Original title: From institutions to community care in Victoria: what difference has evaluation made?

Revised title: Dual diagnosis policy and its evaluation in Victoria

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Introduction

The last 20-25 years have seen major changes in mental health and alcohol and drug service sectors in Victoria. I am embarking on a study of the role of evidence in these changes: How is evidence understood? Whose evidence? How is it used?

My particular interest is the development of policy affecting people with co-occurring mental health and alcohol and other drug problems. I will also use the terms 'dual diagnosis' 'comorbidity', and 'complex needs', which are interchangeable for the purposes of this paper.

The landscape of evidence, policy, mental health and alcohol and other drugs is one of many contestations. It is essential to explore it if we are to let people in from the margins of society.

Changes in the landscape in recent decades include the shift from large psychiatric hospitals to care based in the community and in general hospitals, neoliberalism and the purchaser-provider split in health and human services, attempts to reorient health in line with the Ottawa Charter and the growing profile of comorbidity in policy and practice discourse. Something that seems to have changed little is an awareness of the need to break down government siloes and provide client-centred services.

For this paper I am drawing on personal observation of the field(s), my experience as an evaluator of programs and systems over the last ten years, preliminary analysis of the academic literature and Australian policy documents, reports, NGO monographs and the like and brief consultations with key informants. I appreciate this opportunity to offer interim thoughts. A journal article is planned when the literature review and document analysis stage of my research is complete.

Mental health and substance use

Mental health is everyone's business: in a twelve-month period, one Australian adult in five will experience a mental disorder and mental disorders account for 13% of the total burden of disease, coming third after cardiovascular disease and cancer. Within the mental disorders, anxiety and depression account for 56% of the overall burden and substance use disorders account for 23% (Teesson & Proudfoot, 2003). Psychosis and bipolar major mood disorders affect about 3% of the population at some time in their lives (ABS, 2008).

Among the substance use problems, and not counting tobacco, alcohol is the major issue, with 82.9% of the population registering some level of risky drinking in the past

year, according to the 2007 National Drug Household Survey. Misuse of other licit drugs and of the illicit drugs was noted in the same survey at 13.4% of the population (AIHW, 2008).

This is not the place to rehearse the extensive array epidemiological data available. My main points are these: having more than one disorder is the norm rather than the exception (up to 80% of clients of mental health services need help with an alcohol and other drug problem and vice versa); the more disorders a person has, the more the physical, psychological and social problems compound; people with more than one problem have not historically been well-served, as services have passed the buck to each other..

In experience of dual diagnosis and treatment there is complexity at all levels – individual, professional, political, social,. Some say the individual is the least complex and intractable of these.

For the individual, multiple factors are possibly at play: this is recognised, for example, in the standard alcohol and other drug assessment form, which runs to many pages and at least an hour and a half of questioning, and which is recommended to be covered in at least two sessions between a client and an experienced worker. In another example, I found ‘Comorbidity: a brief guide for the primary care clinician’ that runs to 154 pages. Of course the aim is to deal with the whole biopsychosocial picture where little is irrelevant.

Professionally, there is the search for the magic bullet or the quick fix. Psychiatrists, addiction medicine specialists, neuroscientists, geneticists, social workers, psychologists, (and more) look each in their own way for the best treatment, the best drugs, the best talking therapies and the best way to match the treatments to the clients in all their variations.

Politically, mental illness and alcohol and other drug use become highly sensitive when there is street violence, when police shoot citizens, when high profile people’s lives are in the news, when the prime minister speaks of his daughter’s heroin addiction. Yet in the hierarchy of health budget items they are low on the list. Further complications arise from the involvement of multiple government sectors (primary and tertiary health, welfare, housing, homelessness, justice, employment, education) as well as private providers.

Socially, concepts of mental illness and addiction have a long and varied history; definitions are contested, and there is enduring stigma and ignorance that forms a large part of the problem.

Case study

For this paper I have inquired into the influence of evaluation on dual diagnosis policy in Victoria and offer some comments on the developments leading up Victoria’s current policy document (2007).

Starting in the late 1980s with the first national drug strategy (the National Campaign Against Drug Abuse) and the early nineties with the first national mental health plan, there has been a series of Commonwealth and State strategy documents. It takes

several iterations before either side mentions the other, and the terms dual diagnosis, co-occurring disorders or comorbidity appear in the language only in recent years.

What helped to bring dual diagnosis onto the agenda in Victoria? Initially the cause was championed by advocates in the non-government sector, based on US research from people such as Drake and Minkoff in the 1980s. A government-funded community action research project led up to publication of 'Not Welcome Anywhere' (McDermott & Pyett, 1993). There followed a pilot dual diagnosis project and its evaluation (Fox, 2000): the Substance Use and Mental Illness Treatment Team (SUMITT) worked with clients with severe mental illness and alcohol and other drug problems and also trained workers in both sectors on awareness of the 'other' problem and ways of providing coordinated, if not integrated, treatment and care. Funding came from a ground-breaking collaboration between the mental health and the drugs branches of the Department of Human Services (DHS). This continued in the 2001 roll-out of SUMITT-type metropolitan teams and individual rural clinicians across the state. While this statewide initiative was settling in, and developing in different ways in each region, the DHS commissioned an evaluation (in which I declare an interest). The chosen evaluation process was collaborative, bringing the dual diagnosis teams into a common working group. Recommendations on, for example, reasserting the vision, supporting a capacity-building theory of action, and on setting up statewide training were acted upon. Momentum increased towards improving the ability of services to respond promptly and sensitively to people presenting with the 'other' condition (i.e. an alcohol or other drug disorder in a mental health service, a mental health disorder in a drug treatment service) and the phrase 'no wrong door' began to replace 'not welcome anywhere'. The goal of 'dual diagnosis capability' became part of policy in the DHS' 'Key Directions' document of 2007. Change has also occurred at the federal level (through the National Comorbidity Initiative): I have yet to explore the federal/state interactions. Certainly at state level in Victoria, it seems clear to me that evaluation - the government's commitment to it and the sector's response - has played an essential role in dual diagnosis policy and practice development.

Challenges for evaluation, and its strengths

Evaluation needs to incorporate a synthesis of the relevant research evidence. Are we in a golden age where evidence is accumulating around us and we just have to mix and match? For people with dual diagnosis, finding out what works in practice is problematic. The 'evidence' is of course often based on the white male aged about 30, and certainly on notionally homogeneous groups. Further, the research often does not ask wide enough questions, the questions beyond the clinical intervention, yet more is likely to be funded at the expense of social research and research with 'difficult' groups (Orford, 2008). As evaluators we know evaluation can help us get to the wider questions and settings, to the tensions and contradictions and the most useful knowledge available in any given circumstance.

When we turn to evidence and policy there is 'a tendency for the programs that are most effective to be the least likely to be implemented and those that are the most popular to be the least effective' (Hamilton et al., 2004) Peter Bycroft and David McDonald have already spoken at this conference and I refer you to their thoughts on the use of policy

theories as tools to help us understand and work with the policy process in our evaluation endeavours.

My final musings are 'If as a society we are more aware of the way multiple needs are the norm, and that they co-exist and interact, does this open up the possibility of more creative approaches to gathering and using evidence?' My understanding is that evaluators have a major part to play in helping society deal with complexity, in assembling and interpreting the evidence from diverse sources, describing and valuing the whole and thus informing policy. We are explicitly committed to hearing all stakeholders, considering rival theories, summing up the evidence and making judgements – the role of judge. In our role as teachers, I am with Hallie Preskill (2009) in her confidence in the power of facilitating dialogue and learning across social, systemic, political and professional boundaries.

Note: later stages of this PhD project will involve further literature synthesis, policy document review and stakeholder interviews, with an intended completion date in mid 2012.

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References

ABS. (2008). *4326.0 - National Survey of Mental Health and Wellbeing: Summary of Results, 2007* Australian Bureau of Statistics.

AIHW. (2008). *2007 National Drug Strategy Household Survey: detailed findings. Drug statistics series no. 22*. Canberra: Australian Institute of Health and Welfare

Fox, A. (2000). *SUMITT Evaluation*. Footscray, Victoria: Substance Use and Mental Illness Treatment Team.

Hamilton, M., King, T., Ritter, A., & Otmar, R. (2004). Contemporary issues and future challenges. In M. Hamilton, T. King & A. Ritter (Eds.), *Drug Use in Australia: Preventing Harm*. South Melbourne, Australia: Oxford University Press.

McDermott, F., & Pyett, P. (1993). *Not Welcome Anywhere, Vols I and II*. Fitzroy: VICSERV.

Orford, J. (2008). Asking the right questions in the right way: the need for a shift in research on psychological treatments for addiction. *Addiction, 103*(6), 875-885.

Preskill, H. (2009). Reflections on the dilemmas of conducting environmental evaluations. In M. Birnbaum & P. Mickwitz (Eds.), *New Directions for Evaluation* (Vol. 122, pp. 97-103).

Teesson, M., & Proudfoot, H. (2003). *Comorbid mental disorders and substance use disorders: epidemiology, prevention and treatment*. Canberra: National Drug and Alcohol Research Centre.

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