12. Recommendations

The workers who participated in the Dual Diagnosis Project shared many ideas and suggestions for changes and developments to improve the responses available to people with dual diagnosis issues. The following recommendations outline a wide range of both practical and ideological developments, and provide a summary of possible future directions for work in this field. The points following each recommendation provide some explanatory notes outlining the rationale and intention of the recommendation.

RECOMMENDATION 1A. THAT CLP ADOPT THE DUAL DIAGNOSIS PRACTICE MODEL AS THE FRAMEWORK FOR SERVICE DELIVERY WITH CONSTITUENTS EXPERIENCING DUAL DIAGNOSIS.

The research and analysis conducted throughout the Dual Diagnosis Project has led to the conceptualisation of a practice model to guide CLP's response to dual diagnosis issues (see table overleaf). The model is comprised of three parts, each of which is integral to the development of an improved service response to people with dual diagnosis issues. The parts are:

1. Individual Work
2. Organisational Response
3. Policy and Service Development

1B. THAT CLP SEEK GOVERNMENT AND TRAINING AUTHORITY SUPPORT TO DEVELOP A DUAL DIAGNOSIS TRAINING PROGRAM.

The CLP Dual Diagnosis Practice Model requires workers skilled in implementing a range of individual, organisational, and policy responses. The information presented on the table overleaf outlines the knowledge and skills workers need to respond to dual diagnosis issues, and provides an overview of potential staff training needs.

<table>
<tr><th><u>INDIVIDUAL</u></th><th>ISSUE</th><th>INTERVENTION</th><th>SKILLS/KNOWLEDGE</th></tr>
<tr><td rowspan="5"></td><td rowspan="5">1. RISK FACTORS

• Those same risk factors to which the general population are vulnerable (see pp 15/16).

PLUS

• Abuse, exploitation & trauma
• Poverty & disadvantage
• ‘Care’ & institutionalisation
• Separation from family
• Family dysfunction (conflict and abuse)
• Living with a learning disability
• Medication & drug use
• Lack of purpose & meaning in life
• Biological
• Physical health
• Social dislocation (not belonging)
• Stressful and exploitative relationships
• Unresolved grief & loss
• Poor education experiences
• Inappropriate contact with mental health systems</td><td>1. GENERAL SUPPORT WORK</td><td>• Communicate and build trust
• Observe mental health changes
• Name strengths
• Plan and create positive experiences
• Support structure and organisation
• Awareness and identification of exposure to risk factors
• Reflection, analysis, planning</td></tr>
<tr><td>2. PHYSICAL HEALTH PROMOTION</td><td>• Develop and support opportunities for exercise
• Promote healthy eating
• Sleep assessment and intervention</td></tr>
<tr><td>3. RELATIONSHIP BUILDING</td><td>• Support links with family, friends, community
• Profiling and intentional relationships – identifying appropriate people to build supportive, non-exploitative relationships with</td></tr>
<tr><td>4. SKILL DEVELOPMENT</td><td>• Name and encourage strengths
• Encourage and support new skills
• Plan for and support practice of new skills</td></tr>
<tr><td>5. STRESS & ANXIETY REDUCTION</td><td>• Safety and security from violence
• Systems and strategies to counter life chaos
• Strengths-focussed
• Muscle relaxation, deep breathing, etc
• Teach and support self-awareness
• Stress scales
• Behaviour management
• Reality testing
• Focusing exercises</td></tr>
</table>

	• Constant change • Lack of self-determination and personal control • Self-harm • Poor self-esteem • • • Learned hopelessness	6. CRISIS RESPONSE	• Risk assessment • Safety planning, safety networks • Stress and behaviour management • Appropriate referral
		7. MEDICAL INTERVENTIONS	• Support to access medication • Access to assessment and diagnosis • Relationship building with health systems • Advocacy from an informed position
		8. THERAPY	• Individual or group work • Creative strategies • Therapeutic techniques (eg. CBT; Narrative) • Appropriate referral
		9. APPROPRIATE REFERRAL	• Knowledge of and access to specialist services. • Undertake joint work when appropriate • Involved or informed to support work
		10. PERSONAL AGENCY (Locus of control in own life)	• Challenging faulty self-perceptions • Challenging self blame • Challenging disabling stereotypes • Promoting sense of personal value • Stress management • Facilitating and supporting opportunities for success
	2. WARNING SIGNS/INDICATORS • Sudden changes in behaviour or routine • Erratic behaviour • Irrational behaviour • ‘Acting out’ behaviours • Antisocial behaviours • Internal preoccupation • Decline in self care • Physical complaints • Obsessive/compulsive behaviours • Hallucinations • Overwhelming worries	1. *AS ABOVE (1-10)*	• *AS ABOVE*
		2. ASSESSMENT	• Regular contact • Observe mood & behaviour • Support self-awareness and identification of emotion • Stress scales • PAS-ADD checklist • Mini PAS-ADD • BAI (Beck Anxiety Inventory) • Understand the relationship between learning difficulties, mental health issues, and drug use

	• Scattered thoughts and behaviour • Depression • Sadness • Stress symptoms • Change in level of activity • Loss of skills and capabilities • Presenting as ‘up’, ‘hyper’, ‘manic’ • Addictions • Self harm and suicidal ideation • Disturbed sleep patterns	3. PSYCHOEDUCATION	• Explain and support people to understand their mental health • Support self-awareness and identification of emotion
	3. TREATMENT	1. DIAGNOSIS	• Schizophrenia & Psychotic Disorders - Schizophrenia - Schizophreniform - Schizoaffective - Delusional disorders • Affective Disorders - Major Depression - Dysthymic Disorder - Bipolar I Mood Disorder - Bipolar II Mood Disorder - Mania - Hypomanic • Anxiety Disorders - Generalised Anxiety Disorder - Acute Stress Disorder - Post Traumatic Stress Disorder - Social Phobia - Specific Phobia - Obsessive Compulsive Disorder - Panic Disorder • Developmental & Personality Disorders - Intellectual/Learning Disability - Borderline Personality Disorder - Antisocial

		2. COGNITIVE BEHAVIOUR THERAPY	• Locate and challenge debilitating core beliefs • Create and implement alternatives/counter thoughts • Identify and break Physiological-Cognitive-Behavioural cycle • Strengths focussed
		3. AROUSAL REDUCTION	• Stress Scales • Progressive Muscle Relaxation • Deep Breathing • Mantras • Strategies assisting structure and organisation
		4. PROBLEM SOLVING	• Q Map (Body/Thoughts/Feelings/Behaviours) • Assertiveness training • Relaxation • Recall steps • Generalise to new situations • Steps to achieving goals
		5. EXPOSURE THERAPY	• Imaginative and In Vivo • Support • Cues to relax • Recall steps • Generalise to new situations • Identify and process feelings
		6. MEDICATION	• Knowledge of medications and side effects • Support to access medication and use correctly • Support to identify and articulate the effects of medications • Relationship with medical professionals for treatment, information and advocacy
		7. PHYSICAL HEALTH	• Exercise • Nutrition • Sleep assessment • Healthy Lifestyle
		8. RELATIONSHIP BUILDING	• Support links with family, friends, community • Develop supportive networks • Involvement of significant others in safety plans

		9. PERSONAL MEANING & MEANINGFUL USE OF TIME	• Paid work • Volunteer work • Physical health • Recreational opportunities • Group membership • Experiences of belonging
		10. PERSONAL AGENCY	• Challenging faulty self-perceptions • Challenging self blame • Challenging disabling stereotypes • Promoting sense of personal value • Stress management • Supporting opportunities for success
	4. COLLABORATION AND REFERRAL	1. MENTAL HEALTH SYSTEMS 2. PRIVATE COUNSELLORS	• Understand systems and help people negotiate them • Advocate for appropriate diagnosis and treatment • Build relationships with service providers • Be involved and informed to support therapeutic work
ORGANISATIONAL	**ISSUE**	**INTERVENTION**	**SKILLS/KNOWLEDGE**
	5. ORGANISATIONAL RESPONSE	1. WORKER TRAINING	A. ASSESSMENT • Risk factors • Warning signs • PAS-ADD, Mini PAS-ADD • Beck Anxiety Inventory (BAI) • Identification of emotion • Lifeskills profile • Mental Health inventory B. DIAGNOSIS • Mental Health Problems • Mental Disorders • DSM-IV criteria

			C. INTERVENTION • Relaxation • Problem solving • Cognitive Behaviour Therapy (CBT) • Understanding medications • Strengths-based practices • Narrative therapy • Intentional relationship building • Grief and loss • Self-esteem • Behaviour management • Promoting physical health •
		2. GROUPS AND PROJECTS	A. EMOTIONAL AND PHYSICAL WELL BEING • Exercise programs • Resources and opportunities to try new things • Relaxation • Nutrition • Healthy lifestyle • Hygiene B. SELF WORTH • Self-esteem • Political power • Speakouts • Rebels With Attitude • Talking About Schools • "No Less Perfect" video • Standing Proud workshops C. RELATIONSHIPS • Social support and friendship • Intentional relationships • Key Ring Project • Sharing Accommodation
		3. ORGANISATIONAL POLICY	• Individual needs • Valued status • Community participation and inclusion • Decision making and choice • Exploitation policy • Crisis response procedures • Suicide response policy

<table>
<tr><td></td><td></td><td>4. STAFF SUPPORT AND SUPERVISION</td><td>• Line management
• Team building and peer support
• External supervision
• Debriefing
• Critical incident response
• Practice Reflection Days</td></tr>
<tr><th><u>POLICY</u></th><th>ISSUE</th><th>INTERVENTION</th><th>SKILLS/KNOWLEDGE</th></tr>
<tr><td rowspan="3"></td><td rowspan="3">5. GOVERNMENT POLICY AND NEW SERVICE DEVELOPMENT</td><td>1. RESEARCH GAPS</td><td>• Research
• Analysis
• Documentation
• Information exchange</td></tr>
<tr><td>2. COLLABORATION BETWEEN MENTAL HEALTH AND DISABILITY SERVICES</td><td>• Joint work
• Education exchange
• Peer support
• Information sharing
• Advocacy
• Knowledge of mental health and disability systems</td></tr>
<tr><td>3. LOBBY FOR FUNDING OF NEW SERVICES</td><td>• Lobbying/advocacy
• Collaborative work
• Communication
• Program evaluation</td></tr>
</table>

RECOMMENDATION 2. THAT QUEENSLAND HEALTH FUND A DUAL DIAGNOSIS TRAINING PROJECT TO BUILD KNOWLEDGE OF DUAL DIAGNOSIS AMONGST HEALTH PROFESSIONALS.

- Psychiatrists need information and training around how to assess people with intellectual disability, and how to support them with cognitive and therapeutic interventions.
- Workers need access to medical professionals experienced in working with people with learning difficulties and dual diagnosis, whom they can call on for information, resources and advice.
- People with dual diagnosis need access to doctors who spend time with people, rather than just write scripts.
- Educate health professionals on learning difficulties and dual diagnosis.
- Identify counsellors and therapists who acknowledge the effects of trauma in the lives of people with learning difficulties, and who will engage this population in therapeutic interventions.
- Develop a directory of GPs, Psychiatrists, Psychologists and other professionals who specialise in dual diagnosis work.
- Develop and implement specific hospital procedures for responding to the needs of dual diagnosis patients, including detailed record keeping, proper assessment and treatment, and appropriate referral.

RECOMMENDATION 3. THAT QUEENSLAND HEALTH AND DISABILITY SERVICES QUEENSLAND DEVELOP A JOINT DUAL DIAGNOSIS EDUCATION PROGRAM THAT SUPPORTS A COLLABORATIVE RESPONSE TO DUAL DIAGNOSIS ISSUES.

- Cross-training involving disability and mental health services is essential. This should involve content information on learning difficulties and mental health issues, as well as training on collaborative work practices.
- Joint work between disability and mental health services – forums, mutual education, case management, liaison.
- Cross-functional community support workers to prevent people falling between the cracks on the borders between disability, mental health and drug & alcohol services.
- Joint approach to care and support from disability and mental health systems, based on recognition of dual diagnosis as a joint concern of both sectors.
- Workers supporting people with learning difficulties need to understand the mental health and disability systems, and the roles and liaison between each of its members.

RECOMMENDATION 4. THAT QUEENSLAND HEALTH AND DISABILITY SERVICES QUEENSLAND DEVELOP AN OUTREACH MENTAL HEALTH SERVICE FOR PEOPLE WITH DUAL DIAGNOSIS.

- A flexible community based support able to assess a person in their home environment, with time to explore the issues affecting a person, and provide intervention options, referral, and follow up support to key support workers.

RECOMMENDATION 5. THAT QUEENSLAND HEALTH AND DISABILITY SERVICES QUEENSLAND DEVELOP A DUAL DIAGNOSIS CRISIS RESPONSE FACILITY.

- Accessible and appropriate after-hours mental health services.
- Assessment and Accommodation services where people can go during acute periods in their illness. A place where they can be intensely observed and supported, to better identify the interaction between their learning difficulty and their mental health issues.
- Supervised residential places so people can get bail and get out of jail.
- Safe and appropriate alternatives to hospitalisation.

RECOMMENDATION 6. THAT DISABILITY SERVICES QUEENSLAND INCREASE FLEXIBLE FUNDING AND RESOURCESTO SUPPORT DUAL DIAGNOSIS RESPONSES.

- Increase funding to pay qualified direct service workers to support people with dual diagnosis.
- Provide funding for intensive one-on-one support, at least through crisis.
- Funded support and supervision of service providers. Without these there is worker burn out and a high turnover of staff.
- Allow creative use of funding packages to help alleviate stress. For example, buy a bed, go on a holiday.

RECOMMENDATION 7. THAT CLP INITIATE A DUAL DIAGNOSIS WORKING GROUP OF DISABILITY SERVICES TO PROGRESS A GOVERNMENT POLICY RESPONSE TO DUAL DIAGNOSIS ISSUES.

- A coalition should be formed to represent to government the needs of people with dual diagnosis.
- Raise the profile of dual diagnosis issues with the key advocacy groups. Get the needs and issues of this population on the advocates agendas.
- Joint lobbying and advocacy by Mental Health and Disability services.

RECOMMENDATION 8. THAT CLP INITIATE A DUAL DIAGNOSIS WORKING GROUP OF DISABILITY SERVICES TO CALL ON THE DISABILITY SECTOR TO DEVELOP PRACTICE RESPONSES THAT RECOGNISE EARLY INTERVENTION AND PREVENTION RESPONSES TO DUAL DIAGNOSIS.

- Mental health issues are often recognised only at the point of crisis intervention. Understanding and implementation of early intervention and prevention responses to mental health issues will facilitate improved quality of life for people with a learning disability.

13. Appendices

APPENDIX A **SERVICE PROVIDER QUESTIONNAIRE**

APPENDIX B FOCUS GROUP CASE STUDY

APPENDIX C CLP COLLABORATIVE PROJECT FEEDBACK

A. CLP WORKERS

The key learnings CLP workers identified regarding the use of psychological and therapeutic interventions with people with dual diagnosis were:

1. Clear articulation of assessment, diagnosis and intervention processes is essential. People need to know what is going to happen, what the goals of the work are, and who will be involved.

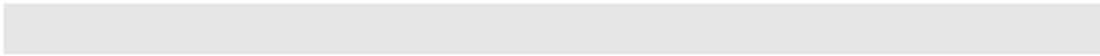
2. The role of the support worker needs to be clear (in the case of involvement of an external 'therapist'). Clear communication processes between the support worker and the therapist need to be established.

3. The support worker needs to be involved in, or have comprehensive knowledge of what happens in sessions conducted by the therapist. This is integral to the support worker being able to engage in meaningful follow up work to support any therapeutic interventions.

4. Relaxation techniques and problem solving techniques are helpful, and generally easily mastered by constituents.

5. Structured separate times to focus on therapeutic techniques are helpful. Otherwise, the other priorities or demands of the day can encroach on the time and space needed to use the therapeutic techniques.

B. CLP CONSTITUENTS (see next page)



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