynamics of 'diagnosis' are relevant here: a major professional conflict between the worlds of acute mental illness treatment and AOD treatment paradigms lies in the very term 'dual diagnosis' (and underlies the alternative terms such as co-occurring disorders and comorbidity). Diagnosis enables entire structures of funding, medical specialisation, bureaucracy and power (Rosenberg, 2002) and confers (limited) status on the psychiatrist. Medical diagnosis is considered less important by AOD practitioners (including the medically qualified), who are described as working primarily with the individual's needs and motivations, taking multiple variables into account and aspiring to a biopsychosocial model of health (KI 12, KI 13). Key informants described polar opposite philosophies: 'social', 'environmental 'and 'self-determining' on the one hand, 'paternalistic' and 'medical', on the other (KI 3, KI 16). Psychiatry's 'self-serving' emphasis on diagnosis is 'unrelated to needs and allows avoidance of action' (KI 7). Under-resourced AOD and other community services take a pragmatic and sometimes cynical view of diagnostic trends:

> *If you work in a community service, whenever you hear these new diagnostic categories, you automatically think about how you can get additional resources by reclassifying the people you're currently working with (KI 7).*

Similarly, MH services reportedly saw the arrival of dual diagnosis clinicians as adding to 'their' resources, ignoring the needs of other dual diagnosis clients (KI 5). Some informants ascribe the MH professional's lack of awareness of a person's needs to a generational gap in their education about AOD problems, with little attention paid to the subject in initial and ongoing professional training over a significant period. MH professionals, particularly those without recent training, are often reported in the research literature as overlooking AOD use and problems (Kavanagh, et al., 2000; Lubman, Hides, Jorm, & Morgan, 2007) and may tend to resist additional training , believing they are already competent enough (Hamilton Brown et al., 2002).

> *Mental health people just think they do it already. They have no real understanding of what's involved in drug and alcohol – the whole biology of it, the whole psychology. I think they see it as far too simplistic – as just a behavioural thing (KI 11).*

In this study it is the fourth type of boundary issue, the cultural, that suffuses the other three and dominates informants' perspectives. Cultural issues relate to whether models of care are complementary or conflicting, and differing views about service users. A psychiatrist recalls observing an 'almost culturally bound' reluctance to ask certain questions:

> *I noticed that in psychiatric services, staff were very coy about asking about substance use – it was like a taboo thing. They didn't have a problem asking people about*

hallucinations, delusions and, you know, their sexual activities and all of that! But substance use was sort of a no-go zone for them. . . . Once you kind of established a matter-of-factness about it, it was OK. But there were still certain staff who had a lot of problems sort of crossing that line (KI 12).

Where AOD problems are recognised, a sense of hopelessness prevails: problems are thought to be self-inflicted and 'too hard and complicated' when the professional does not have the 'fancy treatments' to offer (KI 1). Informants described negative attitudes towards people experiencing AOD problems, using terms such as 'fatalistic and nihilistic' (KI 16) or 'pessimistic' (KI 2). By extension, attitudes to AOD specialist treatment and the people who provide it (the two tend to be conflated) are reported to be frequently dismissive. Two perceptions are said to come to the fore among outsiders to the AOD field:

(1) That most AOD workers are current or former service users.
(2) That few have professional qualifications and these are of poorer quality than those held by MH staff.

AOD staff expertise has struggled to be taken seriously.[2] As one informant reflects:

There was a sense [in the 1990s] that people with what we talk about now in mental health as 'lived experience' . . . were now working there . . . Did we really want to refer to these services? Were these people skilled and qualified to make a difference? Or were they just druggies?! . . . we're still dealing with this in mental health (KI 12).

Such attitudes seem to be reinforced by organisational differences. With hospitals as the medically dominated, hierarchical, professionalised and hyperspecialised 'centres of gravity' (Rosen, Gurr, & Fanning, 2010), equal, respectful relationships with community organisations and their cultures are a challenge. A key informant spoke of a 'deep lack of understanding from both sides' (KI 5). Another (also a MH professional) noted that a kind of 'professional snobbery' came to light when a scheme of reciprocal rotations of staff between MH and AOD services was under way. He ventured a cultural explanation:

Highly qualified drug and alcohol workers [were] coming into mental health and being treated like students (. . .) – because they were coming from drug and alcohol they were sort of seen as inferior. There seemed to be a real disdain for the person. (. . .) I think it's still there, an undertone. Maybe the people in mental health, because of the clinical risk or whatever, I don't know – or just the way they are acculturated as a service. They probably deal with more serious stuff than drug and alcohol issues – it's almost that moral view that drug and alcohol is just the individual's responsibility and how hard is it? I don't know, but that's part of the stuff that goes on. (. . .) We train people up in risk assessment and managing some legally fairly significant things. Maybe just by implication of doing that they think that they are a more superior service than other services (KI 11).

These thoughts represent several themes in the discourse: the effect of the power entrusted to MH professionals, the exclusiveness of the acute MH services culture, the belief that AOD problems are a simple moral issue, and the way all of this becomes expressed in unhelpful interpersonal relationships. Such issues are often obvious to service users. As one young person has observed to an Australian researcher:

*It feels divided. AOD and mental health workers are from completely separate worlds –
that is how it feels. I think there is a bit of resentment – it's like an unspoken war – the
mental health workers think they are better than the AOD workers and the AOD workers
feel a bit invalidated/sidelined by the psychiatrists (Russell, 2009, p. 28).*

Where next? Implications, strategies

So what are the answers to better partnership between MH and AOD? Of course
there is no single answer, but staying for the present with the issue of MH
professionals' attitudes to AOD, is it enough to educate MH clinicians about
prejudice and stigma and train them in AOD issues? Would greater AOD
professionalisation and equal pay and conditions be the solution? Workforce
development is indeed prominent in informants' minds, described in terms of
reflective dialogue that is aided by adequate professional supervision and
opportunities to share expertise at every level of the system from policy to grassroots
practice. The need for adequate remuneration and other resources is a constant
theme. But it is the interpersonal and cultural strategies that are emphasised above
all in the literatures and by this study's informants in the Victorian context.

The interpersonal as the primary focus

Key informants' memories of the evolution of dual diagnosis discourse are peopled
by champions and catalysts, from visiting American researchers to local workers. In
the mid-1990s, for example, before the existence of funded dual diagnosis training, a
general practitioner in a regional town organised a small group of workers from
different sectors in his region to attend a week's dual diagnosis training in another
state, with lasting effects on their intersectoral work (KI 11). In Melbourne a loose
coalition of interested consumers, carers and workers developed a network to lobby
for more government attention to dual diagnosis (KI 2). Across the state several
small dual diagnosis projects were trialled with short-term funding, and workers in
an inner city suburb organised a 'pivotal' conference (KI 2, KI 14, KI 15). Several of
the main players in those years are still seen as among the key catalysts and bridge-
builders.

Boundary problems are about human interaction and solutions follow
different models of expected human behaviour. Comparing neoliberal market
mechanisms, traditional health system hierarchies and networking models,
Hudson et al. (1997) see networking as the most promising theory for the
minimisation of boundary problems. Networks rely on egalitarianism, coopera-
tion, trust and mutual respect. Their creation is 'as much a question of politics,
personalities and culture, as legislation and finance' (Hudson et al., p. 30). The
contested, diverse and somewhat beleaguered fields of MH and drugs are ripe
territory for the networking concept and the encouragement of a respect that
overcomes traditional barriers, even as the market mechanisms and traditional
hierarchies (perhaps inevitably) persist. As Room (2009) notes, the way forward
should not be about institutional or professional hegemony – where psychiatry,
for example, appropriates the AOD field. Brousselle et al., proposing that
achieving better care through better integration is a complex and dynamic process
involving many intertwined processes, conclude that 'although there are various
ways of fostering integration, the primary focus must be on the relationships
among the people involved' (2010, p. 220).

A 'multicultural' perspective

While lamenting the perceived therapeutic pessimism and aversion to change in acute MH services, informants were generally optimistic that better paradigms of care can prevail. They advocated a person-centred and strength-based approach that embraced opportunities to learn from each other, as in, for example, the statement that

> We have to be multicultural … united by the person and family in the centre *(KI 10)*.

Placing the person (or patient, consumer, service participant or client) as an active participant in the centre of discourse about their care is a key aspiration of current health care practice. The insight that this has to be a multicultural exercise – one that implies acceptance of difference and of the right to keep separate cultural identities while coming together with a common focus – may be helpful in guiding dialogue. Can it be combined with a strength-based approach that builds on common principles and characteristics and, rather than emphasising separate turf, identifies the different strengths that can be brought onto common ground? Such is a major recommendation of Rush et al.' s (2008) thorough inquiry into the dual diagnosis integration issue in Canada. The key informants hoped that both sides might reject historic 'baggage' (KI 18) through reflective dialogue centred on the person/patient/client. They saw the AOD sector's strengths as nuanced AOD-related expertise, working with the whole person, respecting their autonomy and tolerating risk, and MH strengths as lying in highly professional clinical skills and systems. Some expressed the fear that AOD strengths are easily overlooked in collaborations and may be lost: clearly an effective strength-based approach has to take account of – or, better still, remedy – power and status inequalities.

Some warnings are sounded in the literature. Room (2010) reminds us that 'person-centred' approaches should not overlook the effect of the social standing and power of clients – their 'needs' are often determined by another, not by client choice, plus they are marginalised and stigmatised, and often under some kind of coercion, so have little bargaining power: 'the greater the degree of coercion in the system, the more it can be organised so the benefit to the clients is secondary to the convenience of those staffing the system' (Room, 2010, p. 578).

Conclusion

'Dual diagnosis' has been called a 'wicked problem' (Australian Institute of Primary Care – AIPC, 2009, p. 28; Rittel & Webber, 1973) – an unfortunate choice of terminology, one could argue, when the stigmatisation and marginalisation of the individuals affected is so harmful and prevalent. But there is some normalising value in identifying it with other hard-to-solve problems such as climate change and social and health inequality.

The informants' relative pessimism about the MH system's attitudes towards AOD issues may seem outdated in the current world of enlightened dual diagnosis capacity building and this author would in no way diminish any claims that progress has been made. Changes to cultural and professional habits move, however, at a glacial pace. There is a risk of papering over the proverbial cracks in the system into

which people who seem difficult to work with can fall. Key principles for the reduction of professional and cultural barriers can be proposed:

- Resistance to market and hierarchical models and their emphasis on competition and status, in favour of an egalitarian networking model (after Hudson and others).
- An informed focus on the individual's needs that not only transcends debates on care models (Brousselle et al., 2010; Rush et al., 2008) but also combats the social marginalisation of people with alcohol and drug and MH problems.
- Adoption of a strength-based approach to collaboration (Rush, 2008).

A strength-based approach should not steer away from contentious issues. It is worth emphasising that structural interventions are a high priority. Gradually Australian governments have been providing for people with mental illness the supports for daily life that were lacking in the original process of deinstitutio-nalisation – housing with support, personal helpers and mentors, respite care and other community MH programmes. In theory (and only in theory, unless serious investment continues) better community services and more social acceptance should reduce people's need for acute and inpatient treatment and thus make redundant the exclusionary culture in these facilities. Unless the issue of professional turf is explicitly addressed, however, it will continue as a barrier to realising ideals of holistic, person-centred care. People who present (or are against their will presented to) our health services for whatever reason have a right to respect. The professionals around them will bring different, complemen-tary perspectives and must be united by respect for each other as well for the individual.

This study has the limitations and intended strengths of qualitative, interpretive research, such as depth rather than generalisability, rich contextualisation and a focus on individual interactions (Denzin & Lincoln, 2005; Geertz, 1973). It is unusual in its focus on the narratives of professional interest groups and policy makers, the 'hidden populations' (Berridge, 2000, pp. 46–47) at the middle level of the health system.

Key informants have welcomed the opportunity of confidential and discursive reflection on the years since deinstitutionalisation and the development during that time of a dual diagnosis movement. There remains much to unpack about the meanings of dual diagnosis discourse for the improvement of health systems. Other insights are to be drawn from their narratives and linked with analysis of policy processes. They resonate both locally and internationally and cluster around such questions as: does 'dual diagnosis' as a concept promote person-centred care or is it too narrow a focus that diverts attention from other co-occurring health and social difficulties? Will AOD expertise be 'swallowed up' and lost in the MH silo or, more optimistically, help embed in MH practice a more social model of health?

Notes
1. Individual key informants are indicated by code numbers in brackets.
2. The number of AOD workers with experience of problematic alcohol or drug use is unknown and there is little or no study of the value or stigma placed on workers in either sector who 'come out' as having relevant 'lived experience' (as distinct for being employed as 'consumers'). In the matter of qualifications, however, a recent census (Department of Health, 2011) suggests that about two-thirds of the workforce have a formal qualification in AOD studies and 97% hold these or other relevant qualification or are engaged in further AOD-related studies.

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Dual diagnosis narratives and their implications for the alcohol and other drug sector in Australia (publication)

Monash University Declaration for Thesis Chapter Four

Roberts, B. and Jones, R. (2013) Dual diagnosis narratives and their implications for the alcohol and other drug sector in Australia. *Contemporary Drug Problems, 30:4,* pp. 663-685.

Declaration by candidate

In the case of Chapter Four publication, *Dual diagnosis narratives and their implications for the alcohol and other drug sector in Australia*, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Concept, research, all drafts, revisions after peer review	90%

The following co-authors contributed to the work:

Name	Nature of contribution	Extent of contribution (%) for student co-authors only
Rebecca Jones	Reviewing drafts, suggestions on language and structure	n/a

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate's and co-authors' contributions to this work.

Candidate's Signature	██████████████	Date

Main Supervisor's Signature	██████████████	Date

Dual diagnosis narratives and their implications for the alcohol and other drug sector in Australia

BY BRIDGET ROBERTS AND REBECCA JONES

Dual diagnosis discourse, concerning people who are diagnosed with both mental health and substance use problems, has attracted little critical analysis. This article aids reflection on its implications for alcohol and other drug (AOD) treatment services. Qualitative analysis of 19 interviews with a purposive sample of service providers and public servants was validated with informants. Three contrasting narratives emerged—progressive (dual diagnosis discourse has lifted the sector to a level where services can better respond to complex needs in general); remedial (it has simply helped to improve the workforce's expertise in AOD treatment and "catch up" with mental health services); and radical (by patching a fragmented system it has dampened demands for major system reform). The diversity of views supports an argument for a metanarrative which, combining the strengths of the three narratives, continues to pioneer, to educate and, crucially, is explicitly conceptualized as part of a broader picture of well-resourced structural reform.

KEY WORDS: *Alcohol and other drug services, policy, discourse, narrative, Australia.*

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The context of this article is a movement, during the last 20 years, towards better treatment and care, and a reduction in system-related barriers, for people with both substance use and mental health problems. This condition is variously known as "dual diagnosis," "co-occurring disorders" or "comorbidity," among other terms. Problems associated with dual diagnosis entail diverse and complex physical, psychological and social difficulties for a wide range of people (see, for example, Teesson, Slade, and Mills' report on the Australian National Survey of Mental Health and Wellbeing [2009]). Health systems that are designed to deal with one problem at a time struggle to provide coordinated, seamless services (Staiger, Long, & Baker, 2010). Jurisdictions in Australia, Canada, the United States, United Kingdom and elsewhere have developed specific policies and initiatives aiming to build dual diagnosis capacity across the mental health (MH) and alcohol and other drug (AOD) sectors, so that both can respond more effectively.

The conversations, stories and documents associated with such work form a discourse which invites analysis. This article, a case study of the State of Victoria, Australia, examines the implications for the AOD sector of the emergence of dual diagnosis discourse and its role in service system improvement. We draw on interviews with key professionals concerning their experience of the health system's response to dual diagnosis. Informants note that dual diagnosis discourse has influenced the general quality of service provision in the AOD sector but perceptions of its value differ. Through analysis of the informants' interviews we have identified three narratives of dual diagnosis and AOD service provision: a "progressive narrative," which provides an optimistic picture of major and continuing improvement; a "remedial narrative" has change of improvement from a low base; and a "radical narrative" in which dual diagnosis is a narrow, perhaps distracting, concept in the context of the need for fundamental structural change. We conclude that dual diagnosis discourse has added value to the AOD sector by providing a focus for quality improvement. The common implication of

all three narratives is, however, that the initiatives so far taken are not enough in themselves to secure welcoming services and overcome the structural barriers to treatment, support, and social inclusion of people with dual diagnosis. The barriers for people with dual diagnosis are symptomatic of the challenge of providing person-centered care.

Background

The following contextualizes the history of dual diagnosis by introducing two key factors in contemporary discourse. First, we problematize the use of the term dual diagnosis. Second, we outline the context of policy development by tracing the history of the use of the term in dual diagnosis initiatives in Victoria, Australia.

"Dual diagnosis"

How "dual diagnosis" is understood in practice varies widely and rests on contested foundations. The body of epidemiological and clinical literature on dual diagnosis has burgeoned since the late 1980s. Few researchers have challenged its findings on prevalence and the need for the integration or better coordination of the specialist mental health and AOD treatment systems. Frederick Glaser (1993) in a commentary and Robin Room (1998) in a review of the evidence are among the few suggesting that greater (attempted) precision of diagnostic criteria and the intrinsic overlap in symptomatology between AOD and MH problems means that more co-occurrences of mental health and AOD problems are being identified. They therefore note the likelihood that some artefactuality is built into the measurement of dual diagnosis.

The issue of problem definition is not confined to psychiatric diagnosis. There is ongoing tension among moral, psychiatric, and general medical perspectives on AOD problems, which are variously conceptualized as psychiatric disorders, physical disorders, and personal choices. They appear, for example, in the Diagnostic and Statistical Manual of Mental Disorders

(DSMV) (American Psychiatric Association, 2010) as a category of mental health disorder, and in the International Classification of Diseases (ICD-10) (World Health Organization, 1993) variously in mental and physical classifications. A recent survey of people living with psychosis in Australia (Morgan et al., 2011) reports on AOD use and problems entirely as part of "physical health and at-risk behavior" and not at all as a comorbid mental health problem. And while mental illness, particularly depression, has become somewhat less stigmatizing as a result of high profile campaigns, drinkers and drug users continue to be marginalized (Talmet, De Crespigny, Cusack, & Athanasos, 2009).

It is unsurprising that dual diagnosis is a vexed discourse, when there are multiple concepts of mental health and illness, of AOD use, misuse and harms, and, even within the hegemonic clinical discourse, dual diagnosis encompasses many possible combinations of mental, physical, and social problems. The term also becomes synonymous with the structures and workforce specializing in dual diagnosis treatment.

Dual diagnosis in Victoria   The term dual diagnosis in its current usage in Victoria emerged during major developments in the public Victorian mental health and drug systems, which matched the international deinstitutionalization trend towards locally accessible services. Large psychiatric hospitals were closed between 1988 and 1998, and a range of community-based services took over (Gerrand, 2005; Meadows, Singh, & Grigg, 2007). The government also reorganized AOD services, contracting them out to nongovernment organizations and mainstreaming them with community and general health (Department of Human Services, 1997). Victoria differed somewhat from other Australian states in its less medicalized and wholly nongovernment specialist AOD workforce without funding for addiction medicine and addiction psychiatry support. Throughout the process of restructuring, mental health services and AOD services were (in Victoria as well as the rest of Australia) conceptualized as separate systems. It has often been claimed

(e.g., Lubman, Hides, & Elkins, 2009) that the problem of dual diagnosis is essentially one of a dual system.

Dual diagnosis was not an apparent issue in the restructure, although warnings existed: Much seminal research was published in the late 1980s highlighting people's experience of dual diagnosis and the need for a more integrated response (e.g. Carey, 1989; Drake & Wallach, 1989; Minkoff, 1989) and there was a brief assertion in the 1994 framework for Victorian mental health services (Department of Health and Community Services, 1994) that services "should not engage in buck-passing" but build in work with AOD agencies. From the later 1990s, however, pilot dual diagnosis projects were funded, followed by longer-term capacity-building initiatives. The Victorian Dual Diagnosis Initiative (VDDI) focused on both sectors while the National Comorbidity Project (Teesson & Burns, 2001; Teesson et al., 2009) targeted the AOD sector alone. In 2007 the state government mandated mental health and AOD services to become "dual diagnosis capable" (Department of Human Services, 2007).

A large proportion of dual diagnosis capacity building was based on the view that the AOD sector in particular was in need of remediation. Yet the Victorian Auditor General (2011) recently found that, overall (and irrespective of co-occurring mental illness), the AOD treatment service system had not met its objectives of effective case management, continuity of care and consistent high quality services. It remained difficult for clients to access and navigate, and did not provide seamless pathways to other health and social support services. In the same year, independent evaluation of the VDDI (Australian Healthcare Associates, 2011) found that, while the initiative had had a dramatic impact with regard to building recognition that "dual diagnosis is everyone's business," there was far less progress on integrated care and collaborative practice. More capacity-building was required. On a more positive note, a 2009 evaluation (AIPC) of dual diagnosis treatment models in 17 Australian services (six of which were in Victoria) found

that AOD staff were better qualified and had better links with MH services than was suggested in the research literature.

In summary, attention to the concept of dual diagnosis in Victoria has grown in the last 20 years from small beginnings in the aftermath of deinstitutionalization. Problem definition has been an enduring issue affecting the search for solutions. Today there are several separate streams of action: state-funded capacity building for both mental health and AOD sectors, and national funding allocations for AOD organizational improvement, for research and for training. According to audit and evaluation findings, however, improvements in service access and coordination were limited.

International qualitative literature on dual diagnosis is relatively sparse, compared with epidemiological and clinical studies. Consumer perspectives on service system responses to dual diagnosis agree that a positive, client-centered therapeutic relationship is key, and better service integration, communication and cross-training are required, to redress shortcomings in holistic care (Kavanagh et al., 2000; Russell, 2009; Staiger et al., 2010), although David Webb (2009) cautions that consumers may not trust an AOD service with close links to MH as there may be a greater risk of coercion into involuntary MH treatment. An Australian study with young service users with a dual diagnosis (Russell, 2009) noted that the AOD services were experienced as more supportive, more personal, and less formal than MH services. Kavanagh and colleagues (2000) found that intersectoral liaison was more difficult for AOD staff than for mental health staff. Service providers in American, United Kingdom, and Australian studies of clinicians highlight the emotional impact of working with complex problems for which solutions are unclear or unavailable: the words "frustrated," "helpless," "hopeless," and "powerless" recur (Coombes & Wratten, 2007; Deans & Soar, 2005; Mericle, Alvidrez, & Havassy, 2007; Rosedale & Strauss, 2010). Systemic negativity about people identified as having a dual diagnosis, who are seen as a low political priority, is consistently noted (Carey, Purnine, Maisto, Carey, & Simons, 2000).

These studies from several continents typically end with recommendations for routine screening and assessment, improved coordination or full integration of services, and a range of workforce development strategies. This article makes a distinctive contribution in critically inquiring into continuing tensions in the dual diagnosis discourse in a jurisdiction which has begun a number of these recommended improvements over recent years.

Approach

Our approach to examining the dual diagnosis phenomenon in the Victorian AOD service sector assumes that understanding and honoring the perspectives of "meso" level stakeholders will illuminate the space of dual diagnosis, inform the field, and help overcome unnecessary barriers to effective action. Stakeholders at the policy and service provision level tend to be overlooked in qualitative health research, where the voice of the patient/consumer/client experience is more often heard, and they are in some ways another "hidden population" (Berridge, 2000).

The contribution of qualitative research is, through a detailed description of a phenomenon placed in its social/cultural context—"thick description" (Geertz, 1973)—to illuminate the problems of system fragmentation as they are lived. We use discourse and narrative as analytic lenses. We understand dual diagnosis discourse to be the spoken and written language used in a variety of forms to create and develop the concept of dual diagnosis and to give it a distinct identity (Phillips & Hardy, 2002). We follow narrative analysts (Mishler, 2005; Riessman, 1993; Roe, 1994) in noticing narrative components (such as a structure with a plot, characters, and a beginning middle and end) and in paying close attention to the way in which explicit and implicit narratives in the discourse create contrasting realities. Another advantage of narrative analysis is that it encourages the researcher to avoid extracting disembodied content

and to place in context the whole story (both the stated and the implied) that the participant is telling. Narrative analysis offers a navigational aid in the complexities of dual diagnosis, guiding a path between post structuralism and the prevailing essentialism of the dominant clinical research literature. As Eliot Mishler (2005) (citing Charles Briggs) reminds us, differing narratives create, sustain, and mediate conflict, without eliding or suppressing it. Applying narrative analysis to the study of complex, uncertain and polarized policy problems, Emery Roe (1994) recommends extracting a "metanarrative" from stories and counter-stories which can be, even temporarily, a stabilizing influence on decision making and can combat "weary pessimism" about solutions.

Method

This article, part of a larger case study of the evolution of dual diagnosis policy and practice in Victoria, Australia 1985-2010, draws on interviews with 19 key informants. Participants were purposively sampled (Patton, 1990) to enable the research to tap into narratives of experience from different subsectors of the field and thus to document diversity. Based on knowledge of the field the first author developed a list of 60 potential participants, cross-referenced by gender, discipline, experience in one or more relevant roles, and by degree of involvement with specific dual diagnosis initiatives. She ranked them in order of priority for interviewing based on their involvement with dual diagnosis work and to maximize diversity of well-informed perspectives. Seventeen interviews were conducted and a further two as a result of recommendations by participants. Answers to a "snowballing" question at the end of each interview confirmed that the sample was basically well founded. After preliminary analysis of 19 interviews the first author determined that saturation had been reached: the transcripts contained enough varied insights to enable interpretation and illuminate answers to the research questions, and little new material was emerging.

The informants had experience in mental health service provision (MH), psychiatric disability rehabilitation and support, or alcohol and drug (AOD) treatment. They included consumer-researchers, nurses, occupational therapists, psychiatrists, psychologists, and social workers, with their main roles defined as current or former state government policy executives (three), consumer advocates/researchers (two), or service managers and clinicians (fourteen). All the service managers had a background in a health profession.

Semistructured interviews (lasting between half an hour and 2 hours) sought narratives of relevant experience over recent decades. Topics included key turning points, the interrelationships of relevant service sectors, and views on the "winners and losers" in dual diagnosis discourse. The interviewees read and validated the transcripts of their interviews. Through analysis of themes and narrative threads (using manual data management techniques and QSR NVivo computer software), we developed key propositions relating to the reasons for and consequences of the emergence of dual diagnosis discourse, and invited the informants to respond to these in writing. Thirteen (68%) responded. This article presents and discusses all responses as they relate to the AOD sector. The research was approved by Monash University Human Research Ethics Committee.

Results: Informants' views of the consequences of 20 years of talking about dual diagnosis

This section will describe and illustrate major threads in informants' contributions. It begins with informants' perspectives on the problem of the unstable ground beneath conversations about dual diagnosis before identifying three narratives, here labeled progressive, remedial and radical.

The problem of definition — Definitions of dual diagnosis vary and each tends to be situation-specific. Informants demonstrated this in their narratives and many, as in the following example, recognized the multiplicity of definitions as a problem:

The two service systems think of things quite differently. If you talk about dual diagnosis and you're sitting in a psychiatric inpatient unit, they are talking about people who are psychotic who are using heroin and drinking themselves to death. They don't think beyond that. Mainly they don't see people with lesser problems. Talk to people in the AOD sector and either they are talking about that group, because they are so unable to assist them in a safe and expert way and they can't do anything with them (they think "this is not our responsibility" but can't get them in anywhere else) [or] that great big group that we know about with anxiety, depression and so on (KI 41[1], manager).

This informant points to a narrowness of focus in acute psychiatric wards, in contrast to the AOD sector's experience of seeing people experiencing problems at almost any point on the spectrum of symptom severity. Another informant agrees that mental health services focus on psychosis rather than other mental health problems:

They are not really psychiatric services, they are psychotic services. You even have some people in psychiatric services who don't think of nonpsychotic disorders as being psychiatric disorders—they've become that narrow (KI 5, clinician).

In figurative terms:

I think it's the fact that we're both talking about different ends of the elephant: even though we both love the elephant, we're talking about different ends, that makes our life very difficult (KI 16, policy executive).

The classic metaphor of the blind men touching different parts of an elephant and each creating a different image of the whole entity works to emphasize that multiple perspectives exist and should be communicated as such. Further, there are differing views about patient/client rights:

We are caught a bit between our ideas of patient autonomy (so if I choose to wreck my brain or wreck my body it's my right to do so) and a paternalism that says we should be assertively looking after people's physical health as well as their drug and alcohol health as well as their mental health. If you want to be helped, that looks good. If you don't want to be helped, or if you are on the margins of society or you are one of the vulnerable, then that means you

really get dropped by the wayside. What I'd say is we now need to be clearer in a policy sense about what we mean by "assertive" and what we mean by "access to services." It's not just their availability, it's also what happens to you when you access them, whether you are engaged with them—and it clearly crosses with primary care (KI 16, policy executive).

This informant names polarities in dual diagnosis discourse: individual rights (to use drugs or not, to seek help or not) and the professional's duty of care (to allow risk taking or to assert control) and invokes the moral concept of the deserving or undeserving sufferer. Such issues—rights, social justice and social inclusion—go far beyond the duality of mental health and AOD systems and diagnoses.

Three narratives

Turning to the three dominant narratives identified in analysis of informants' responses, there follows a synthesis of views on the ways in which a focus on dual diagnosis has (a) transformed the sector, which we have labeled the *progressive narrative*, (b) aided it to some limited extent, a *remedial narrative* or (c) missed the point and distracted attention from bigger-picture issues, *the radical narrative*. After each narrative, we summarize informants' counterarguments.

The progressive narrative

The progressive view is that the move in AOD agencies towards willing and able screening, assessment, and treatment for mental health problems has gained real momentum across the state and has transformed it.

It's lifted the sector. They were lifted kicking and screaming, but that's been good—it's helped them to be more professional (KI 19, clinician).

The narrative began in the 1990s with dual diagnosis "champions," clinicians acting as role models, leading special projects and attracting funding for ongoing development, with the help of supportive individuals in government departments. In this view, the sector is still at a stage of partial improvement but there is little reason to doubt that, as a whole, it is approaching a uniformly better condition than 20 years ago.

Indeed, in this narrative, raising the capacity to deal with dual diagnosis will have benefited all clients, not only those with co-occurring mental health problems: the standard of screening, assessment and treatment has been raised and staff are better able to apply the techniques of secondary consultation, case coordination, and case management. Further, the processes of capacity building and facilitation of change have been and will be transferable to service delivery improvements for other neglected population groups, such as young people, families of service users, or people with acquired brain injury. This is generally the view held by people who have been closely involved with dual diagnosis projects and initiatives. One informant, for example, sees dual diagnosis as a step towards creating a system where multiple needs are addressed:

I think we are moving to a focus on complex needs rather than just mental health and substance use... looking at people's plethora of needs [with] no-wrong-door service systems, much more effective models of early recognition and intervention with youth (KI 2, clinician).

The progressive narrative thus begins with pioneers and ends with the enlightenment of the AOD sector and beyond. Dual diagnosis discourse is recognized as having led the way.

Rebuttals to this view invoke the perceived "tokenism" in the implementation of dual diagnosis activities in the AOD sector, referring to inadequate investment in improving the response to people with mental health problems and general underfunding across all AOD sector functions. They also question the expertise of dual diagnosis specialists (KI 6, KI 15, clinicians). Others refer to the opportunity costs: dual diagnosis-specific work is seen as marginal to the AOD sector's needs, and can mean that other issues (such as physical health comorbidities, social exclusion, finance, housing) receive less attention (KI 4, KI 7, service managers). This counternarrative also rejects the idea that the learning is systematically diffused across the AOD sector. The reality, some informants emphasize, is more haphazard:

It does go well in some places for a while and that depends on the luck of having the right people in the right place and the right resources. The system doesn't seem to be able to identify that and encourage and reproduce it... it's not so much about dual diagnosis itself it's about the whole health bureaucracy (KI 5, clinician).

This informant had earlier talked about the way the temporary presence (owing to a project grant) of a psychologist and a psychiatrist in an AOD service had led to identification of "a lot of people who had undiagnosed psychoses, who did much better when we treated them [for their substance use problems]" (KI 5, clinician). Similarly the 2011 Victorian Auditor General's report on the running of the AOD system (Victorian Auditor-General, 2011, p. 24) heard from service users that once they gained access to the service system there was a tendency for service providers to rely on personal contacts when making referrals. This meant that if the client saw a less experienced (and therefore less well connected) worker they were not assured of getting appropriate referrals to other services and supports. This supports the view that treatment in this AOD sector depends more on chance than good systems and challenges the story of dual diagnosis capability suffusing the sector.

The remedial narrative   Another perspective revealed in analysis of the interviews emphasizes the intrinsic limitations of the AOD sector and points to dual diagnosis discourse as one agent in helping to improve its quality. This narrative begins with the observation that the workforce is not professionalized (especially in comparison with clinical mental health services) and that it over-values employment of workers with personal experience of AOD problems. Following from this there is, in the sector, a perceived overemphasis on the AOD service user's self-motivation and readiness for treatment, and inadequate attention paid to effective engagement and treatment methods. This view, from informants in both the MH and AOD sectors, holds that tackling these limitations through dual diagnosis capacity building has begun to make the AOD sector a more equal partner with MH services. An informant with extensive experience of managing an AOD service saw dual diagnosis work as:

an opportunity for this sector (AOD) to actually become expert. Because mental health won't tolerate workers who are not properly qualified…. Let's try and insist that we do have expert treatment available instead of half-baked, good-communicating, we-like-you-and-we-care-about-you mush. Good communicating and care is absolutely essential to these people, but that's not expert drug treatment (KI 1, manager).

Such criticisms of the AOD sector are qualified or countered in part by querying whether views on its poor quality are informed by recent experience. Some informants refer to recent improvements (such as the increasing proportion of qualified staff) but more strongly to enduring prejudice:

Highly qualified drug and alcohol workers [were] coming into mental health and being treated like students… Because they were coming from drug and alcohol they were sort of seen as inferior (KI 11, clinician).

A counterstory is that dual diagnosis training can erode rather than build the AOD sector's confidence in their ability to welcome people who are seeking help:

In some ways that's the downside of dual diagnosis—that people think it's a more complex diagnosis and they don't feel they have the skills to respond. That means that people don't get the services (KI 7, clinician/manager).

We've still got a way to go with treatment. There's still an issue of clinicians being unrealistically pessimistic about how efficacious they can be with treatment (KI 2, clinician).

The remedial narrative, in summary, begins with the AOD sector at a low base, with good intentions but fragile confidence, challenged by the low status of its workforce in comparison with the mental health workforce. A focus on dual diagnosis may offer a step up the ladder and greater respect for its expertise in alcohol and other drug treatment. The end of this story may be an expert professional drug treatment sector that more closely resembles the mental health sector.

The radical narrative   A third narrative is one of frustration with the last 20 or more years of health service system adaptations and restructures. In picaresque style, there have been a series of episodes leading

to a mixture of gains and losses, and no great improvement or resolution. This aspect of the interview data suggests that, while improving education, training, supervision and other supportive resources for the workforce is clearly beneficial, real progress for effective AOD services cannot be made without bold structural investment focused on the needs of the service users. Dual diagnosis discourse serves to distract attention from the need for major change:

I think there's such ingrained structural problems with getting good quality treatment that I don't know whether an initiative like this would mean great change for any group. As a consequence, because there's a perception that things might be different and people are now being better responded to, [everyone might be losing]. If you hear about it enough, and you hear government saying "We've got this no-wrong-door policy and everybody that goes into this system will be assessed and blah-di-blah"—it's almost like "tick, tick, tick, everybody's happy" (KI 4, clinician/manager).

Further reform and new funding models are envisioned which overcome the unhelpful self-interest of existing organizations, as in:

Until everyone rethinks the model and standards and all those sorts of things, [mental health and drugs] are going to be worlds apart... There's an allegiance to the organization rather than an allegiance to the patient. Most clinicians and workers are engaged in—and have to be—engaged in the needs of the organization, stopping people coming through the door and all those sorts of things... I think as managers we are obsessed with bigger budgets and getting bigger and more influence and all of that, and at the end of the day my concern is how we influence the system and how we change it, because it's inadequate (KI 18, clinician/manager).

This informant acknowledges that clinicians and workers are inevitably protective of their organizations and will tend to perpetuate fragmented service structures. Another informant notes that this need for protection arises from the funding levers in operation: funding AOD services by episode of care led to stricter gatekeeping, "a much more differentiated and separated set of clients" (KI 1, manager) and hence more risk of gaps between services.

In the radical narrative, the final chapter would describe a well-resourced and interlinked service system able and prepared to recognize and respond to need, with specialist MH and AOD services a part of the broader and enlightened system of general health and social care, aided by legislative reform such as decriminalization of drug use. Unlike the progressive and remedial narratives, the radical narrative does not see the dual diagnosis lens as particularly relevant or helpful.

Discussion and conclusion

Three narratives drawn from informants' reflections shed light on concerns about the implications, for the AOD sector, of the turn towards a dual diagnosis focus. They invite the listener to believe different truths: that dual diagnosis discourse has helped services to be more responsive to complex needs in general (progressive), that it has simply helped to improve expertise in AOD treatment (remedial), or that it has been a distraction from the need for major system reform (radical). Quietly underlying all three narratives is conceptual confusion and uncertainty about diagnoses per se, as well as awareness that the term dual diagnosis bears the weight of many combinations of perceived problems. Finally, the much wider discourse of social justice and marginalization surrounds the narratives, which all carry the assumption that we are a long way from a satisfactory closing chapter. While this study has focused on the State of Victoria, Australia as a case study of dual diagnosis discourse, the different narratives identified resonate with other jurisdictions where a focus on dual diagnosis has been introduced into policy and practice.

Our informants believe, and dual diagnosis program evaluations have found (Australian Healthcare Associates, 2011; Australian State and Territory Peak Alcohol and Other Drugs (AOD) Non-Government Organisations, 2011), that dual diagnosis discourse has had a positive influence on the general quality of screening, assessment and treatment by AOD serv-

ices. At the same time the informants all recognize notable barriers to quality improvement: inadequate service models in which the survival needs of organizations are misaligned with the needs of potential service users; high expectations that the sector will provide, from a low funding base, specialist, professional expertise as well as the more generic support needed by people who, as one informant put it, have been "dropped by the wayside" because of the failings of the broader system; feelings of frustration, inadequacy and pessimism associated with not only the nature of mental health and AOD problems but the systemic barriers. A recent international research review on integrating MH and AOD services (Torrey, Tepper, & Greenwold, 2011) suggests that the Victorian experience is far from unique.

What is the elephant?

The metaphor of the blind men describing separate parts of an elephant is worth exploring as one means of drawing together the implications of these narratives. First, there are the varying guiding images of dual diagnosis as a set of problems of the brain, the mind, the will, or the environment. Second is the polarization between the mental health system's idea of dual diagnosis as referring to people with severe mental illness and the AOD sector's inclusion of those with more common, mild, or moderate mental health problems. The metaphor is a reminder to be clear about who and what are the subjects of conversations about dual diagnosis and to attempt to describe the whole creature. Further, informants' narratives suggest that a focus on dual diagnosis as the elephant leads only to incremental improvements, while significant sociocultural and systemic barriers (the elephants in the room?) call for more radical change.

The work of the narratives

Each narrative can be seen as having particular functions (or "doing work") in the AOD discursive field. We have drawn attention to three parallel narratives (and there are potentially more) to bring to light tensions in the field which are seldom seriously addressed in clinical research, implementation studies or evaluations.

We speculate that the work of the progressive narrative is to inspire, through its vision of a system-changing endeavor that promises transcendence from dual diagnosis to a higher vision of more humane and inclusive care for all across the health and social service systems. With its champions marshaling limited resources and small bands of followers, its "no wrong door" catch cry and its evident successful skirmishes with hegemonic beliefs and practices, it is a classic tale that can rally support. As is the way with visionary narratives, it has its disbelievers who are dismissive of its claims. In a field, however, where the fostering of hope is critical to the service user's recovery and therefore to the therapeutic outlook of the sector, this narrative clearly contributes an exemplar. The remedial narrative covers work in the middle ground, with its pragmatic moral that any thoughtful new investment of time and money is worthwhile in the context of a chronically underfunded sector. It can thus be seen as a mediating narrative, although it risks offending those who are sensitive to misunderstanding of the nuances of the AOD sector's expertise, are wary of a takeover by psychiatry, and would bristle at criticisms such as that good communication and care is not expert treatment. The radical narrative arguably works to inspire and empower big-picture thinkers but could also, if seen as a too-hard narrative, be disempowering. All three narratives acknowledge that the problems of dual diagnosis are as much about social structures and inequities as they are about clinical classifications and treatments. Traditional professional turf and status play a part (Roberts, 2012).

As well as having distinct functions, the narratives share some plot components, such as the ideal of a welcoming therapeutic approach and of a "no wrong door" service system. They could all close with a common celebration of a health and welfare system that is resourced and able to provide well-tailored, timely treatment and care. Government policy makers, looking for a metanarrative or grand overarching theory, clearly embrace the progressive narrative, and this is the most prevalent narrative in policy discussion (Department of Human

Services, 2008, 2009). Accommodating other legitimate, although at times conflicting and even subversive, narratives is, however, an important consideration in gaining widespread cooperation and due investment in better services and systems. Otherwise there is a risk of differing perspectives being rejected as resistance to change, with a consequent potential loss of the knowledge and wisdom of those who differ, and a continuation of weary pessimism about solutions.

Acknowledging, even embracing, narratives that are not only empowering but are also critical enables a metanarrative of policy and practice that is more nuanced and better reflects divergent experiences of different players. It also creates a narrative that not only highlights the strength of the dual diagnosis journey but also acknowledges further need for reform. If dual diagnosis discourse (with the initiatives it has generated) continues on a separate and specialist path, it risks fading from fashion and itself falling into the system's gaps, however attractive its claims to be creating welcoming and appropriate treatment for all. "Dual diagnosis" is but one way of concentrating hearts and minds on the imperative of improving services. The diversity of informants' views in our case study supports an argument for a metanarrative which, combining the strengths of the three narratives, continues to be pioneering, brings additional knowledge and skills to AOD services, and is explicitly conceptualized as part of a story of structural reform.

Such a metanarrative, while desirable, may be optimistic in the current global economic climate. At the time of writing AOD service providers in Victoria are expecting imminent and major reorganization of state government funding, which will mean mergers and closures. At a time when cost-neutral change management is politically attractive, the progressive dual diagnosis narrative may continue to have continued currency and the energy of dual diagnosis champions will be needed, but the alternative stories will continue to provide a critical viewpoint, further highlighting deficiencies in an already stretched sector. We conclude that the next chapter in our meta-

narrative must be concerted action to secure adequate resources and raise the political priority of just and equitable service provision.

Note

* Key informants are identified by the code KI # and their primary role(s)

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Dual diagnosis discourse in Victoria, Australia: the responsiveness of mental health services (publication)

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Roberts, B. M., & Maybery, D. (2014). Dual Diagnosis Discourse in Victoria Australia: The Responsiveness of Mental Health Services, *Journal of Dual Diagnosis, 10:3*, pp. 139-144. DOI: 10.1080/15504263.2014.929332

Declaration by candidate

In the case of Chapter Four publication *Dual Diagnosis Discourse in Victoria Australia: The Responsiveness of Mental Health Services*, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Concept, research, all drafts, revisions after peer review	90%

The following co-authors contributed to the work:

Name	Nature of contribution	Extent of contribution (%) for student co-authors only
Darryl Maybery	Reviewing drafts, suggestions on language and structure	n/a

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate's and co-authors' contributions to this work.

Candidate's Signature		Date

Main Supervisor's Signature		Date

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Dual Diagnosis Discourse in Victoria Australia: The Responsiveness of Mental Health Services

Bridget M. Roberts, MA,[1] and Darryl Maybery, PhD[2]

Objective: In recent decades, psychiatric services have been challenged to be more responsive to patients' coexisting problems, in particular those concerning substance use. In Australia this has been referred to as a "No Wrong Door" approach. This paper explores the meanings of this move for the acute mental health sector, including attitudes toward a No Wrong Door approach to people with a dual diagnosis of mental illness and substance use disorder. **Methods:** This qualitative study involved a review of the research literatures, analysis of policy documents, and interviews with 19 key informants in a case study of the State of Victoria, Australia. **Results:** The analysis resulted in two broad themes surrounding the implications of dual diagnosis discourse for the mental health sector. The first involves progress regarding the concept of No Wrong Door with subthemes including interprofessional cultural conflicts, intersectoral professional status issues, terminology, problem definition, perspectives on serious mental illness, the role of the client, and pharmacological treatment. The second overarching theme focuses upon informants' thoughts on future directions for the sector and highlights divided opinion on the implications of dual diagnosis discourse for the mental health service and social care systems. **Conclusions:** While the perspectives on system change and multiple issues such as resource concerns and cultural clashes are presented here, the informants in this study also gave clear guidance for the future of dual diagnosis work in the mental health sector (e.g., focusing on orienting services toward consumer strengths and recovery), along with recommendations for future research. This paper contributes to the small body of qualitative research on the history and course of efforts to develop appropriate practice in mental health services with regard to patients who have substance use problems and other mental health disorders. (*Journal of Dual Diagnosis*, 10:139–144, 2014)

Keywords dual diagnosis, service systems, qualitative research, Australia

Public mental health services in Australia, as elsewhere, have seen a long period of change. Familiar themes are closure of stand-alone psychiatric hospitals, development of community-based care models, closer ties with general health and social services, shorter hospital stays, developments in pharmacotherapies, the pioneering of early intervention for psychosis, the growth of a consumer movement and of non-government support services, and the rise of a population health framework (Meadows, Singh, & Grigg, 2007). The mental health sector has been "awash with innovation and piloting" (Swerissen, 2008, p. 71). A focus on dual diagnosis has been among the innovations and has produced a distinct discourse. It is a discourse in the sense of a language, written texts, and social practices around them that give the term dual diagnosis meaning and that can be analyzed in an exploration of the relationship between discourse and reality. Dual diagnosis discourse is a hybrid of interconnecting and somewhat conflicting discourses of mental illness and substance misuse. It is visible in the dual diagnosis labels for groups of service users, designated professional positions, dedicated funding, government policy documents, screening and assessment forms, training courses, practitioner networks, and specialist academic journals.

The body of research in this discourse has burgeoned since epidemiological and medical studies of dual diagnosis began to proliferate in the late 1980s, particularly in the US (Lehman, Myers, & Corty, 1989; Minkoff, 1989; Osher & Kofoed, 1989; Regier et al., 1990). In Australia, key studies included one on the prevalence of psychotic, affective, and substance-related disorders in homeless people in inner-city Melbourne (Herrman, McGorry, Bennett, & Singh, 1990; Herrman et al., 1989) and an action research project on service access (McDermott & Pyett, 1994). Putting the resulting knowledge into practice, however, is an enduring challenge, as international reviews (Adams, 2008; Torrey, Tepper, & Greenwold, 2011) and a local evaluation (Australian Healthcare Associates, 2011) have found. Professional attitudes are among the factors at play in a general consensus that the relevant service systems are on a long road to effectiveness.

Interest in the treatment of substance use has waxed and waned in the short history of European psychiatric services

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in Victoria. Specialist institutions for substance use problems (usually just alcohol) have come and gone, facing still-familiar issues of government support, treatment effectiveness, and debates about medical and moral approaches (Clark, 2012). The creation in 1987 of a section on alcohol and other drugs (later termed addiction, to include gambling) in the Royal Australian and New Zealand College of Psychiatrists took considerable effort on the part of its champions. One report claims that the college originally sought to exclude addiction from psychiatry, on the grounds that "low status, unreliable, and insightless alcoholics would do a disservice to the emerging specialty" (Lubman, Jurd, Baigent, & Krabman, 2008, p. 39). Writing 20 years after the birth of the college's section on addiction, these authors still saw a need to argue that addiction was a worthwhile interest for the profession and to urge members to take an active role in the addiction field.

The claim that psychiatry has an uncomfortable relationship with addiction is supported by research on the attitudes of psychiatrists and other mental health clinicians. Numerous studies have identified these professionals' attitudes as among the main barriers to effective treatment of dual diagnosis. An early UK study (Farrell & Lewis, 1990) found that psychiatrists were more likely to rate patients described as having a past diagnosis of alcohol dependence as difficult, annoying, less in need of admission, uncompliant, having a poor prognosis, and less likely to receive psychiatric aftercare. More recently, Victorian rural mental health clinicians were described as frustrated, resentful, and powerless in their attempts to understand their clients' substance misuse (Deans & Soar, 2005) and an Australian survey found under-recognition of substance use problems in young people presenting with depression (Lubman, Hides, Jorm, & Morgan, 2007). Some Australian studies of mental health clinicians (e.g., Pinikahana, Happell, & Carta, 2002) present an optimistic view, finding that clinicians recognized the prevalence of dual diagnosis and were open to further education and training. A review of 18 studies of mental health clinicians' attitudes to substance use problems (including five from Australia) was able to distinguish between parts of the mental health system, speculating that staff in secure forensic facilities and acute inpatient wards held more negative attitudes because of the greater severity of illness in those settings (Adams, 2008). Professional attitudes are not, however, necessarily about patient characteristics. There is a dynamic in the move to integrate mental health and substance use services that is principally about competition among treatment models and a desire to gain professional influence (Rush, Fogg, Nadeau, & Furlong, 2008). These authors echo critical analyses of the social and bureaucratic structures that develop around diagnostic categories (e.g., Rosenberg, 2002).

A perceived discomfort among mental health professionals in matters other than severe mental illness is not confined to dual diagnosis discourse. Collaboration between mental health and other services is also an issue in the literature on working with children and families (Maybery & Reupert, 2006, 2009), or with people with an intellectual disability (Rose, Kent, &

Rose, 2012). Comparative studies of stigma, however, suggest that alcohol and drug misuse is more stigmatizing than other co-occurring problems (Boyle et al., 2010; Room, 2005).

Positive responses to people experiencing dual diagnosis require a change of culture in clinical mental health services (Australian Healthcare Associates, 2011; Stanhope, Tuchman, & Sinclair, 2011). Writing from international experience of the implementation of community mental health care, Thornicroft (2010) emphasizes the need to manage change well. Clinical leadership is a strong factor in the change process (Brousselle, Lamothe, Sylvain, Foro, & Perreault, 2010). Torrey et al. (2011) emphasize active on-site leadership supported by organizational and system mechanisms and, importantly, an expectation that the process may take years. In Australia, the language of government policy, which since the early mental health and drug strategies of the late 1980s and early 1990s has always mentioned intersectoral collaboration, is now also explicit that this necessitates assertive cultural change (Department of Human Services, 2009, p. 131).

The nature of such change in relation to responsiveness to people experiencing dual diagnosis appears to have been uneven in Victoria. Victoria is an interesting case because it stands out as a jurisdiction with a strong history of innovation as well as adaptation of models from North America and Europe. It is also a case, along with other Australian jurisdictions, where the substance use service system is separate from the mental health system. A "No Wrong Door" policy has been in effect since 2007, directing that people presenting to a mental health service should not be turned away if they are considered to be experiencing substance use problems and, in turn, that substance use services welcome people presenting with comorbid mental health problems. Evaluators of 10 years of a statewide dual diagnosis capacity-building initiative found that clinical mental health organizations were particularly unwilling to drive No Wrong Door reform in their own organizations (Australian Healthcare Associates, 2011). The current paper examines this perceived reluctance, captures perspectives on dual diagnosis discourse that may inform future developments, and contributes to understanding how the discourse has played out in relation to the mental health sector in the State of Victoria.

METHODS

Participants and Procedures

This paper draws on analysis of the literatures on service integration, government policy documents, and the perspectives of key informants in Victoria, Australia. The primary data comprises 19 in-depth interviews conducted during 2010 and 2011 with senior policy executives ($n = 3$), service providers ($n = 14$), and consumer researchers ($n = 2$): 10 women and 9 men with expert knowledge the field of dual diagnosis in Victoria. The informants were purposively selected to include opinion

leaders in their spheres (some national and cross-sector, some more local and sector-specific). Informants were from a range of professional backgrounds (medical, nursing, social work, and a variety of experience in the relevant service sectors). The interview was semi-structured, asking participants to recall their experience of dual diagnosis discourse and reflect on its implications. Each participant reviewed and confirmed the accuracy of his or her interview transcript. Thirteen also provided written answers to a follow-up consensus-seeking questionnaire on key themes from the interviews.

After complete discussion of the study, informants gave written informed consent to being interviewed.The study was conducted in accordance with the Declaration of Helsinki and approved and monitored by Monash University Human Research Ethics Committee.

Data Analysis

Qualitative analysis included iterative study of themes, narratives, and metaphors as they arose from the informants varied standpoints in the discourse and was aided by a computer software package (QSR International NVivo).

RESULTS

We report here two broad themes from our analysis of key informants' perspectives on the implications of dual diagnosis discourse for the mental health sector. The first theme reflects on progress in relation to the concept of No Wrong Door, outlining a number of subthemes including how interprofessional cultural conflict is a feature that is seen as delaying progress toward integration. Other subthemes include intersectoral issues such as relative professional status, terminology, problem definition, and differing perspectives on serious mental illness, the role of the client, and pharmacological treatment. The second overarching theme focuses upon informants' thoughts on future directions for the sector and highlights divided opinion on the implications of dual diagnosis discourse for the mental health service and social care systems.

"No Wrong Door" Progress in the Mental Health Sector

Responding to our study's online consensus-seeking questionnaire, informants agreed that dual diagnosis was generally accepted as "core business" and that dual diagnosis discourse had leveraged real, though incremental, improvements in screening and assessment in specialist mental health services in Victoria. Informants strongly agreed that mental health services were still, however, excluding many people with dual diagnosis. Opinion was divided on the specific question of whether mental health clients in acute inpatient services were now more

likely to have substance dependence and withdrawal symptoms recognized. A minority of informants held the strong view that investment in dual diagnosis initiatives had achieved little in the context of two under-resourced service systems. For example:

. . . I suspect that there have been only marginal changes from when I first commenced in the mental health/alcohol and other drug system 35 years ago. Pretty unsatisfactory really. . . . Top down policy developments with limited associated resources will continue to frustrate service providers and ultimately those who need help will miss out (KI 4, psychiatric nurse and alcohol and other drug service manager).

Alongside these strong claims that resource shortages were at the heart of the problem, informants discussed the role of cultural attitudes toward substance use services and problems. Enduring barriers included ideology, policy, language, and client-related factors. From experience spanning direct care, management, and policy executive roles, informants strongly identified these issues as pivotal barriers to progress. For example:

The cultures of the staff that do those jobs now in the public sector are a long way apart. . . . They are talking different languages, different conceptualizations of condition or problem. . . .The cultural differences between clinical mental health, psych disability support, drug and alcohol, and intellectual disability are significant. And I think that's at the heart of it (KI 10, policy executive/service manager).
Dual diagnosis is a mental health concept anyway. The psychiatric disability and alcohol and other drug sectors aren't interested in diagnoses, so it's a mental health construct to start with (KI 13, psychiatric nurse and dual diagnosis clinician/leader).

These accounts introduce the multicultural challenge of dual diagnosis and the way definitions of the problem are culturally situated. Another informant (KI 16, policy executive) adds a rich analogy with the fable of the blind men describing an elephant based only on the part they can touch. A fourth informant (KI 5, psychiatrist) observed that, for many mental health clinicians, asking a patient about substance use was still felt to be taboo and inappropriate, something to be avoided as far as possible. Another recalled the cultural clash playing out in the drafting of a state policy document (Department of Human Services, 2007) that would require services to demonstrate dual diagnosis capability:

We went backwards and forwards, draft after draft after draft. We'd put across something and they'd come back with it rewritten (KI 3, alcohol and other drug policy executive).

One element of the cultural clash, according to key informants, is that the clinical mental health workforce tends to have a disparaging attitude toward the expertise of the substance use services workforce. They noted therapeutic pessimism about the value of substance use screening, assessment, and

treatment and, moreover, an underlying sense of medical cultural superiority:

> I think there is still a sense in mental health that we're all skilled and trained and we're one of the Big Five—nurse, doctor, social worker, psychologist, occupational therapist, whatever—and that the others [in alcohol and other drug and other sectors] are not . . . rather than that it's a different model and different people are required for it. I think that'll be a maturing when we all kind of work that out. (KI 12, occupational therapist, service manager).

Three further points of friction stand out in the interview texts: the nature of serious mental illness, the role of the client, and the use of medication. The first of these issues was faced in the policy drafting process, where the inclusion of "high prevalence" disorders in a dual diagnosis policy was reported as a major stumbling block. As one informant noted, dual diagnosis discourse developed at the same time as "the increase in public awareness around the legitimacy of clinical depression and chronic anxiety" (KI 3, *alcohol and other drug policy executive*) and associated expectations that mental health services should broaden the scope of their treatment into unaccustomed areas. The second strong cultural difference identified in the interviews was between mental health practitioners' tendency toward paternalism and substance use practitioners' favoring of client autonomy. As one informant put it, the mental health workforce was still adjusting (post-deinstitutionalization) to clients having more autonomy and being able to "live their lives messily in the community." Third, attitudes toward use of medication in a given case can differ widely:

> In psych, they'll medicate for behavior. If someone's behaving badly they'll give them some medication to shut them up. In drug and alcohol you don't medicate for behavior—it goes back to 'you don't treat a drug problem with a drug' (KI 19, alcohol and other drug nurse).

Each of these matters touches on core beliefs about illness, health, and appropriate care. A strong minority view was one of disappointment that the need for resolution of such issues had not been met by sufficient creative leadership. For example:

> Bringing the two areas, mental health and alcohol and other drug[s], together was always going to depend on leadership over a sustained period to embed new thinking and new ways of doing things. . . . [Without this] the rhetoric takes on more substance than the reality (KI 5, consumer researcher).

Another wrote of the short attention span built into the policy cycle, suggesting the way that such leadership can be deflected:

> They are always on to the next big thing—one year, dual diagnosis, the next early intervention (KI 6, mental health clinician).

All acknowledged the difficulty of integrating very different, stressed, and politically difficult systems, as in:

> There remains a significant difference in policy regarding targeting, legislation and model of service provision. Both systems are under pressure—mental health more so—which means that

> there is not the service availability or culture to respond in a way that best engages and limits harm (KI 16, public servant).

Future Directions

Opinion on the implications of dual diagnosis discourse is divided. For some, dual diagnosis initiatives and related administrative changes are a diversion from holistic work. For example, a substance use service manager felt that a closer bureaucratic relationship between mental health and substance use services led to "a greater emphasis on dual diagnosis at the alcohol and other drug service level and all the other issues (physical health comorbidities, social exclusion, etc.) received less attention" (KI 4, psychiatric nurse and alcohol and other drug service manager). This view raises the image of dual diagnosis as a construct that risks increasing the isolation of mental health services, with both dual diagnosis and substance use as specialties within clinical mental health services. Several informants also acknowledged the prevailing fear in the substance use services sector that their culture and expertise (with its intersectoral, public health approach) would be taken over and subsumed by the dominant clinical mental health system.

Others, in contrast, understand dual diagnosis as working the opposite way, in that it has strengthened a social model of health in mental health services practice and supported integration into the whole health and social care system:

> I think that when our department was framed as the drugs and mental health division, it was partly a hopeful step in terms of leadership from the alcohol and other drug sector to influence the way that mental health services do business. For example, we started to see a much stronger policy awareness of the person's social context and of the role of trauma in service users' lives (KI 5, consumer researcher).

Many informants saw a mismatch between a diagnosis-based system and the real problems people experience, with several indicating that for them dual diagnosis discourse was in fact going beyond diagnostic labeling and becoming synonymous with "complex needs." A clinician with a background in the mental health sector saw potential for dual diagnosis work to lead to a broader contextual awareness in the specialty sectors and a corresponding acceptance of mental health and substance use work in the wider system:

> We really need to move beyond thinking alcohol and other drug and mental health but rather just "health." Dual diagnosis is a part of every component of the health and welfare system so needs much greater attention across the health system (KI 11, dual diagnosis clinician).

Many informants returned repeatedly to the need to increase investment to match the scale of harms arising from dual diagnosis and the potential for improving treatment and care. Recommendations included improving and sustaining quality control; good training, supervision, and networking within and across sectors; and a focus on strengths and recovery (KI 4,

psychiatric nurse and alcohol and other drug service manager; KI 6, mental health clinician). There was consensus that realizing a common vision of holistic health services would require mental health and substance use services to be consistently led and allocated a higher priority. Perhaps above all, combating stigma should be a common concern for both the mental health and the substance use services sectors:

> There is an historical political "pecking order" in relation to policy and investment in the fields of mental illness and alcohol and other drug[s], affected by community attitudes and stigma (KI 14, mental health manager).

DISCUSSION

Our analysis of these key informants' perspectives indicates that the discourse around dual diagnosis may be less pessimistic than 20 years ago, but tensions remain. Dual diagnosis is still associated with intractable conditions that do not fit the treatment system; the psychiatric and substance use treatment models are seen as polarized; and the concept of dual diagnosis as a platform for system improvement is variously seen as threatening or promising for ways of working that practitioners consider good practice. Our analysis of key informants' perspectives is consistent with other research and evaluation findings on the responsiveness of acute mental health services to the problems of dual diagnosis. We are with Adams (2008), in particular, in emphasizing that the cultural values and beliefs held in each service sector must be considered seriously in service, workforce, and system development.

Dual diagnosis discourse in some ways exemplifies the tension between public health and clinical approaches to organizing health services. For the mental health sector, dual diagnosis discourse appears an uneasy hybrid of public and clinical health, moral, and medical models. Psychiatrists consistently encounter what Grant Gillett (2012) calls "quilting points": nodes where multiple discourses intersect in an entity (a human being or a disease event). To be expert one has to "embody multiple quite possibly anomalous discourses" across science, art, and morality, and "there is no science of the intersection between biological organisms and the world of institutions, statutes, rules, social expectations, political structures, and local discursive contexts" (Gillett, 2012, p. 60). Questions of individual moral responsibility for health and illness and the role of social and structural determinants are universal and timeless. Clinical and implementation studies will offer guidance for more effective and respectful treatments, better service systems, and effective approaches to change management but will not take the heat out of fundamental moral and cultural issues. These issues arise in debates about mental health services' responsiveness to a range of co-occurring problems involving physical health, family health, intellectual disability, or the catch-all category of complex needs. The research literature on dual diagnosis is dominated by the traditional sciences, none of which will suffice on its own to solve the problems of the brain and mind. There is, therefore, a need

for people to step outside the world of their own education and training to embrace a more interdisciplinary approach and challenge the hegemony of the single (or even dual) diagnosis as the organizing principle for health care (Barnett et al., 2012). Dual diagnosis discourse emerged when psychiatrists were beginning to accept addiction as a proper object of their expertise. Addiction is still, however, considered somehow peripheral to their discipline (Lubman et al., 2008), and there is a great need for more psychiatrists and other mental health practitioners to play a leading role in encouraging respectful conversations across boundaries (Rosen, 2001). An important step in this move is to encourage the participation of patients and other service users into practice and research (MacDonald, Herrman, Hinds, Crowe, & McDonald, 2002).

The informants in this study also gave clear guidance for the future of dual diagnosis work as part of the mission of the mental health sector. Leverage for change can develop through improving and sustaining quality control and good workforce development, including interprofessional/intercultural elements and the secondary consultation skills that are essential for an integrated health system. Further, a focus on orienting service toward consumer strengths and recovery may also lead to important practice improvements.

Future research could further study the ways in which dual diagnosis discourse can influence the opening of doors to effective and welcoming mental health services. Our study has taken a crucial step toward intercultural understanding by eliciting and sharing perspectives from multiple standpoints. The process of cultural change could be further illuminated and promoted through inquiry into multiple ways to embed cross-cultural listening and understanding. Cross-cultural communication can, for example, be built into workforce development, enhanced through judicious co-location of services, codified in memoranda of understanding, and supported through acknowledging parity of expertise.

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DISCLOSURES

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Summary

This chapter has set the scene of a case study of dual diagnosis discourse in Victoria and has provided a comprehensive analysis of the emergence, development and implications of dual diagnosis. Analysis of key documents and events and of key informants' perspectives has illuminated the drivers of the discourse, the meaning of intersectoral tensions and implications for the specialist MH and AOD sectors. The publications suggest wider systemic conclusions concerning boundaries and collaboration.

The next chapter will provide a general discussion and elaboration of these major themes.

Chapter Five: Discussion and conclusion

Introduction

This case study of dual diagnosis discourse in the Australian State of Victoria set out to investigate how dual diagnosis discourse emerged and developed over 25 years. The findings as outlined in the five papers illustrate and answer the three core research questions of (1) why dual diagnosis discourse emerged, (2) how it evolved in the two specialist sectors within the various practices and structures of care, and (3) the resultant implications for governments, professions, services and service users..

Each publication in Chapter Four, approaching somewhat different questions for different audiences has, each in its own way, synthesised and discussed the study's findings. The purpose of this chapter is to integrate discussion of the findings in relation to each research question. Finally, discussion of the study's quality and value (strengths and limitations) leads into directions for future research along with potential directions for future practice and policy in Victoria.

Why dual diagnosis discourse emerged

We have seen in Paper One (Roberts, 2013) that dual diagnosis discourse emerged from concerns about service fragmentation. Advocacy grew for those who were falling into gaps between services, who were becoming homeless and whose health was deteriorating. Dual diagnosis became a concern in Victoria in the 1980s and 1990s during a time when comprehensive community based care that 'put people first' was an aspiration, but services were fragmented. It is widely assumed that the main factors influencing this fragmentation were deinstitutionalisation and a lack of resources. My argument is that New Public Management and diagnosis-specific funding models were also major contributors in Victoria to the exclusion of people experiencing dual diagnosis and the emergence of concern about dual diagnosis. Professional interests were also at play: with evidence of improvements in AOD treatment, psychiatrists saw an opportunity to enter or re-enter the field, forming a special RANZCP interest group in 1987. The

concept of dual diagnosis offered them a new medical specialty, although optimism about treatment was not widespread.

How the discourse evolved across the two sectors

As action coalesced around the needs of people considered to have a dual diagnosis (Paper Two, Roberts, Maybery, & Jones, 2013), momentum grew for capacity-building as a solution to fragmentation: building the capacity of each specialist sector to inquire into and respond appropriately to the 'other' set of problems (mental health problems in the alcohol and drug sector and alcohol and drug problems in the mental health sector). Capacity-building entailed change management (top down and bottom up) across the mental health and alcohol and drug sectors that would effect a cultural shift. It would challenge over-specialisation, language differences, incomplete assessment of those seeking help, and discontinuity of care. Federal and state governments funded initiatives that promoted leadership, networks and workforce development, such that all relevant services would work towards a welcoming response to people with dual or multiple problems.,. I found that the mental health and AOD sectors took slow but noticeable steps towards a 'no wrong door' service culture.

During the period there was also an important shift in the way the service system was conceptualised. The base of mental health and AOD strategies was broadened to encompass the whole population, health promotion, prevention, primary care,and early intervention. The model was most fully articulated in the Victorian mental health reform strategy of 2008, 'Because Mental Health Matters'. This visualises the specialist sectors within a networked system with negotiable pathways, and recognises numerous ways in which mental health problems may be associated with AOD problems. In doing so it also brings into the picture a broader workforce, as well as families and communities, and recognises their influence on health and wellbeing, including on mental health and AOD use. By the end of the period, responsiveness to people experiencing dual diagnosis was seen as essential for mental health and AOD services and the concept of broad-based,

networked services was well known. At the same time, there were enduring inhibitors of change: resource pressures, a crisis orientation in the acute mental health services, and tensions among service organisations and professionals.

Dual diagnosis discourse acquired a focus on capacity building across services rather than the development of dual diagnosis clinical specialists. There was work at every level in policy and service provision. The personal qualities and attitudes of advocates and champions, top-down policy direction and a targeted injection of funding were the main enablers. Changes in attitudes, skills and service access were slow to develop.

Implications of the discourse for government, professions, service organisations and service users

The final research question addresses the meanings or implications of dual diagnosis discourse for some key groups of stakeholders. Three publications presented and discussed the research findings in relation to the two service sectors – Papers Three, Four and Five (Roberts, 2012; Roberts & Jones, 2012; Roberts & Maybery, 2014). Those findings are further reflected upon below in relation to government, professional groups, service sectors and consumers/service users.

Government

In spite of more than 25 years of national and state mental health and AOD policies and strategies, mental health and AOD investment still suffers from low status in government budgets. This means that services are crisis-oriented and struggle to provide effective, integrated and evidence-based services. Paper Four (Roberts & Jones, 2012) discussed the limited gains offered by government dual diagnosis initiatives to an impoverished AOD sector. Paper Five (Roberts & Maybery, 2014) noted key informants' consensus that mental health and substance use services should be consistently allocated a higher priority if the people they treated, whether or not they were experiencing dual diagnosis, were to receive adequate and appropriate care.

Key informants generally saw funding shortages as inevitable: there was sometimes in the interviews for this study a sense of the futility of dwelling on the issue. It was recognised, however, that resource limitations added to the barrier between services. Leading advocates in this area[12] have increasingly promoted the idea that investment in solutions to mental health and AOD problems (currently 3% of the research budget and 8% of the health budget) should more nearly reflect their 14% contribution to the burden of disease. Public health campaigns have raised the profile of depression and drawn more attention to the harms of alcohol and ways of reducing these harms, emphasising the need for change throughout the community and its health system. Federal and state governments are responding at least in part, with funds for early intervention and for developing online screening and interventions for alcohol problems, depression and anxiety. There is cross-party support for reform.

This thesis has suggested that dual diagnosis discourse, by drawing attention to the need for better service system integration, has contributed to something of a shift in government priorities. None of the evidence I have explored, however, suggests that governments are yet adequately resourcing the mental health and AOD sectors in Victoria or elsewhere. Further, New Public Management funding models continue to militate against collaboration: the government purchases direct service delivery, however measured, and encourages competition among service providers.

People with mental health and AOD problems remain stigmatised, often seen as undeserving and too hard to treat. It is hard to avoid the conclusion that social attitudes prevent adequate funding allocations for health and welfare, which in turn constrains delivery of what is known to work and innovation for improvement. Poor treatment outcomes then feed into the perception that inestment in treatment is not warranted.

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[12] (For example, the ANCD's 2013 Alcohol Action Plan, the work of psychiatrists Ian Hickie, of the Brain and Mind Research Institute and Patrick McGorry, of Orygen Youth Health and its Early Psychosis Prevention and Intervention Centre).

The need to combat stigma is likely to increase as a result of the continued widening in the diagnostic net, with the release of DSM 5, which defines a spectrum of substance use disorders including moderate problems, thus apparently lowering the threshold for diagnosis (Teesson, Slade, & Mewton, 2011). Teesson and colleagues argue that diagnostic broadening could be advantageous for the people affected but they point out that it will lead to more people with multiple diagnoses and potentially more social exclusion as a result.

This thesis supports a commitment to anti-stigma campaigns that not only reduce social exclusion but make it politically more acceptable to raise the level of investment to match the level of distress experienced. Analysis of the evolution of dual diagnosis discourse has highlighted the potential for mental health and AOD advocates to work together to increase government commitment to improvement.

Professions

Professional hierarchies form a significant barrier to service integration. Paper Three (Roberts, 2012) addressed interprofessional and intersectoral relationships, concluding that, unless organisational and systems-related barriers are addressed, then simply increasing workforce capability is unlikely to translate into more responsive and integrated care at the level of the person. The paper offered insights into the factors that inhibit the provision of a co-ordinated and integrated systemic treatment response. Strategies that arose from the findings placed interpersonal relationship-building at the centre and were congruent with those in the broader international context.

Paper Five (Roberts & Maybery, 2014) considered dual diagnosis discourse in light of the psychiatric profession's longstanding discomfort with people presenting with alcohol and drug problems. It continues the theme of cultural clashes and an enduring therapeutic pessimism, and the challenges of multicultural intersectoral work.

The term 'multicultural' in this contect recognises that services develop distinct cultures, based on their values, their mission, whom they see as their clients, whom they employ, and their definition of good practice. In integrated care (at whatever depth of integration), a multicultural approach entails understanding our own and others' cultural identities, resisting stereotyping, knowing the differences and similarities in practice and being prepared to discuss genuine dilemmas in decisions about treatment. Typical issues for dialogue have included whether people on psychotropic medication are eligible for participation in a drug-free therapeutic community; the prescription of Valium to an agitated, drug-dependent man in an Emergency Department; and applying a harm reduction philosophy in residential psychiatric rehabilitation facilities.

Service organisations

We saw in Paper Four (Roberts & Jones, 2012) that the quality of care in the alcohol and drug sector was generally agreed to have benefited from the extra, though limited, resources that were released under the dual diagnosis banner. Chronic under-investment remained, however. I proposed a narrative of dual diagnosis that wove together three contrasting narratives presented by key informants: it recognised the transformative role of champions and change agents, the incremental gains offered by dual diagnosis initiatives to an impoverished sector and at the same time the message that larger structural reform was overdue. The crisis-oriented, equally under-resourced acute mental health sector was perceived as having been slower to adopt a positive view of dual diagnosis capacity-building (Paper Five, Roberts & Maybery, 2014).

Resource limitations were acknowledged as a significant driver of the strict 'gatekeeping' that has often made service access difficult for people experiencing dual diagnosis. Another key issue for the two sectors, as identified by key informants, was misunderstandings about what could be provided by each service.

Key informant and research evidence on dual diagnosis discourse suggests a range of possible impacts on service provision. Briefly, one view is that advances in dual diagnosis responses contribute to the development of more humane, 'whole-of-person' and 'client-centred' care, the opening of doors across health and community services and the wider acceptance of multiple problems being a legitimate concern for specialist sectors. Another view is that psychiatry will dominate alcohol and drug treatment and erase the expertise built up in the alcohol and drug treatment sector. A middle view holds that the legacy of dual diagnosis discourse and endeavours will be only faintly discernible among those of other quality improvement initiatives and essentially little will have changed in attitudes to mental illness and to alcohol and other drug use. Dual diagnosis discourse has contributed somewhat to a general improvement in service quality, although perhaps more so in the AOD sector than in mental services. This limited claim is based on key informant perspectives and evaluations of quality improvement initiatives across the sectors (AIPC, 2009; Australian Healthcare Associates, 2011; Australian State and Territory Peak AOD NGOs, 2011; Victorian Auditor-General, 2011). Also, as outlined in the publications (Chapter Four), standardised, evidence based tools and techniques, including modified screening, assessment and treatment models, have been developed with and through collaboration across boundaries and promoted by education, training, accreditation/credentialling and other workforce and system development activities. Above and around all these behavioural mechanisms is the promotion of a core value of positive regard: positive regard for people with dual diagnosis (the therapeutic relationship) and, likewise, for colleagues with differing expertise. This includes a willingness to find the common ground without losing the nuances of specialist expertise.

The developments I have explored in the thesis have of course occurred in, and interacted with, a wider context. . One of the changes in public discourse over the period has been away from the 'war on drugs' and its confusing moral rhetoric that demonised illicit drug

use while keeping relatively silent on the harms of alcohol and other legal drugs13.

Specific alcohol strategies are now prominent. The harm reduction message has substantial political support. We are now in an era of drug diversion schemes, drug courts, decriminalisation of cannabis use, primary health centres and needle exchanges for drug users, and growing support for legalising the medical use of cannabis and other drugs.14. Such shifts have potentially aided acceptance of people experiencing dual diagnosis and helped to legitimise dual diagnosis discourse.

Service users

Policy reform documents in Victoria have repeatedly asserted that their main focus is the person in need of treatment, care and support, not the institutions and systems in place. Advocates for the dual diagnosis initiatives claim they have reinforced this message and paved the way for more person-centred systems for people with multiple or complex needs.

There is no evidence in Victoria or elsewhere of greater satisfaction with services and better treatment outcomes as a result of services becoming more dual diagnosis aware or capable. The strong emphasis on providing welcoming and engaging services is well supported by research. Key informants for this study were not, however, optimistic that services had improved.

Some service users (e.g Webb, 2009) have reservations about integrating mental health and AOD services. When seeking treatment for an AOD problem they do not want to risk becoming coerced into mental health treatment. This highlights the importance of the AOD service taking client preferences into account and having the capacity to work appropriately with mental health problems from their own skill base and in consultation as appropriate with mental health specialists.

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[13] Tobacco was an exception, as non-smoking legislation, funded Quit programs and athe National Tobacco Campaign moved on apace (Woodward, 2003)

[14] Moralistic attitudes endure, however, as seen most obviously in the fact that only one safe injecting facility exists in Australia, irrespective of successive evaluations demonstrating its benefits to injecting drug users and the community. (Salmon & Maher, 2010)

Broader implications

Finding common ground across the specialist MH and AOD sectors and combatting the marginalisation of people with a dual diagnosis has been an ongoing challenge as social stigma and the social and structural determinants of ill-health have endured. Progress has been slow. This case study concludes, however, with a note of hope that the learning from ongoing dual diagnosis discourse will help to resolve wider systemic questions as well as those specific to dual diagnosis. An overarching finding from my research is that a focus on dual diagnosis has been a (limited) step towards a larger goal, namely a better quality, more effective response to complex, multiple needs, moving beyond dual diagnosis, as one clinician put it, to 'health'. Dual diagnosis discourse includes key contemporary issues in health care delivery: individualised and comprehensive care, workforce planning and development, sustainability and quality assurance. In particular my work recommends that better interprofessional and intersectoral practices are critical factors in the wider public health vision of person-centred care. This thesis also clearly highlights that success in these realms entails cultural change: longstanding beliefs, practices and hierarchies may be threatened; organisations and professions may not survive in their current form. The initiatives undertaken in Victoria to improve dual diagnosis capability have demonstrated the effectiveness of champions and catalysts working at the service level to provide education, training, mentoring and supervision, supported by top-down policy direction. The reported unevenness of success, on the other hand, underlines the inadequacy of funding in relation to the magnitude of the task, and the need for funding models to stimulate linkages and shared care.

Finally, the overall intention of this thesis was to provide a detailed analysis of the development of dual diagnosis discourse in the context of a particular time and place, its implications for service providers within those sectors, for policy makers in government and potentially its meaning for consumers and for other sectors. By studying, in context, the operation of a medical construct, I have highlighted two things. First, that challenging

the single-diagnosis approach is a step towards and can give impetus to health and social care that sees and respects the whole person. Secondly, the path towards such a perspective continues to be limited by stigma and cultural barriers. Together these findings contribute a fresh perspective to dual diagnosis discourse. The thesis contributes to the body of qualitative research on the history and course of efforts to develop appropriate treatment and care for people experiencing difficulties with their mental health and their use of alcohol and other drugs. In doing so, the thesis also illuminates the development and implications of a medical construct over time in a particular context, adding to arguments for quality improvement, interdisciplinary, intersectoral workforce development in an integrated, adequately funded health and social support system.

Strengths and limitations

This thesis has clear strengths and limitations. The study has involved unique first-hand accounts of developments over recent decades, engagement with a range of international research literatures and analysis through the lens of written government policy. The qualitative approach suited the research purpose by generating grounded, contextualised data. Informants were well positioned to give a systemic view of dual diagnosis discourse and highlighted the cultural, philosophical, and experiential differences between the mental health and AOD treatment fields. The additional perspectives of other groups, such as service users and newcomers to the workforce, would make an important complement to the particular meso-level perspectives required to answer the thesis questions. The richness of detail and depth of analysis was, however, constrained by the nature of a single-researcher study and constraints of a PhD thesis .

A weakness is that the thesis focused solely on a single State as its study area. Although this allowed a detailed and intimate examination of the way the concept of dual diagnosis evolved within specific interprofessional and policy frameworks, the focus does limit the generalisability of the findings. The methodology employed, however, provides a model for future researchers to apply to other states of Australia and Internationally. Future

research could focus upon highlighting similarities and differences to the current case study.

Further, within Victoria, there is scope for research on collaboration across the non-government sector, housing, community health,primary care. andthe legal and correctional systems. This would extend understanding of the development of dual diagnosis across a broader range of sectors and give a fuller understanding of the changes and developments of the last 25 years.

A key strength of the work is that the peer-reviewed publication record demonstrates that this study is internationally relevant and has contributed to ongoing dual diagnosis discourse, thanks largely to a growing number of dual diagnosis journals. Two relatively new dual diagnosis journals, both launched in 2008, published three papers between them, finding that the work was appropriate for their interdisciplinary and practice-based focus. The paper on interprofessional relationships (the third paper in Chapter Four) was highlighted on an Australian dual diagnosis website for its articulation of the challenges facing service improvement.

Reaching an audience beyond the dual diagnosis community of interest and practice has been challenging. *Contemporary Drug Problems (CDP)*, an international, 40-year-old multidisciplinary social science journal, was the only journal not specialising in dual diagnosis to accept a paper from this study. (I submitted papers to four non-dual diagnosis journals in all.) Importantly, *CDP* is the only journal in the AOD field that has no word limit for articles, thus allowing space for the proper exposition of qualitative research (Rhodes, Stimson, Moore, & Bourgois, 2010). Publication bias towards specialist topics and experimental, or at least quantitative, research, with tight word limits, may be an issue. There is a need to promote the value of qualitative and critical research in dual diagnosis and its relevance to readers of specialist mental health or AOD journals, and beyond to journals in the broader social science and health fields.

Directions for future research

This thesis illustrates important directions for future research. The above limitations highlight workers new to the field, consumers and the PDRS sectors as important participants in future research. Better understanding of what works and how to improve service integration without losing the nuances of specialist services requires the involvement of consumers/clients.

Consumers and consumer movements are potentially critical in bringing the right people to the table and reaching workable solutions. Participation should be improved across the possible spectrum of participation intensity, from simply providing adequate information, to consultation and collaboration and ultimately to empowerment, wherein consumers drive the research agenda and lead the research. Researchers can continue to play a part in strengthening how this happens, and identifying the case for appropriate investment in consumer participation.

One of the barriers to consumer participation is the double stigma of dual diagnosis. This extends to the issue of professionals' own experience of dual diagnosis in themselves or those close to them. There is much scope for research on questions about appropriate self-disclosure and its implications. The value of 'lived experience' was a minor theme in this study's primary data. It was raised particularly in the context of the stigmatisation of AOD workers not only by association with stigmatised drug users but also because of the assumption that many workers were former service users. More open reflection is currently heard about lived experience but the perspectives of professionals about their personal experience are inadequately researched.

The work of the non-government PDRS sector (about to be reformed as community mental health services) with people with mental illness and their lives in the community has burgeoned in recent decades. The sector provides a promising subject for further exploration of the development of dual diagnosis awareness and capability.

Policy and program evaluation has been influential in building an argument for a focus on dual diagnosis over the period covered in this case study. Future evaluations should explore the risks and benefits of dual diagnosis and other intersectoral initiatives and attempt an assessment of their influence on consumers and significant others. The justice system is also another location for the study of the dynamics of dual diagnosis discourse as experienced by those who come into contact with it and those who run it.

Ongoing monitoring of explicit mentions of dual diagnosis in relevant spheres would build the body of knowledge on the influence of the discourse. For example, in Australia a National Mental Health Commission has been set up to watch and provide advice on whole-of-government responsiveness to mental health problems. It is prioritising the lived experience of people with mental illness and those around them and will produce an annual report card combining qualitative data with quantitative epidemiological data. This may help improve dual diagnosis awareness and capability. The data will only be comprehensive, however, to the extent that consultations themselves are comprehensive and people are willing to include experience of AOD issues in their stories and other feedback, rather than being constrained by shame, or by the belief that the issues are not relevant. It is heartening to note that the Commission's 2013 Report Card (National Mental Health Commission, 2013) includes the profiles of three people experiencing co-existing mental health difficulties and substance use problems and a strong recommendation on the need for coordinated, non-discriminatory, innovative and appropriately funded assessment, treatment and follow-up. Scope exists for research into and evaluation of the process and impact of the Commission's inclusion of dual diagnosis issues.

As service systems and their politics shift and change (Victoria, for example, is in a new era of reorganisation and renewed efforts to provide integrated health services), research on the maturing of perspectives on dual diagnosis will be relevant, with questions about the extent to which dual diagnosis responsiveness has become embedded – and whether in fact the discourse survives or merges into the background to be replaced by another.

Future research on responses to dual diagnosis calls for interdisciplinary teams – members of the many relevant fields working together using multiple models to define the problem, multiple data sources and analytical approaches, to produce findings that are intelligible to all relevant audiences. At the same time, such research should avoid raising walls around dual diagnosis studies as a sub-discipline that in effect adds another entrenched viewpoint and increases fragmentation. Rather this research should, as soft systems analysts advise, approach complexity with a soft focus, use peripheral vision and maintaining open dialogue.

Conclusion

This case study has illuminated the development and implications of major changes to services over time in a particular context and adds to the evidence base for improving the quality of treatment and care. Many analytical lenses are available for understanding dual diagnosis discourse and informing the future of this highly contested field. This thesis has sought to draw out the interests at play when 'dual diagnosis' is identified as the subject. My hope is that this work ignites, in the right quarters of the health system, greater confidence in working together to develop better, intelligently and sensitively integrated social and health service approaches and systems.

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Appendices

1. Tracking the story of dual diagnosis (non-peer-reviewed publication)

New Paradigm, the Australian journal on psychosocial rehabilitation, 'Unfinished business: pathways to social inclusion', Fitzroy, Victoria: VICSERV, Summer 2009/2010, pp. 31-32.

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Tracking the story of dual diagnosis

Bridget Roberts, PhD candidate, Monash University Department of Rural and Indigenous Health.

Some years ago I wrote a piece for New Paradigm (December 2005) on 'spinning threads across the divide". It was a story of my learning about ways of working with people with co-occurring mental illness and alcohol and other drug (AOD) use and misuse. I wondered then about the unrealised synergies between PDRS and AOD workers. The question remains as to whether there is some unfinished business there, and some aspects of my current study may help shed some light on where we have come from and where we are going.

Common ground

The article observed[1] that PDRS and AOD have much common ground that can be overlooked in the dominant crisis-oriented discourse, where the focus is on acute, clinical issues rather than relapse prevention, rehabilitation and long term psychosocial support. This common ground can be found in their position in the service system, their philosophies, and the people and the issues they are working with day to day. PDRS and AOD have structural similarities, such as isolation in large catchment areas, a mix of large and small organisations, a range of governance types, and worker backgrounds in psychology, social work, nursing, occupational therapy, education, welfare and community development. Along with highly diverse characteristics, participants/service users bring common issues to both sectors: trauma, grief and loss, relationship issues, general health problems, deficits in housing, income, employment and education, social exclusion,

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[1] As did Gary Croton in the same issue (2005)

various degrees of coercion by the legal system, trajectories of relapse and recovery. The sectors share a rights-based history. Both sectors work in the context of social stigma.

The AOD sector differs in combining clinical and non-clinical services but both sectors highly value social justice and service users' right to self-determination and draw a distinction between their approaches and those attributed to clinical mental health services. A recent qualitative study of primary health and social care providers in Victoria (Mitchell, 2009) articulates four interconnected discourses: 'an informal as opposed to a formal approach; a normalising as opposed to a pathologising approach; holistic social and emotional health and wellbeing, and an individualised or client-focused model of care as opposed to an illness-focused model.'

'No wrong door'

In 2010 dual diagnosis policy (DHS, 2007) and its strategies are now reasonably familiar to the psychiatric disability field. The use and misuse of alcohol and other drugs (AOD) among participants is understood to be the norm rather than the exception. Workers are encouraged to be dual diagnosis aware and to learn ways of assessing and working with people when they are having problems with alcohol or other drug use. Capacity-building is under way. Importantly, across the health and welfare system, different sectors and professions are urged to work together better. There has been considerable activity in the shape of training programs, assessment and treatment guidelines, exemplary programs and services, improvement of referral pathways, worker exchanges and the expansion of specialist worker roles.

Exploring 'dual diagnosis'

Nearly two decades after the project that led to the influential report 'Not Welcome Anywhere', it seems timely to reflect on where dual diagnosis policy came from and what it means in the larger health and social scheme of things. This is the theme of my current study. Perspectives on the relationship between the PDRS and AOD sectors will be one important thread of inquiry: what has been 'the business' between PDRS and AOD over the years and where could it be extended?

The idea for the study came when I was reflecting on the last 20-25 years: the first national and Victorian drug strategies date from 1985, VICSERV was created in 1986, closure of the large psychiatric hospitals began with Willsmere in 1988, a national mental health plan came into being in 1992. In this period there are cross currents of philosophies and knowledge related to drugs and mental health, from the recovery movements to neuroscience to pharmacology. There are debates about the nature of the problems and the effectiveness of treatments, and when coercion has a role. Tensions

exist between pharmacotherapy and talking therapies, and there are political contestations about harm minimisation and 'zero tolerance' alongside classifications of licit and illicit drugs that are unrelated to their intrinsic risks to health. All of the above is part of the experience of people who are now our experts in making or advising on policy, managing services, commissioning and leading research and leading consumer advocacy. What, I thought, would they have to say about the state of play today, and in particular about 'dual diagnosis'?

During the coming year I aim to interview a number of these people, including those who can comment on the PDRS sector, with the idea of understanding the dynamics of dual diagnosis policy through their multiple different views. Their stories will guide the study, but a literature review has already brought up numerous questions about how the policy emerged, the roles of power and politics and about where the policy and its implementation might lead, intentionally or otherwise. For example, after systematically reviewing psychosocial research on psychosocial interventions for dual diagnosis, Drake and others argue for a greater sociological emphasis in future research. They warn against dual diagnosis acquiring a clinical 'life of its own' without regard for the 'environmental, cultural and professional conditions that may exacerbate the problem' (Drake, O'Neal, & Wallach, 2008: 136).

The problem of dual diagnosis may lie more, it is often said, in the service system than within the citizen and the community. A better collective understanding of that system, its origins and motivations, may inspire better collaboration.

Biographical note: In the nineties I was part of the Out Doors team running the Going Places outdoor adventure program. I served on VICSERV's management committee and spent two years as their policy and research officer. After nearly ten years' involvement with psychosocial rehabilitation I moved into the AOD field in 2001, working at Turning Point Alcohol and Drug Centre on evaluations of programs and systems in the AOD and mental health fields.

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2.   Research documents

The following pages contain:

- Ethics committee certificate of approval
- Participant information sheet
- Participant consent form
- Interview guide
- Timeline of the study
- Literature search strategy

MONASH University

Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

Date: 7 January 2010

Project Number: CF10/0006 - 2009002013

Project Title: Dual diagnosis policy in Australia: an exploration

Chief Investigator: Associate Professor Janice Chesters

Approved: From: 7 January 2010   To: 7 January 2015

Terms of approval

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, and a copy forwarded to MUHREC before any data collection can occur at the specified organisation. **Failure to provide permission letters to MUHREC before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research.**
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must contain your project number.
6. **Amendments to the approved project (including changes in personnel):** Requires the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **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.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **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 Ben Canny
Chair, MUHREC

cc: Ms Bridget Roberts

Monash University Human Research Ethics Committee Certificate of Approval

MONASH University

Explanatory Statement

Dual diagnosis policy in Australia: an exploration

This information sheet is for you to keep.

My name is Bridget Roberts and I am conducting a research project towards a PhD at Monash University, funded by an Australian Postgraduate Award. This means that I will be writing several articles for research journals.

I invite your participation because your knowledge and expertise in the fields of alcohol and other drugs or mental health is highly relevant to the research. Your views will be important among those of a varied group of participants with knowledge of the health system from the perspectives of policy making, service use, advocacy and service provision.

The purpose of the research
Separate treatment services for mental illness and for alcohol and other drug problems are being urged to work more closely together in order to include people who have traditionally been turned away from both types of treatment. The purpose of this study is to describe how 'dual diagnosis' policy has evolved and explore its meaning for the future of treatment, care and support for those affected. My initial analysis of the research literature and policy documents will inform interviews with key stakeholders. These participants have been chosen with the aim of building a rich picture that includes service-user, gender, rural, Indigenous and culturally diverse perspectives. I will draw conclusions on the strengths, limitations and future of dual diagnosis policy.

Possible benefits
The research will focus on rural and metropolitan Victoria since 1988 during a time of significant change beginning with the closure of large psychiatric hospitals, the growth of community-based care and the evolution of a national drug strategy. Dual diagnosis policy offers a vantage point from which to acknowledge and evaluate recent history. My work aims to be a resource for policy and service development.

What does the research involve?
The study will involve a semi-structured interview at a time and venue convenient for you, approval of a transcript and a review of preliminary findings.

The interview will require half an hour to an hour of your time. Within four weeks of the interview I will send you a transcript of the interview so that you can check and approve its accuracy. There may be reason to contact you for a further brief interview for clarification. Later I will send you a brief summary of the preliminary findings for comment.

Participation should not place any unusual burden on you or involve any risks beyond those of your normal work.

If you participate you are under no obligation to answer all my questions.

Can I withdraw from the research?
Being in this study is voluntary and you are under no obligation to consent to participation.
Once you have consented to participate, you may only withdraw prior to having approved
the interview transcript.

Confidentiality
Most of the information will be reported thematically. I will make every effort to ensure you
are not identifiable in publications arising from the study, unless you specifically agree to
be identified. You can tell me whether you wish to be named as a participant. You can
also tell me whether you consent to being directly quoted in the text, in which case you will
have a chance to comment on the relevant section(s).

Storage of data
Storage of the data collected will adhere to the University regulations and be kept on
University premises in a locked cupboard/filing cabinet for five years. Electronic data will
be password-protected and will be deleted or erased after five years.
Thank you for your interest.
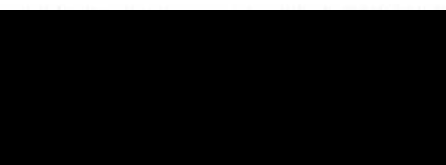
Bridget Roberts

For any **further information**, please contact Bridget Roberts, ██████████████████████ or the project supervisor: Dr Rebecca Jones, Monash University Dept of Rural and Indigenous Health School of Rural Health, Faculty of Medicine, Nursing and Health Sciences PO Box 973 Moe, VIC 3825	If you have a **complaint** concerning the manner in which this research (Project no. CF10/0006 – 2009002013) is being conducted, please contact: Executive Officer, Human Research Ethics Monash University Human Research Ethics Committee (MUHREC) Building 3e Room 111 Research Office Monash University VIC 3800

Monash University Department of Rural and Indigenous Health
PO Box 973, Moe, VIC 3825, Australia
3 Ollerton Avenue, Moe, Vic 3825, Australia
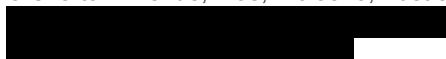
Web: http://www.med.monash.edu.au/srh/mudrih/index.html
ABN 12 377 614 012 CRICOS provider number 00008C

Consent Form

Dual diagnosis policy in Australia: an exploration

NOTE: This consent form will remain with the Monash University researcher for their records

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records.

Specifically, I agree to:

1. be interviewed by the researcher   ☐ **Yes** ☐ **No**

2. allow the interview to be audio-taped (optional)   ☐ **Yes** ☐ **No**

3. check a transcript or notes of my interview   ☐ **Yes** ☐ **No**

4. make myself available for a further interview if required (optional) ☐ **Yes** ☐ **No**

5. read and comment on a summary of preliminary findings (optional) ☐ **Yes** ☐ **No**

6. be named as a participant in the final report of the research (optional) ☐ **Yes** ☐ **No**

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project before approval of the transcript of interview data without being penalised or disadvantaged in any way.

I understand that any data that the researcher extracts from the interview for use in reports or published findings will not contain names or identifying characteristics unless I have given written consent after viewing a draft of the relevant section.

Participant's name

Signature

Date

Interview guide

Dual diagnosis policy in Australia: an exploration

Researcher: Bridget Roberts

Notes:

- *in my preparation I will research the participants and angle each question according to their area of knowledge and expertise, e.g. towards the national or state context, towards Indigenous or other cultural perspectives)*

- *some participants may cover Section 2 in the process of answering Section 1*

1. Recalling the history

- Most significant and influential moments (or events or publications) feeding into current dual diagnosis policy

- Observations on how current policy emerged: change mechanisms, key actors and their roles, professions, individuals, pressure groups

2. Reflections

- Throughout the last 20 years the policy rhetoric has been to do with 'integration' and 'partnership' in a social model of health. What are your comments on the interrelationships of relevant sectors? (acute mental health, alcohol and other drug, psychiatric disability rehabilitation and support, general health, welfare)

- In what respects do you think dual diagnosis policy is 'evidence-based'? (What is your view on the term 'evidence-based' in relation to dual diagnosis policy?)

- Who is benefiting from dual diagnosis policy? Who is not?

- What are the strengths and limitations of dual diagnosis policy?

- What do you think is the future for dual diagnosis policy?

3. Participant context

- Where do you go for information on dual diagnosis?

- Who or what most influences your thinking on dual diagnosis policy?

- Who are the people you think I should be sure to speak to or whose work I should read?

Study timeline

Date	Activity
March 2009	Study commenced (literature review, design, policy document analysis, preliminary consultations)
Dec 2009	Application submitted to Human Research Ethics Committee
Jan 2010	Ethical approval received
Feb 2010	First interview
Dec 2010	16th interview completed
May 2011	19th and final interview
June 2011	Paper accepted for publication Interprofessional relationships in dual diagnosis discourse in an Australian State: Are we respecting each other yet? *Mental Health and Substance Use Dual Diagnosis, 5:2, pp 148-159.* DOI: 10.1080/17523281.2011.618995.
Sept 2011	Invitation to complete online questionnaire
Sept-Nov 2011	Responses to online questionnaire
June 2012	Paper accepted for publication: Dual diagnosis narratives and their implications for the alcohol and other drug sector in Australia. *Contemporary Drug Problems.30:4, pp 663-685.*
Sept 2012	Paper accepted for publication: The seeds of dual diagnosis discourse in an Australian State. *Mental Health and Substance Use Dual Diagnosis, 6:4, pp 325-338.* DOI: 10.1080/17523281.2012.741611
Nov 2012	Paper accepted for publication: Reflections on capacity-building initiatives in an Australian State. *Advances in Dual Diagnosis: 6:1, pp 24-33.* DOI 10.1108/17570971311309006
Dec 2013	Paper submitted: Dual diagnosis discourse in Victoria Australia: the responsiveness of mental health services. *Journal of Dual Diagnosis.*

Principal policy documents and policy evaluations reviewed

Pre 1999

Victorian Drug Strategy Unit. (undated). *The Victorian drug strategy: The first 6 years 1985-1991.* Health Department Victoria.

Australian Health Ministers. (1992). National Mental Health Policy. Canberra: Commonwealth of Australia.

Australian Health Ministers' Advisory Council. (1992). National Mental Health Plan. Canberra: Commonwealth of Australia.

Miller, M., Hamilton, M., & Flaherty, B. (1992). The evaluation of Australia's national campaign against drug abuse. *Journal of Drug Issues, 22*(3), 487-506.

Department of Health and Community Services. (1993). Victorian Drug Strategy: Strategic Plan for 1993-1998. Melbourne: State of Victoria.

National Drug Strategy Committee. (1993). National Drug Strategic Plan 1993-97. Canberra: Ministerial Council on Drug Strategy, Commonwealth of Australia.

Department of Health and Community Services. (1994). *The framework for service delivery*. Melbourne: State of Victoria.

Australian Health Ministers' Advisory Council. (1996). National Standards for Mental Health Services. Canberra: Commonwealth of Australia.

Department of Human Services. (1997). Victoria's Alcohol and Drug Treatment Services: The Framework for Service Delivery. Melbourne: Department of Human Services.

Single, E., & Rohl, T. (1997). The National Drug Strategy: mapping the future. An evaluation of the National Drug Strategy 1993–1997. Canberra: Ministerial Council on Drug Strategy, Commonwealth of Australia.

Australian Health Ministers. (1998). Second National Mental Health Plan. Canberra: Commonwealth of Australia.

Ministerial Council on Drug Strategy. (1998). National Drug Strategic Framework 1998-99 to 2002-03. Building partnerships, a strategy to reduce the harm caused by drugs in our community. Canberra: Commonwealth of Australia

2000-2005

Victorian Department of Premier and Cabinet, & Health Outcomes International Pty Ltd. (2000). *Evaluation of Turning the Tide [electronic resource]: final report.*

Urbis Keys Young. (2001). Evaluation of the emotional and social wellbeing (mental health) action plan. Canberra: Department of Health and Aged Care.

Department of Human Services. (2002). New Directions for Victoria's Mental Health Services: The Next Five Years. Melbourne: State of Victoria.

National Mental Health Education and Training Advisory Group. (September 2002). *National Practice Standards for the Mental Health Workforce.* Canberra: Commonwealth of Australia.

Thornicroft, G., & Betts, V. (2002). International Mid-Term Review of the Second National Mental Health Plan for Australia. Canberra: Mental Health and Special Programs Branch, Department of Health and Ageing.

Australian Health Ministers. (2003). National Mental Health Plan 2003-2008. Canberra: Australian Government.

Success Works Pty Ltd. (2003). Evaluation of the National Drug Strategic Framework 1998-99 to 2003-04. Melbourne: Success Works.

Ministerial Council on Drug Strategy. (2004). National Drug Strategy: Australia's Integrated Framework 2004-2009. Canberra: Commonwealth of Australia.

2006-2013

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

Australian Health Ministers. (2008). National Mental Health Policy 2008. Canberra: Commonwealth of Australia.

Australian Health Ministers' Advisory Council (2008). Council of Australian Governments National Action Plan for Mental Health 2006-2011, Progress Report 2006-2007: Australian Health Ministers Conference.

Department of Human Services. (2008). A new blueprint for alcohol and other drug treatment services 2009-2013. Client-centred, service-focused. Melbourne: State of Victoria.

AIPC. (2009). Comorbidity Treatment Service Model Evaluation: Final Report. Bundoora, Victoria: Australian Institute of Primary Care, La Trobe University.

Australian Health Ministers. (2009). Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009-2014. Canberra: Commonwealth of Australia.

Siggins Miller Consultants. (2009a). Evaluation and monitoring of the NDS 2004-2009 Final Report: Vol 1, findings and recommendations. Brisbane: Siggins Miller.

Siggins Miller Consultants. (2009b). Evaluation and monitoring of the NDS 2004-2009: Vol 2: Case studies, literature reviews, and headline indicators. Brisbane: Siggins Miller.

Department of Human Services. (2009). Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019. Melbourne: Department of Human Services, State of Victoria.

Australian Healthcare Associates (AHA). (2011). Evaluation of the Victorian Dual Diagnosis Initiative. Melbourne, Victoria.

Australian State and Territory Peak AOD NGOs. (2011). Outcomes from the National Improved Services Initiative Forum (2010): A Tale of Two Systems. Adelaide: Australian State and Territory Peak Alcohol and other Drug Non-Government Organisations.

WANADA. (2011). Review of the impact of the AOD Improved Services Initiative in Western Australia. Canberra: Western Australia Network of Alcohol and Other Drug Agencies, for the Department of Health and Ageing.

Victorian Auditor-General. (2011). Managing drug and alcohol prevention and treatment services. Melbourne: State of Victoria.

Literature search strategy

Databases	Principal search terms
Informit Online Ovid Medline Proquest PsycINFO Scopus Monash University Library Search and Multisearch	1. Dual diagnosis, Comorbidity, mentally ill chemical users, co-occurring disorders, coexisting disorders +/- Mental health, mental illness, mental disorder mental health problem +/- Alcohol, drugs, substance +/- addiction, dependence, abuse, misuse, disorder
	2. Prevalence
	3. Psychiatry, psychology, social work, nursing + 1 + 4 + 5 + 6,
	4. Treatment, treatment systems, integrated treatment systems, capability, + 1
	5. Deinstitutionalisation + 1
	6. Attitudes, stigma + 1
	7. Qualitative research + 1
	8. Managerialism + 1 + 12
	9. Interprofessional +1+4
	10. Organizational change+12
	11. Intersectoral collaboration+12
	12. Health care services, health care policy
	13. Specialisation / hyperspecialisation + 12

Examples

Date	Database	Search terms	# relevant citations
01/05/2009	Multisearch	deinstitutonalization + substance	27
06/10/2010	Scopus	Profession* interprofessional boundaries	13
13/10/2010	Scopus	MH, AOD, profession* attitudes	32
13/3/2012	Ovid, PsychINFO, Scopus	Dual diagnosis (years 1981-2010)	2321

Sample coding methods

Table 1: Example of preliminary manual coding framework for key informant interview transcripts

KI #	Emergent theme – 'turf'							
	Service system history	Professionalisation	Disciplinary/ professional trends	Attitudes	How demonstrated	Responses/implications	What works	Metaphors and terminology
1	Was always hard to get people admitted to psych hospital – even with psychosis	Pleasant view had a professional staffing profile (1974-1994)	Psychiatrists rule in AOD NSW but not Vic	We underestimate importance of relating as peers; easy to dismiss AOD now – has slipped back		Could lose nuances of AOD knowledge	Better funding to match the two systems	A bit of wallpaper over a huge crack
2								
3 (etc)								

Note: summary views or verbatim quotations (with page number of transcript) were inserted in the table (in Excel). A printed copy was further coded for sub-themes using colours and arrows.

Table 2: Sample summary of interview analysis – what are the implications of dual diagnosis discourse for service users/consumers, services, professions and governments?

Source: notes developed from preliminary manual coding and later NVivo coding of 19 interview transcripts

Stakeholder Group	Positive/Successes/Wins	Negatives/Shortcomings/Losses
Service users and would-be service users/ clients/ patients/consumers	Choice of and access to the right service at the right time?	Neglect beneath the spin? More coercion?
Professions	Career paths More territory for psychiatry?	Loss of AOD expertise?
Government	'Dual diagnosis' was a concept that could be used as a lever for more funds for AOD and MH.. Could be seen to be doing something while avoiding the problem of health system inequalities?	Criticised as tokenistic

Online questionnaire for key informants – summary results

The purpose of this post-interview online questionnaire of key informants was to test propositions that had emerged from the research literature, policy document analysis and analysis of interviews.

The question wording, drawn from interview analysis, included some direct, anonymous quotations.

Completion was voluntary and no questions were compulsory.

Closed questions used Likert-type response options. Large text boxes were provided for comments.

Thirteen of nineteen possible responses were received, a response rate of 68%.

Analysis: Responses to the closed questions were used to rank the items. Text responses were incorporated in the narrative analysis of the interview transcripts.

Summary findings: Question 1

Influences on the emergence of dual diagnosis discourse were, in order of priority:

- Local research: 'Not Welcome Anywhere' report
- Other research, international and Victorian
- The greater visibility of people experiencing psychosis

Further major influences mentioned were

- 'practical reality' complaints from service users and carers in both systems about lack of access, poor integration and differing responses (3 respondents)
- closure of government Drug and Alcohol Treatment Centres which treated psychiatric and AOD issues together. NGOs had minimal professional training and skills (2 respondents).
- changes in funding pattern with contracted-out services working to capacity and tending to take the 'easier' clients – funding levers always important (two respondents)
- knowledge of the prevalence, the harms and potential for effective responses

Increased drug availability, AOD use at younger ages, and the heroin epidemic and push for HIV/AIDS prevention were considered minor influences. There was little support for the influence of US concern about reimbursement for comorbidities.

Summary findings, Question 2, consequences for service users, governments, service providers,

Service users

Benefits for service users

Strong agreement (92%) that AOD clients benefited from the AOD sector becoming better qualified (through dual diagnosis training) and generally more expert rather than 'half-baked'. Ten agreed, seven (58%) strongly that dual diagnosis discourse inspire hope that MH and AOD services will become more humane and focused on people's needs. 69% agreed (one strongly disagreed) that mental health service clients in acute services are more likely to have withdrawal symptoms recognised. There was 54% agreement that AOD clients were benefiting who lived with 'quiet' psychosis, which was impeding their ability to tackle AOD problems.

Text comments on benefits

> 'Clients with DD are far more likely to be identified and we are a fair way from where we were… DD is on everyone's radar … there is a plethora of stories of better outcomes that have accrued from the increases in clinicians' dual diagnosis treatment skills'

> 'Staff are getting very good at screening and here are certainly expert staff'

Concerns about consequences for service users

Patchy progress in dual diagnosis responsiveness means that service users cannot rely in receiving appropriate responses to disclosure of the 'other' problem (92%). A strong collective sense that service users still suffer from negative staff attitudes (91%); from MH exclusiveness (84%); and from unresolved tension between MH and AOD services regarding autonomy and paternalism (84%). There was weaker agreement (62%) that there is a mismatch, which DD focus helps perpetuate, between the problems people experience and the diagnosis-based system, and that treatment in the 'other' sector may not be desired or even appropriate (61%). 46% agreed that dual diagnosis policies were papering over the cracks. 77% disagreed that coming up with diagnoses and policy documents was largely an irrelevant process to the interaction between service providers and consumers.

Text comments on concerns

> 'only marginal changes from when I first commenced in the mental health/AOD system 35 years ago. Pretty unsatisfactory, really.'

The message of five of eight text comments can be summarised as a view that service users are not benefiting, owing to:

lack of investment, in mentoring/supervision (1), and treatment options after screening (2),

pressure on the systems, especially of paperwork and caseloads in MH (2)

inherent differences between the sectors, in targeting, legislation and model of service (1)

lack of innovative thinking (1)

One respondent wrote of a consequence for service users of merging MH and AOD (which has occurred more recently than the emergence of DD):

'when [AOD/MH] the mergers do occur, there is greater emphasis on dual diagnosis at the service level. All the other issues (physical health comorbidities, social exclusion etc) receive less attention.'

Resource pressure and differences in culture are still a barrier:

'There remains a significant difference in policy regarding targeting, legislation and model of service provision. Both systems are under pressure - mental health more so- which means that there is not the service availability or culture to respond in a way that best engages and limits harm. While MH is linked to treatment, AOD is linked to choice and voluntariness.' (MH perspective)

Government

Benefits for government

Strong agreement (85%) that a DD focus acted as a lever to obtain real, though incremental, service improvements. There were divided views (39% agreed, 31% disagreed) on whether DD policy initiatives had allowed the appearance of action, with minimal investment.

Text comments on benefits for government:

learning from DD capacity building has contributed to 'much greater sophistication and effectiveness from government and central planners in designing and deploying other capacity building/system change initiatives.

Meaningful discussion around DD is great …

Drugs and mental health division formed in Dept of Health – 'a hopeful step in terms of leadership from the AOD sector to influence the way that mental health services do business. For example, we started to see a much stronger policy awareness of the person's social context and of the role of trauma in service users' lives.' (but leadership fell away)

Concerns

Divided views (46% agreed, 23% disagreed) that piecemeal reform damages credibility and is ineffective.

Text comments:

'Historical pecking order, affected by community attitudes and stigma' MH higher than AOD but 'neither funded according to evidence of need'.

'I have a very strong view that some of the recent dual diagnosis developments are more about being seen to be doing something rather than actually doing something. The latter requires innovative thinking and considerable resource investment.'

Hard for DD to stay at the top of the heap for health service delivery. 'Need to move beyond thinking AOD and MH but rather just health. DD is part of every component of health and welfare system so needs much greater attention across the health system.'

Service providers

Benefits for service providers

Strong agreement (77%) that DD is now seen as core business.

Moderately strong agreement (6/9; 66%) that new DD positions attracted and retained staff and increased professionalisation. There was some support (5/10; 50%) for the proposition that the focus on DD had stimulated workforce development and generally improved service quality.

Weak agreement that the sectors benefited from new dual diagnosis positions.

Very weak agreement that DD had stimulated AOD workforce development and service quality.

Three respondents identified benefits:

- awareness of dual diagnosis, more targeted training, networking, screening, interventions other than short term training
- more effective treatment of target and co-occurring disorders

- dual diagnosis discourse had facilitated a more integrated way of thinking – in some services

One respondent framed learning about needs as a benefit: DD discourse had helped the field identify the need to

- use the same screening and assessment tools,
- become more recovery and strengths focussed;
- provide effective MH supervision in AOD and vice versa;
- use the DD funding for something other than short term training
- address the fact that 'both sectors still feel misunderstood by the other';

Concerns

Statements attracting the strongest agreement were that the nuances of AOD expertise remain under-recognised in the clinical MH sector (77%, 1 unable to answer); and that action on dual diagnosis depends on luck – having the right people in the right place at the right time (62%, 3 undecided/unable to answer).

There was agreement that the nuances of PDRS expertise remain under-recognised in the clinical MH sector (62%, %, 3 undecided/unable to answer); many MH clinicians remain pessimistic about AOD screening, assessment and treatment (54% 3 unable to answer),

Weak agreement (42%, 3 unable to answer) that DD funding had been distributed inequitably.

Weak disagreement (46%) that the AOD sector will be swallowed up by the MH sector and that 'dual diagnosis' is more about career development than service improvement (38%, 3 undecided/unable to answer).

Text comments:

'some services have used it to continue to complain and remain confused… ' lack of 'real thinking' about potential consequences of embracing more than their own 'patch' expertise. 'MH services less responsive to trying to manage the mix'

Highlights **lack** of common tools, a recovery and strengths focus, lack of cross-supervision, mutual understanding, clear expectation of what is provided by whom, funding

Highlights 'acceptance of low level workforce qualifications in the AOD sector will always limit capacity to respond effectively to more complex presentations'

MH and AOD 'doing what they can with very limited resources' 'Top-down policy developments with limited associated resources will continue to frustrate service providers.'

Dual diagnosis - consultation with informants – questionnaire and results (excluding text comments, which are summarised above), September – November, 2011

Welcome and introduction

This questionnaire feeds back to you some ideas from the interviews I have conducted as part of an exploration of dual diagnosis discourse in Victoria. The interviews have tapped into your experience over the last couple of decades. After analysis of the interviews, two questions now stand out:

1. Why did dual diagnosis become part of our discourse in Victoria?
2. What have been the consequences for service users, service systems and government?

1. Name

2. **Why did dual diagnosis become part of our discourse in Victoria? Please indicate how strongly you think each of the factors listed below influenced the growth of concern about co-occurring mental health and substance use problems in Victoria. Note that you can be 'undecided' or 'unable to answer'. You can add comments on the next page.**								
	Strength of influence							**Total**
Answer Options	**Negligible**	**Minor**	**Moderate**	**Major**	**Paramount**	**Undecided**	**Unable to answer**	
The Victorian action research project 'Not Welcome Anywhere: people who have both a serious psychiatric disorders and problematic drug and alcohol use' (McDermott & Pyett, 1993)	0	0	5	6	1	0	1	13
International research in the 1980s, e.g. on cannabis decriminalisation, cannabis and psychosis; US work on integrated treatment; prevalence of dual diagnosis	0	1	5	6	0	0	1	13
Victorian research on the prevalence of psychotic, affective and substance-related disorders in homeless people in inner-city Melbourne	0	1	6	3	1	0	2	13

	Strength of influence							Total
Answer Options	**Negligible**	**Minor**	**Moderate**	**Major**	**Paramount**	**Undecided**	**Unable to answer**	
The greater visibility of people experiencing psychosis during closure of the psychiatric hospitals	1	0	7	2	1	1	1	13
Increased drug availability	0	6	3	3	0	0	1	13
AOD use beginning at younger ages	2	5	3	2	0	0	1	13
The heroin epidemic and the push for HIV prevention.	3	4	3	1	0	0	1	12
US concern about reimbursement for diagnostic comorbidities in general.	5	2	1	0	0	2	3	13

Your comments on why dual diagnosis emerged in Victoria

Introduction to questions on the consequences of dual diagnosis discourse

Seeking to understand what dual diagnosis discourse has meant to different groups of people in the system, I have developed from the richly varied interviews a list of 'benefits' and 'concerns'. These are set out below in three sections, relating to service users, governments and finally to service sectors.

The statements may seem over-simplistic. Please be assured that the nuanced stories behind them are not lost from the study.

3. How has dual diagnosis discourse benefited service users?								
Answer Options	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Undecided	Unable to answer	Total
AOD clients benefit from the AOD sector becoming better qualified (through the dual diagnosis training) and generally more expert rather than 'half-baked'	0	1	0	2	10	0	0	13
Dual diagnosis discourse, particularly awareness-raising and training in screening and assessment, inspires hope that MH and AOD services will become more humane and focused on people's needs	0	0	2	3	7	0	1	13
Mental health clients in acute services are more likely to have withdrawal symptoms recognised.	1	1	0	7	2	2	0	13
AOD clients who were living with undiagnosed and 'quiet' psychosis, which was impeding their ability to tackle their AOD problems, are benefiting.	0	2	3	4	3	1	0	13

Answer Options	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Undecided	Unable to answer	Total
4. What are your concerns in relation to the consequences of dual diagnosis discourse for service users?								
Service users are still suffering from negative staff attitudes.	0	0	1	8	4	0	0	13
Patchy' progress in dual diagnosis responsiveness means that service users cannot rely on receiving an appropriate response to disclosure of the 'other' problem.	0	0	1	6	6	0	0	13
Mental health services still exclude many sufferers who may be living with complicated and severe mental health and AOD problems.	0	1	0	9	2	0	1	13
Service users still experience unresolved tension between Mental Health and AOD services regarding autonomy and paternalism.	0	0	2	7	4	0	0	13
There is a mismatch between the problems people experience and the diagnosis-based system which 'dual diagnosis' helps perpetuate.	0	3	0	6	2	1	1	13
Treatment in the 'other' sector may not be desired or even appropriate.	0	1	2	7	1	0	2	13
Dual diagnosis policies, etc, are partial reforms to the health system, 'papering over the cracks... it's almost like 'tick, tick, tick, everybody's happy'	2	2	0	3	3	0	3	13
Coming up with diagnoses and policy documents is largely an irrelevant process to the interaction between service providers and consumers	2	8	1	2	0	0	0	13

5. Your comments

6. How has dual diagnosis discourse benefited governments?

Answer Options	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Undecided	Unable to answer	Total
Dual diagnosis acted as a lever to obtain real, though incremental, improvements in MH, PDRS and AOD services	0	0	1	8	3	0	1	13
Dual diagnosis policy initiatives have allowed the appearance of action, with minimal investment	1	3	3	4	1	0	1	13

7. What are your concerns in relation to the consequences of dual diagnosis discourse for governments?

Answer Options	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Undecided	Unable to answer	Total
Piecemeal reform damages government credibility and is ineffective	1	2	2	5	1	0	2	13

8. Your comments

9. What are the benefits of dual diagnosis discourse for the mental health, PDRS and AOD sectors?								
Answer Options	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Undecided	Unable to answer	Total
Dual diagnosis' is now seen as core business.	0	0	3	8	2	0	0	13
New positions have been created that attract and retain staff and increase professionalisation.	0	2	1	5	1	1	3	13
The focus on dual diagnosis in the AOD sector (with Commonwealth and State funds) has stimulated workforce development and generally improved service quality	0	1	4	4	1	1	2	13

10. What are your concerns about the consequences of dual diagnosis discourse for the MH, AOD and PDRS sectors?								
Answer Options	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Undecided	Unable to answer	Total
The nuances of AOD expertise remain under-recognised in the clinical MH sector.	0	0	2	6	4	0	1	13
Action depends on luck – having the right people in the right place at the right time.	0	1	1	3	5	1	2	13
The nuances of PDRS expertise remain under-recognised in the clinical MH sector.	0	0	3	5	3	1	1	13
Many MH clinicians remain pessimistic about AOD screening, assessment and treatment.	0	1	2	4	3	0	3	13
Dual diagnosis funding has not been distributed equitably from the start.	0	2	2	1	4	0	3	12
The AOD sector will be 'swallowed up' by Mental Health.	2	4	1	3	1	0	2	13
Dual diagnosis' is more about career advancement than service improvement	1	4	2	3	0	1	2	13

11. In thinking about why dual diagnosis discourse began in Victoria, and where it has led, what issues have I missed?

Thank you

Conferences and principal forums attended

Conference	Paper presented	Venue	Date
Australasian Evaluation Society Annual Conference	Dual diagnosis policy and its evaluation in Victoria	Canberra	2-4 Sept 2009
Improved Services Initiative and Victorian Dual Diagnosis Initiative. *Sustaining the momentum: embedding dual diagnosis practice in organisations*	An exploration of dual diagnosis policy (plenary address)	Lorne, Victoria	3-4 June 2010
Third Qualitative Research on Mental Health Conference. *The disabled self: theoretical and empirical approaches to stigma and recovery*	Meanings of dual diagnosis policy for services and sufferers	University of Nottingham, UK	25-27 August 2010
37th **Annual Alcohol and Epidemiology Symposium, Kettil Bruun Society**	Professional turf and hierarchies – what does dual diagnosis mean for person-centred service systems?	Melbourne, Victoria	11-15 April 2011
Improved Services Initiative and Victorian Dual Diagnosis Initiative. *Across the sectors: dual diagnosis capability and beyond*	-	Werribee, Victoria	30-31 May, 2011
The Australian Winter School Conference. *Concurrent disorders, current discourses.*	-	Surfers Paradise, Queensland	8-9 June 2011
Contemporary Drug Problems. *Beyond the buzzword: problematising "drugs"*	-	Monash University, Prato, Italy	Aug 2011