

Barriers to Service Provision

FOR YOUNG PEOPLE WITH PRESENTING
SUBSTANCE MISUSE AND MENTAL
HEALTH PROBLEMS



NATIONAL
YOUTH
AFFAIRS
RESEARCH
SCHEME

**BARRIERS TO SERVICE PROVISION
FOR YOUNG PEOPLE
WITH PRESENTING SUBSTANCE
MISUSE AND MENTAL
HEALTH PROBLEMS**

A report for NYARS

Tricia Szirom, Debbie King and Kathy Desmond

SuccessWorks

October 2004

THE NATIONAL YOUTH AFFAIRS RESEARCH SCHEME (NYARS) was established in 1985 as a cooperative funding arrangement between the Australian Government and the State and Territory Governments to facilitate nationally-based research into current social, political and economic factors affecting young people. The Scheme operates under the auspices of the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA).

Reports from NYARS studies released since the early 1990s are available free-of-charge on the web site of the Australian Government Department responsible for youth affairs. At the time this report was published, the web site address was: <http://www.facs.gov.au/internet/facsinternet.nsf/aboutfacs/programs/youth-nyars.htm>

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Abbreviations

ADWS	Adolescent Drug and Alcohol Withdrawal Service	NYARS	National Youth Affairs Research Scheme
AIVL	Australian Injecting and Illicit Drug Users League	NYSPPS	National Youth Suicide Prevention Strategy
AOD	Alcohol and Other Drugs	OATSIA	Office of Aboriginal and Torres Strait Islander Affairs
ATSI	Aboriginal and Torres Strait Islander	RFNSW	Richmond Fellowship of New South Wales
BYS	Brisbane Youth Service	RMIT	Royal Melbourne Institute of Technology (University)
CALD	Culturally and Linguistically Diverse	SAAP	Supported Accommodation Assistance Program
CAMH	Centre for Addiction and Mental Health (Canada)	SAMHA	South Australian Mental Health Act
CAMHS	Child and Adolescent Mental Health Service	SAMHSA	Sub Abuse and Mental Health Services Administration
CAP	Crisis Accommodation Program	SEWB	Social and Emotional Well Being
CATT	Crisis Assessment Triage Team	SSYS	South Sydney Youth Service
CMHASD	Co-occurring Mental Health and Substance Disorders Panel	VAADA	Victorian Association of Alcohol and Drug Agencies
CWAV	Children's Welfare Association of Victoria	WANADA	Western Australian Network of Alcohol and Drug Agencies
DHS	Department of Human Services	YiPP-IA	Young People with Psychiatric Illness – Intervention and Assessment Program
DoHA	Australian Government Department of Health and Ageing	YMC	Youth Ministers Council
EPPIC	Early Psychosis Prevention and Intervention Centre	YPPI	Young People Prevention and Early Intervention
FaCS	Australian Government Department of Family and Community Services	YSAS	Youth Substance Abuse Service
JPET	Job Placement, Employment and Training Program		
KRA	Key Result Area		
LIFE	Living Is For Everyone (NSPS)		
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs		
NAAH	New South Wales Association for Adolescent Health		
NACCHO	National Aboriginal Community Controlled Health Organisation		
NCADA	National Campaign Against Drug Abuse		
NCBI	National Centre for BioTechnology Information		
NCP	National Comorbidity Project		
NDS	National Drug Strategy		
NDSF	National Drug Strategic Framework		
NGO's	Non-Government Organisations		
NMHP	National Mental Health Plan		
NMHS	National Mental Health Strategy		
NSPS	National Suicide Prevention Strategy		

Executive summary

Comorbidity or “dual diagnosis” refers to the co-occurrence of one or more diseases or disorders in an individual. It is frequently understood as involving a range of diagnosed or undiagnosed mental health issues that run alongside problematic drug use. When the two illnesses co-occur, the problems of disease management are compounded dramatically. This occurs not only because of the potential for the two types of disorders to interact and create mutual symptomatic exacerbation, but also because of the fact that these people are essentially “*system misfits ... who dare to have more than one disorder in systems of care that are primarily designed to deal with a distinct mental health or substance use disorder only*” (Minkoff 2001).

Research by Mather et al. (1999) found that young people with dual diagnosis tend to fall into two distinct groups:

- those with clinically significant mental illnesses such as schizophrenia, bi-polar disorder and major depression who self-medicate with alcohol and illicit drugs to lessen the distressing symptoms of their illness; and
- those with borderline personality and anti-social personality disorders or anxiety exacerbated by excessive use of substances such as alcohol, marijuana, amphetamines, cocaine and heroin (Mather et al. 1999).

Policy context

The majority of States and Territories are now engaged in a range of policy and program initiatives to improve services to people with dual diagnosis. There is growing recognition that whole-of-government approaches that take into account multi-factorial issues including housing, income, welfare, health, criminal justice, education and training are needed. However, only a few of these initiatives are clearly focused on the unique needs of young people suffering dual diagnosis.

The most significant national policy directions in respect to dual diagnosis include: the Second National Mental Health Plan (NMHP) 1998–2003; the Third National Mental Health Plan 2003–2008; the National Drug Strategic Framework (NDSF) 1998–1999 to 2002–2003 and the National Suicide Prevention Strategy (NSPS). The National Comorbidity Project is a policy initiative that has been established as a joint project under the NMHP and the NDSF.

The policy direction of the Australian Government and the State and Territory Governments for Aboriginal and Torres Strait Islander people sits within a number of interlinking frameworks and policy initiatives. Current policy initiatives relevant to this research include: the National Strategic Framework for Aboriginal and Torres Strait Islander Social and Emotional Well Being and Mental Health (ATSI SEWB Framework); and the National Drug

Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan.

The term “Social and Emotional Well Being” is used by Indigenous services and communities to describe a holistic definition of health. The term is frequently used in this context to refer to mental health, emotional, psychological and spiritual wellbeing. It also includes issues that impact and effect Indigenous people's health and wellbeing such as: substance use, mental illness, suicide and self-harm; incarceration; homelessness; grief, loss and trauma; and family violence (SEWB Framework 2003).

Current practice

Current practice in the delivery of services for young people with dual diagnosis are characterised by:

- different interpretations of the level of comorbidity between service types ranging from 10%–40% for some services to 70%–90% in others and lack of understanding and clarity of the definitions of comorbidity;
- high levels of demand in all services with comorbid clients presenting a significant source of demand;
- lack of youth specific services in some jurisdictions and lack of youth-focused comorbidity services generally;
- varying levels of understanding of the need to focus on engagement with young people, with youth specific services more likely than others to see this as a priority and to make efforts to achieve it;
- lack of appropriate models in the mental health system and in some adult-oriented services to work effectively with young people with comorbidity leading to high levels of referral failure as services are unable to cope with or tolerate non-compliant behaviour;
- strength-based, solutions focused approaches in many successful services, particularly those with a focus on young people. A strong commitment to harm minimisation by most services;
- willingness on the part of many youth accommodation, housing and drug and alcohol services to work together in addressing the needs of dual diagnosed young people with a perception that mental health services have a lesser commitment to multi-sectoral approaches; and
- poor access to mainstream services for Indigenous young people and few youth specific Indigenous services.

Indigenous young people and services

In Australia, mortality and morbidity rates indicate that the health of the Indigenous population is the worst of any other population (ABS 2003; AIHW 2003). Rates of non-fatal injuries, self-harming behaviour, mental illness and substance use have been noted as significantly higher than that of the non-Indigenous population (Swan and Raphael 1995). Indigenous people are also noted to live in conditions that the general Australian population would consider unacceptable including overcrowding, poorly maintained housing structures, high cost housing; and lack of basic infrastructure such as sanitation, water supply and safe housing (NSF for Aboriginal and Torres Strait Islander People 2003).

Site visits to a range of Indigenous services and communities during the consultation phases of this research found that many Indigenous communities (particularly those in rural and remote locations) continue to suffer in conditions that are clearly unacceptable.

Service providers within Indigenous services expressed concern about their inability to manage clients with comorbidity. This was particularly pertinent given the very high levels of demand for services.

Barriers to services identified through the consultations

Homelessness

Consultations for this project identified the lack of suitable and appropriate accommodation for young people with comorbid disorders as the most significant barrier to the access and provision of services. Youth work practitioners commented that without some form of reasonable stability, it was difficult, if not impossible to address the non-crisis and deeper issues (such as comorbidity) that young people present with. Alcohol and drug professionals noted that it was an uphill battle to treat and assist young people to deal with a substance use problem whilst they remained transient or homeless. Homelessness frequently contributed to further complexities and barriers such as involvement in the juvenile and criminal justice systems. Mental health workers stated that while extreme environmental factors remained active in young people's lives, it was difficult to accurately diagnose their mental health condition with any confidence.

Challenging, volatile or violent behaviour

Consultations for this research also found that young people's access to a range of services and supports was largely dependent upon their "reasonable and good behaviour". The complex nature of people suffering from dual diagnosis is frequently not taken into account by those working with young people. The complex nature of comorbidity is frequently exacerbated by a range of other issues unique to young people, least of which can be the often volatile developmental stage of "adolescence". As noted by Tickell (1999) in Chapter One of this report:

Young people are ill-equipped to deal with the series of traumatic events that have been happening to them. They are often suffering from great stress, manifesting all the symptoms that run alongside this – suicidal tendencies, panic attacks, depression and so on. Often they are self-medicating using illicit drugs or drinking to reduce their anxiety and feelings of being out of control. They are mistrustful and sometimes aggressive to people in authority.

(Tickell 1999)

Appointment-based service provision

The views of youth service providers gained during the consultations for this study also highlighted the difficulty young people with complex needs have in living up to the expectations of appointment-based services. Youth focused services, particularly crisis and some counselling services, noted that an understanding and acceptance of adolescent development in the context of the complexities surrounding homelessness and dual diagnosis contributes to an appreciation of young people's psycho-social ability to meet adult expectations (i.e. failing to arrive at appointments on time, acting out behaviour etc.).

Informants from a broad range of services expressed concern about the steady increase in young people presenting with co-occurring mental health and substance use problems. Workers in youth accommodation, generalist youth services and youth crisis services made note that dual diagnosed young people will tend to seek assistance for a variety of "other" complicating issues such as homelessness, ill-health, income support problems, legal problems and relationship/family issues (Labeled 2003).

Often, these young people's lives are in a perpetual state of chaos as they try to grapple with these issues... as well as coping with mental illness/disorder and a substance use disorder. Throw "normal" adolescent issues into the mix and it shouldn't be a surprise that appointments

are missed and behaviour is sometimes less than "socially acceptable ...".

(Labeled 2003)

Defining comorbidity in young people

The distinction between "mental illness" and "mental health problems" is a complex one and appears to be not well understood by practitioners in the field in regard to the identification of comorbidity in young people. Australia's National Mental Health Plan (2003–2008) acknowledges both the complexity and diversity of views in defining mental illness and mental health problems. In addition, the frequent use of different terminologies, such as "mental health disorder", "mental illness", "mental health problem" and "mental health issue" to explain a range of conditions, also serves to exacerbate confusion as to what exactly is defined as a valid mental health condition that can then be diagnosed as comorbidity when placed alongside problematic substance use.

Consultations for this project revealed that many youth service workers stated that 100% of their clients could be thought of as having a mental health issue if post-traumatic stress disorder, a past history of abuse, suicide or self-harming behaviour, depression and anxiety are accepted as "mental health issues". Many youth housing and drug and alcohol workers noted that these conditions, alongside substance abuse, were the rule rather than the exception.

The stigma that is frequently associated with mental health conditions was also reported as a significant barrier to service access, insofar as young people were extremely reluctant to access mental health services for fear of being labelled a "mental case". In addition, there was also consensus from professionals in all sectors consulted that there is a lack of trust from young people toward government or mandated services, particularly mental health services. Services consulted stated that this issue is often exacerbated when mental health service environments are clinical in appearance and approach.

Lack of specialist services and dedicated resources

Specialist services and dedicated resources for young people with co-occurring disorders were reported as "thin on the ground". The National Comorbidity Project found that of the forty-four dedicated comorbidity services in Australia, only three focused exclusively on young people. Consultations also revealed that it was both inappropriate and unsuccessful to attempt to treat young people in an environment or program that primarily targeted adults. Young people frequently felt intimidated, uncomfortable and "out of place" when forced to access adult services. Many young people will be

unwilling to then return to the service. The lack of youth focused specialist services was also reported as having resulted in the need for extended waiting lists, particularly for services of a residential nature.

Lack of expertise and dual skills

Lack of expertise and appropriate skills in the identification, engagement and treatment of co-occurring disorders in young people was also reported in the consultations as a critical barrier. Mental health professionals stated that alcohol and drug practitioners and youth work practitioners were lacking the appropriate skills and expertise to determine potential comorbid disorders through accepted assessment processes. Alcohol and drug workers along with their youth worker counterparts commented that mental health professionals lacked knowledge, skills and expertise in drug and alcohol issues and best practices for working with young people.

Conflicting interests in service provision

Conflicting interests and understandings of the nature and definitions of comorbidity between all key sectors was seen by those consulted as a major barrier to the provision of services and resulted in fragmentation of service provision and a significant contributor to inhibiting access to appropriate services for young people. Young people already in the system were seen as “caught in the middle” of these conflicting interests, with mental health services often insisting on a medicated treatment regime, while drug and alcohol services would emphasise the need for abstinence. This is commonly known among practitioners as the “ping pong effect”.

Barriers for Indigenous communities

Throughout the consultations a number of issues and themes emerged that correlate strongly with existing research on Indigenous populations, service approaches and the barriers that are commonly experienced by Indigenous people in attempting to access appropriate services. For young people in particular, barriers identified in the consultations included:

- a general lack of services both geographically and Indigenous (or Indigenous youth specific);
- homelessness and inappropriate overcrowding in unsafe and unacceptable conditions;
- inadequate access of families and communities to basic infrastructure, such as sanitation, waste disposal, power, water supply etc.;
- high levels of distrust in mainstream services

and workers and associated stigma and shame in relation to mental illness;

- high levels of use of inhalants such as petrol, among young Indigenous people, particularly in rural and remote communities;
- high levels and frequency of conflict with police and other law enforcement agencies as well as resulting incarceration;
- lack of holistic, Indigenous “extended” family-based approaches for young people to social and emotional wellbeing; and
- lack of Indigenous role models.

Strategies to overcome barriers

As a key aspect of this study, the research team posed a range of questions to service providers about how they manage and strategically address the barriers that arise for many of their comorbid young clients. Responses were varied across service sectors and included implementing approaches that were “strengths-based” and “solution orientated”, focusing on early intervention and/or prevention, working within a framework of “risk” and “resilience”, working intensively with families (where appropriate and possible), trialling integrated case management and assertive outreach, and relying on the “goodwill” and “friendships” formed as part of a practitioners professional network with key support services. When it came to housing and accommodation issues however, many informants were at a loss to identify effective practices:

You can't give what you haven't got. I can get some of my clients into some programs just by pushing the friendships and alliances I've built over years of being in the sector. Most [clients] I can do little for in terms of housing – it's just not there.

(Tasmanian Youth Worker)

Similarities in strategies employed by workers and organisations to overcome some of the more common barriers were in the key areas of: improving access; collaboration and cooperation; managing difficult or disruptive behaviour; and reaching agreement on diagnosis and treatment.

Best practice

Achieving a youth-friendly focus

All young people, without exception, stated that having a trusting relationship with a practitioner(s) was the primary factor that they found most helpful in accessing (and maintaining involvement) with services. In addition, young people also stated that they felt most comfortable in an environment

that was relaxed and welcoming, where they could witness other young people in attendance and where they could access appropriate information about a range of issues that they found of interest.

Appointment-based services were criticised by many in the youth-work field who noted that many dual diagnosed young people are subject to punitive consequences for missed appointments and non-compliant behaviour.

Inter-sectorial partnerships and integration

Consultations with service providers clearly indicated that a “seamless service” which involved the expertise, skills and knowledge of both alcohol and drug practitioners as well as mental health clinicians was a key factor for best practice in the identification and treatment of dual diagnosis. However, consultations also highlighted the critical need for these services to adopt a youth-work and youth-friendly approach in working with young people, as adult approaches to engaging and maintaining young people’s participation in treatment failed dismally. In addition, all service providers consulted agreed that assertive mobile youth outreach programs, consisting of appropriately-trained mental health and alcohol and drug practitioners, were highly effective strategies for identifying and engaging dual diagnosed young people who also suffered extreme marginalisation.

Another aspect that was raised by participants as part of an integrated approach was the need for relevant and appropriate assessment and diagnosis as well as shared referral and assessment tools.

Extended (long-term) flexible support

All participants in the consultations, including young people, clearly stated that current interventions were commonly short-term with little, if any follow-up support. Services noted that they were generally not funded to provide quality follow-up and their programs primarily designed to achieve short-term goals. Youth service providers were more likely to provide long-term involvement with young people who accessed their services, however they lacked the resources, specialist’s skills and training to effectively address and support young people with co-occurring disorders.

Best practice working with Indigenous communities

Best practice for working with Indigenous young people must sit within a holistic framework and approach to working with Indigenous families

(including extended family) and communities. Such an example is the model of Social Health Teams (recognised within the Aboriginal and Torres Strait Islander SEWB Framework) that work with Indigenous communities from within Aboriginal Health Services:

- Wuchoperren Health Service (Qld);
- Central Australian Aboriginal Congress (NT);
- Winnunga Nimmityjah Aboriginal Health Service (ACT);
- Nunkuwarrin Yunti of SA Inc. (SA);
- Port Lincoln Aboriginal Health Service (SA).

These Social Health Teams and services offer both mental health and drug and alcohol workers or access and referral into appropriate services as needed.

Elements of good organisational practice with Indigenous communities include:

- understanding and recognising the impact of past policies on the Indigenous community;
- focusing on holistic healing;
- clear directions, planning, leadership and vision;
- integration;
- teamwork and a high quality skilled workforce;
- flexibility and responsiveness to clients;
- established networks, and a commitment to collaboration and partnerships with other key organisations;
- an integrated, holistic approach;
- effective communication systems;
- commitment;
- sound organisational policies and procedures;
- making a demonstrated difference in the lives of those being engaged; and
- building trust.

Summary of recommendations

The following is a summary of the full recommendations that appear in Chapter Seven.

Policy level recommendations

1. That the Australian Government extend its efforts in the area of co-occurring mental health and substance use issues to include and highlight **young people** and **Indigenous young people** as a priority “at-risk” population for comorbidity.

2. That the Australian Government strongly encourage other relevant national strategies that currently extend a relationship to high risk or marginalised young people (i.e. Partnerships

Against Domestic Violence, Stronger Families and Communities, the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA), Ministers Declaration: Stepping Forward – improving pathways for all young people etc.) to ensure the issue of comorbidity in young people is recognised and appropriately addressed.

3. That government ensure that funded mental health and alcohol and other drug services that provide treatment and assistance to young people (aged 12–25 years) suffering dual diagnosis, implement protocols for dual case management.

4. That governments review youth specific SAAP services to identify their allocated resources and their role in housing young people suffering comorbidity. In addition, SAAP services working with young people need to be encouraged to develop appropriate protocols with local drug and alcohol agencies as well as mental health services.

5. That national policy and funding acknowledge the important role of a youth specific focus in development of best practice in treatment approaches to assisting dual diagnosed young people.

6. That future funding of services for dual diagnosed young people acknowledge that such services frequently need to be long-term (i.e. twelve months duration), non-appointment-based, flexible in access times and venues, and adopt a non-punitive response to anti-social, volatile or aggressive behaviour.

7. That the Australian Government further support and encourage the role of the National Comorbidity Project in addressing the range of policy issues apparent in the area of comorbidity in young people.

Service provider level recommendations

8. Comorbidity should be seen by service providers in youth accommodation, drug and alcohol and mental health as a common occurrence rather than an “exception”. Drug and alcohol, mental health and youth accommodation services need to be funded and measured accordingly.

9. Drug and alcohol, youth accommodation and mental health services need to implement screening tools that appropriately cover dual diagnosis as part of general assessment processes for all young people accessing these services.

10. That service providers be supported and encouraged to adopt a youth-friendly, client-centred approach to working with young people in this target group.

Early intervention

11. That the Australian Government and the State and Territory Governments support prevention and early intervention initiatives in educational settings (including primary and secondary schools, TAFE and institutes of higher education) for the prevention and early identification and support for young people suffering co-occurring disorders.

12. That professional development for teachers, particularly secondary school year level coordinators is provided on the prevalence and indicators for comorbidity along with information for secondary consultation and referral services.

Intervention

13. That the Australian Government and the State and Territory Governments fund a range of youth-specific pilot treatment and intervention models for comorbidity that draw on and further test the findings of recent projects and research.

14. That these pilot models are funded for at least a three-year period and operate alongside a separately-funded comprehensive formative and action-research evaluation plan.

15. That homelessness services receive further resources to adequately support the increased demand for housing and accommodation options for vulnerable and at-risk young people suffering comorbid disorders.

16. That all services working with young people suffering comorbid disorders adopt best practice standards which focus on appropriate and effective engagement strategies, tolerance for anti-social and volatile behaviour, provide an holistic approach (treating the whole person rather than the issue) and have a long-term focus.

17. That government, through the Commonwealth State Housing Agreement undertake a review into short, medium and longer-term accommodation options for dual diagnosed young people which include halfway housing, sole occupancy, and shared households – all with appropriately skilled and trained youth worker support.

18. That crisis services, including crisis youth accommodation services and SAAP services, review their entry criteria and policies and procedures on exclusion, as it relates to dual diagnosed young people.

Continuing care and recovery

19. That governments look to increasing resources for programs and projects that work with dual

diagnosed young people as a core business target group and dedicate resources for continuing care, recovery and follow-up services.

20. That services working with dual diagnosed young people look to integrating continuing care, recovery and follow-up strategies as part of their program services.

Law enforcement and police

21. That juvenile and adult justice systems reconsider the appropriateness of appointment-based systems for young people who are suspected of suffering co-occurring substance use and mental health problems.

22. That young people, particularly those aged less than 18 years of age, who are offenders and have a substance use issue, are appropriately assessed for a co-occurring mental health problem and/or mental illness.

23. That governments develop appropriate training packages for police, juvenile justice and adult justice workers, loosely based on the Coffs Harbour Police Liaison Training Program and which reflect best practice standards in the identification and treatment approach for dual diagnosed young people.

Indigenous services

24. That government address the basic health needs of Indigenous communities in rural and remote areas, particularly in regard to the provision of basic and adequate infrastructure to improve the environment health of such communities.

25. That government continue to support, adequately maintain and increase (where needed) culturally appropriate dedicated resources to Indigenous social and emotional health policy and implementation initiatives.

26. That the issue of co-occurring substance use and mental health problems in young Indigenous people is set with current frameworks of social and emotional wellbeing and considered the responsibility of government departments implementing policy that address broader health issues within Indigenous families and communities.

27. That government increase funding to key Indigenous services that are currently working with populations and communities where substance use and mental health problems are prevalent so that youth specific Indigenous services can be developed and provided, where appropriate.

28. That governments increase funding and support to the provision of Indigenous workers

within mainstream services to increase potential access points for Indigenous young people with co-occurring disorders.

Education and training

29. That mental health services acknowledge that substance use among clients with a mental illness or mental health problem is “the norm” rather than the exception. Training for mental health workers needs to cover the indicators, circumstances, issues and best practice strategies for engagement and relapse prevention in working with dual diagnosed young people.

30. That governments implement a well-planned, coordinated training program for NGO’s and government-run mental health and alcohol and drug services, that takes account of the diversity of the health care and community services systems and which is informed by best practice standards for working with young people.

31. That funding is provided as part of a professional development package for current services and staff in the non-government sector, on the issues and current best practice for working with dual diagnosed young people.

32. That government provide funding for the design, development and implementation of training on comorbidity in young people for juvenile justice and criminal justice systems.

About this report

This report details and describes the barriers to service provision for young people with co-occurring substance use and mental health problems. In addressing this issue within the Indigenous population (including Aboriginal and Torres Strait Islander people) the research team adopted the best practice approach of “social and emotional wellbeing”. In line with Indigenous culture the issue of comorbidity in young Indigenous people must be viewed from this holistic perspective. Therefore the information within this report frequently refers to “Indigenous communities” and outlines the emotional and social wellbeing of these communities rather than specifically referring to young Indigenous people with dual diagnosis.

The following report has been structured as follows:

Chapter 1 provides an introduction to the research issue and outlines the purpose and scope of the project. The methodology is also described in detail in this Chapter.

Chapter 2 provides a brief description of the policy context and the conceptual overview of the project and its key issues.

Chapters 3 and 4 draw on both current literature and the consultations conducted as part of this project to identify, describe and analyse current practice as well as barriers to service access in a range of relevant and related services and sectors.

Chapter 5 describes current practice strategies for

overcoming barriers as well as an account of specific initiatives within States and Territories as well as Australian Government.

Chapter 6 identifies best practice from the international stage as well as identifying good practice programs and strategies within Australia.

Chapter 7 draws together the main issues and findings of the research and provides a number of recommendations for future directions.



Project context and methodology

1.1 The National Youth Affairs Research Scheme (NYARS)

The National Youth Affairs Research Scheme was established in 1985 by the former Youth Ministers Council (YMC). In 1993 the YMC was absorbed by a new ministerial body, the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA). NYARS is a cooperative arrangement between the Australian Government and the State and Territory Governments, and is managed by a Steering Committee consisting of representatives from the Australian Government and State and Territory Government agencies responsible for youth affairs.

The aims of NYARS go beyond that of increasing the body of knowledge about youth affairs. NYARS was established specifically to contribute to the formulation and assessment of government youth policy and its implementation. NYARS projects are expected to provide the Australian Government and the State and Territory Governments with topical and timely information on youth issues that are not adequately covered by other research or existing data sources.

1.2 Project scope

In February 2003 Success Works was commissioned

by NYARS, through the Australian Department of Family and Community Services (FaCS), to undertake research into the “barriers to service provision for young people with presenting substance misuse and mental health problems”.

The purpose of the research was to provide a comprehensive insight into the range of services required by young people with mental health and substance misuse problems. The project was not intended to test the adequacy of service provision within the health service system. Rather, the research was to consider the barriers to the provision of a broad range of specialist supports and mainstream services (such as housing, income support and education and training) for, or accessed by, young people with co-existing mental health and substance misuse problems.

Key aspects of the research brief

Access to services for young people with co-existing disorders is frequently compounded by a range of complex issues and structural barriers. Young people with a co-occurring disorder frequently experience:

- unstable living arrangements and homelessness;
 - poor problem-solving skills;
 - familial problems;
-

- loss of support networks (social isolation);
- lack of educational qualifications;
- HIV infection (and other blood borne viruses); and
- contact with criminal/juvenile justice system (New South Wales Association of Adolescent Health 2003).

In commissioning this research NYARS stakeholders shared the view that the needs of young people with co-existing substance misuse and mental health problems were not being met adequately. The need for improved specialist services to these young people was seen as increasingly urgent as they tend to “fall through the cracks” of mental health and drug and alcohol services. This is largely due to differing treatment philosophies and definitional issues that lead to exclusions in service delivery. For example, hospitals and mental health services frequently insist that the substance misuse problem must be addressed before they address the mental illness.

In addition, NYARS stakeholders noted that the problems in accessing services and maintaining a relatively stable lifestyle compound for these highly vulnerable young people. They are over-represented among the homeless and maintaining involvement in treatment programs becomes increasingly difficult if they do not have stable accommodation. Moreover, they are often unwelcome in youth refuges and may lack the life and interpersonal skills and behaviours needed to maintain a tenancy or live independently in the community.

Other key aspects to the research brief included the following points:

- The trauma of mental illness is immense and affects not just the young person but also their family. Their mental health problems can make it difficult for them to maintain relationships, to retain a connection to education, or to hold down a job – all of which are known protective factors against other risks including escalating drug use, crime and homelessness.
- Problems are further compounded for young people from low socio-economic backgrounds, including Indigenous young people, who are less likely to use preventative services and may face multiple barriers to accessing appropriate treatment services.
- Early intervention was seen by stakeholders as the key to minimising risk of adverse outcomes, including comorbidity, for young people with mental health problems. However, the potential for early intervention in this area is inhibited as young people often do not seek help until they

are in crisis and may refuse to participate in or comply with treatment.

Project objectives

The following areas of inquiry made up the scope of the research:

- Mapping current practices and structural, cultural and other barriers in youth accommodation and other services that impede access by and appropriate service provision to young people with substance misuse and mental health problems.
- Identification of strategies that could be utilised to overcome these barriers.
- Identification of models of good practice in working with these clients.

1.3 Methodology

The methodology for this project was based on the following approach:

- An understanding of the alcohol and drug sector, particularly in relation to principles and policies of the National Drug Strategic Framework (1998–1999 to 2002–2003) and the Second National Mental Health Plan (1998–2003).
- A comprehensive knowledge of current drug and alcohol issues, including prevention, early intervention, treatment and rehabilitation, harm minimisation, local drug strategies, and law enforcement.
- A comprehensive knowledge of the mental health sector and mental health issues relating to young people, particularly those who are homeless and/or experience high and complex needs.
- A comprehensive knowledge of current youth issues in a range of fields including: homelessness, domestic violence, abuse, juvenile justice, State care systems, and those leaving care.
- The importance of participation in this project by the widest possible group of stakeholders, in order to provide a comprehensive research project with recommendations that are feasible, practical, acceptable, sustainable and realistic for implementation.
- The adoption of ethical, sensitive, and inclusive consulting practices, with a focus on process as well as product.

There were four main components to the research methodology: a literature and document review; mapping of relevant State and Territory services and activities; consultations; and identification of

good practice models and strategies using brief case studies derived from the consultations and literature.

Literature and document review

Literature was gathered and investigated from a broad range of key national and international sources including: internet and desk searches; Australian Government and the State and Territory Government programs and activities delivered that share an interest in young people and comorbidity; government education; and research institute databases and sources. Relevant international databases and sources included: Drug Scope; National Mental Health Association (USA); ProQuest; National Centre for Biotechnology Information (NCBI) and National Library of Medicine (USA); Tennessee Dual Diagnosis Recovery Network; United States Department of Health and Human Services; Substance Abuse and Mental Health Services Administration (SAMHSA); The Royal New Zealand College of General Practitioners; and Health Canada.

The purpose of the literature and document review was to:

- undertake a scan of national and international literature and current documents relevant to current practices and structural, cultural and other barriers to service access for young people with substance misuse and mental health problems;
- identify and collate information on links/partnerships with other strategies;
- identify current and emerging trends;
- identify examples of best practice from the literature in drug and alcohol and mental health for working with young people with co-existing disorders;
- conduct preliminary interviews/consultations with key stakeholders;
- produce and disseminate a discussion paper with key questions for the research; and
- identify deficiencies or gaps in available data collections to support monitoring and further research questions.

Key stakeholders and informants were also asked to suggest any relevant reports, programs, activities or literature for possible inclusion in the review, and the bibliographies of these were examined for further relevant material.

Mapping of relevant State/Territory services and activities

Prior to conducting consultations the research team contacted a range of peak body organisations in all

States and Territories requesting their assistance in identifying relevant local services, programs, and/or projects that may have contact with young people who suffer dual mental health/substance use disorders. These included: Victorian Association of Alcohol and Drug Agencies (VAADA); Western Australian Network of Alcohol and Drug Agencies (WANADA); and Children's Welfare Association of Victoria (CWAV). A letter was composed, written and emailed by the research team to the heads of all State and Territory Government departments responsible for youth affairs, alcohol and other drugs and mental health. This letter briefly outlined the purpose and objectives of the research and requested their participation in the project and assistance in coordinating the implementation of focus groups consultations in their home State/Territory. Departments were also invited to nominate relevant individuals (i.e. dual diagnosis project managers/workers) as well as services and/or programs that were known to deal with young people suffering dual mental health/substance use problems and were considered "good practice" models.

All departments responded to this request and many went to considerable lengths to obtain relevant information, including local articles and literature, for the purposes of the research.

From the above activities a list of programs, services and individual experts within each State and Territory was developed, and subsequently contacted and briefly interviewed. These contacts were invited to participate in the research consultations as well as assist the research team in accessing and interviewing dual diagnosed young people who had some experience of the service system. All services and individuals contacted in this phase of the research process were also invited to nominate any other services, initiatives or literature that may be considered relevant to the research.

Consultations

In-depth interviews were conducted with approximately 140 key stakeholders from across Australia during the period November 2003 to March 2004. Consultations involved a cross-cut of programs/activities operating at Australian Government and State and Territory Government level, including specialist services, non-government organisations, service users and those who are part of marginalised communities and/or target groups. Geographic coverage included rural and regional, as well as metropolitan areas. Focus group consultations involved a broad range of key stakeholders including: youth accommodation services providers; key informants in health, alcohol and other drug authorities/services; youth generalist services; Indigenous services; education; law

enforcement; corrective services; non-government peak bodies (including alcohol and other drug foundations); mental health services; councils of social services; key community leaders; and young people.

The aims of the consultations were to:

- conduct site visits to a cross-cut of programs and activities operating at Australian Government and State and Territory Government level;
- conduct a series of focus groups/consultations in each State/Territory to discuss potential strategies for overcoming identified barriers to services for the target group;
- focus on current practices and identify structural, cultural and service barriers;
- review program and service specific documents; and

- ensure that young people were consulted and appropriately reimbursed for their expert opinions and views about their experiences.

Consultations with programs and services

Service types identified for the purpose of the consultations were: youth housing and homelessness services; youth counselling and generalist support services; youth drug and alcohol (residential and non-residential); mental health (child, youth and adult); dedicated comorbidity services (youth and adult); youth health services and services for Indigenous communities; and young people. In addition, income support agencies (such as Centrelink), education, employment and training services (such as JPET), as well as general practitioners and allied health services were also consulted. Figure One below provides an account of the number of services and service type, within each State and Territory that were consulted.

Figure One: Number of consultations by service type and State/Territory

	Youth housing	Youth generalist	Youth drug and alcohol	Youth mental health	Mental health	Dedicated comorbidity	Indigenous youth	Peaks and other
VIC	2	2	4	2	1	4	-	2
NSW	2	1	2	-	1	2	-	1
TAS	1	-	1	-	1	-	-	-
QLD	3	2	2	-	2	-	-	-
NT	3	-	-	1	3	-	1	-
WA	3	-	1	1	1	3	1	1
SA	2	4	5	-	4	-	-	-
ACT	2	2	3	1	1	1	1	-

Service providers were asked about their current practice for referral and assessment, service approach/treatment philosophy, instances of young people with co-occurring mental health and substance use issues, and what they perceived as barriers for these young people in accessing services as well as good practice strategies.

Consultations with young people

A total of 54 young people were interviewed across the country for this study. In all, there were 28 young women and 26 young men; however the gender ratio varied within different jurisdictions. Figure Two below provides an account of the numbers of young people interviewed and gender breakdown according to jurisdiction.

Figure Two: Number of young people interviewed by State/Territory

	VIC	NSW	TAS	QLD	NT	WA	SA	ACT
Female	11	4	-	5	3	3	-	2
Male	8	3	-	4	6	2	1	2

Access to all young people interviewed for this study was through the efforts and dedication of service providers who participated in the consultations. In particular the Youth Substance Abuse Service (YSAS) in Victoria provided valuable information and insights

from clients through granting the research team access to documented consultations conducted as part of their research and evaluation process. For the purposes of confidentiality, these services will remain anonymous, however without their participation and

“extra” effort the views of young people would not have been acknowledged or reported.

Young people consulted as part of this research were asked a range of questions on their past experiences with services, family and other support history, current situation and their perspectives on the quality of service provision they had received in the past. All young people interviewed were current services users, with most having been in contact with a specific service for a number of years. Almost all had been homeless in their recent history and of the young women interviewed in Queensland and the Northern Territory, many were pregnant or were young mothers of young children not in their care. Of the young men interviewed all had been accessing services for over three years and some for as long as seven years.

Identification of good practice models and strategies

The final phase of the research involved the identification and discussion of strategies that may be utilised to overcome barriers to services. These strategies were largely identified through the consultations with service providers, young people and front line workers who generously contributed their time, experience and expertise to the research process. This phase also aimed to establish critical issues through identifying the barriers to a broad range of services and supports accessed by young people with dual mental health/substance use disorders.

As part of the process to identify good practice models the research team conducted a comprehensive

quantitative and qualitative analysis of information and data collected over the life of the project. Qualitative research methods were employed to analyse non-numerical data and measure thematic outcomes, and the software packages N5 (Non-numerical Unstructured Data Indexing Searching and Theorising) and Microsoft Word (Windows and Excel) were utilised. A thorough analysis was performed, including the interpretation of all qualitative material in a systematic and comparable way without losing the views and experiences of those involved in the consultative process, nor the detailed information gained from the literature review.

1.4 Limitations

Definitions

As mentioned earlier, there is some debate in the literature in regard to a clear and concise definition of comorbidity. For the purposes of this report, the consultants have settled on the definition of a co-occurring disorder as referred to in the Executive Summary and in Chapter Two of this report. However, it is acknowledged that there are other perspectives that see this as a rather narrow and simplistic definition.

Feedback on draft versions of this report highlighted a concern of stereotyping negative aspects of young people’s behaviour. It is acknowledged, however that often young people exhibit aggressive or problematic behaviour as a direct result of treatment from specific workers or services in the field. Some aggressive and problematic behaviour is therefore not always initiated solely by a young person, rather particular circumstances and treatment approaches may do more to encourage such behaviour than they achieve in addressing it.

Introduction and conceptual overview

Comorbidity or “dual diagnosis” refers to the co-occurrence of one or more diseases or disorders in an individual. It is frequently understood as involving a range (one or more) of diagnosed or undiagnosed mental health issues that run alongside problematic or poly drug use. The prevalence of comorbidity among people presenting to drug and alcohol services, mental health services, homelessness services, welfare, family and youth services as well as general practitioners appears to be increasing. The co-occurrence of mental health problems and substance use disorders is far more widespread than what was first thought and such conditions are repeatedly linked with poor outcomes in identification and treatment, multiple service use and chronic illness.

Successful treatment and disease management of either substance use disorders or psychiatric disorders separately is highly challenging. Both disorders are chronic, relapsing, stigmatising and potentially disabling. It is now widely recognised among practitioners that drug use and symptoms of withdrawal can mimic or conceal some psychiatric symptoms and symptoms of ill-mental health can be produced by drug and alcohol use. In addition, both disorders involve alteration of the individual’s mental status, so that disease management strategies are targeted at someone who is cognitively impaired, possibly with poor reality testing, and who may not adequately recognise the seriousness of his or her condition (Minkoff 2001).

When the two illnesses co-occur, the problems of disease management are compounded dramatically. This occurs not only because of the potential for the two types of disorders to interact and create mutual symptomatic exacerbation, but also because of the fact that these people are essentially “*system misfits ... who dare to have more than one disorder in systems of care that are primarily designed to deal with a distinct mental health or substance use disorder only*”.

(Minkoff 2001)

2.1 Policy context

State and Territory mental health and drug and alcohol services are primarily administered through segregated service systems, usually within State Government Health Departments. The limitations of these administrative arrangements have been both identified and emphasised in a number of forums as well as in the literature. A significant number of non-government agencies also play a major role in providing services to young people with co-existing substance misuse and mental health problems.

The majority of States and Territories are now engaged in a range of policy and program initiatives to improve services to people with co-existing mental health and substance misuse problems, largely through the mental health service system. However, there is growing recognition that whole-of-

government approaches that take into account multi-factorial issues including housing, income, welfare, health, criminal justice, education and training are needed. In addition, only a few of these initiatives are clearly focused on the unique needs of young people suffering dual diagnosis.

There are a number of national strategies that clearly recognise the importance of addressing issues around co-existing mental health and substance misuse problems. These initiatives acknowledge and include the impact of both licit and illicit drugs, as well as other substances such as inhalants. The most significant national policy directions include: the Second National Mental Health Plan (NMHP) 1998–2003; the Third National Mental Health Plan 2003–2008; the National Drug Strategic Framework (NDSF) 1998–1999 to 2002–2003 and the National Suicide Prevention Strategy (NSPS). The National Comorbidity Project, referred to extensively in this report, is a policy initiative that has been established as a joint project under the NMHP and the NDSF.

The National Comorbidity Project

At the Australian Government level the National Comorbidity Project (NCP) is probably the most significant of the current policy directions. The NCP is a joint initiative under the National Mental Health Strategy and the National Drug Strategy. The Second National Mental Health Plan (1998–2003) and the National Drug Strategic Framework (1998–1999 to 2002–2003) recognised the importance of addressing issues around co-existing mental health and substance use disorders. Both strategies identify the need for a national response to this priority area, including the development of better care and management. The NCP Project's aim is to:

...identify and develop appropriate policy, prevention, and treatment and service delivery approaches (at all levels of the health care system) to comorbidity in mental illness and substance abuse.

(Australian Government Department of Health and Ageing 2003)

The National Comorbidity Project has identified the following priority areas:

- prevention and early detection;
- carers and consumers;
- research and evaluation;
- education and training;
- integration or collaboration between services; and
- whole-of-government approaches.

The National Comorbidity Initiative is an arm of the NCP and specifically aims to improve service coordination and treatment outcomes for people with both illicit drug addiction and mental illness. The initiative targets improved coordination mechanisms across psychiatric/mental health services and drug treatment services. In addition, it aims to develop best practice guidelines for service delivery as well as increase the provision of professional development, education and training.

The National Mental Health Plan

The National Mental Health Plan (1998–2003) identified the need for specific attention to be paid to improving services for children and adolescents, people with mental illness and problems with alcohol and drug misuse, and people with severe personality disorders.

The most recent National Mental Health Plan (2003–2008) adopts a population health framework. This framework is based on an understanding that the influences on mental health occur in the events and settings of everyday life. The new plan is guided by four priority themes:

- promoting mental health and preventing mental health problems and mental illness;
- increasing service responsiveness;
- strengthening quality; and
- fostering research, innovation and sustainability.

The plan also recognises:

...the effect of mental illnesses occurring comorbidly with drug and alcohol problems and other conditions. The corollary of this is that a population mental health approach recognises that effective linkages must be forged with other sectors in order to achieve collaborative planning in a way that builds capacity and takes account of local needs and circumstances.

(NMHP 2003–2008)

The National Drug Strategy

The National Drug Strategy (NDS) and its predecessor, the National Campaign Against Drug Abuse (NCADA), involve a cooperative venture between the Australian Government and the State and Territory Governments as well as the non-government sector. The aim of the NDS is to prevent and reduce the uptake of harmful drug use and minimise the harmful effects of licit and illicit drug use in Australian society.

The National Drug Strategic Framework (NDSF) 1998–1999 to 2002–2003 is the policy document of the NDS

and sets out a shared vision and framework for cooperation and partnership, as well as a basis for coordinated action to minimise the harm caused by drugs in Australia over a five year period until the year 2003.

The NDSF identifies links to the National Mental Health Strategy and the National Suicide Prevention Strategy as two of the key areas where overlapping issues can be addressed, improving services to clients with co-existing mental health and substance misuse problems.

The National Suicide Prevention Strategy

The National Suicide Prevention Strategy (NSPS) builds on the work begun by the National Youth Suicide Prevention Strategy (NYSPP) July 1995–June 1999. The key objectives of the NSPS are:

- to support national suicide prevention activities across the lifespan; and
- to develop and implement a strategic framework for a whole-of-government and whole-of-community approach to suicide prevention across all levels of government, the community and business.

The importance of local level suicide prevention activities, support of community organisations and the development of community models of suicide prevention is a priority under the NSPS. The NSPS continues to focus on youth suicide and has been expanded to include other age groups and those identified as being at high-risk, such as young adult men, rural residents, the elderly, people with mental illnesses, people with substance use problems, prisoners, rural communities, and Aboriginal and Torres Strait Islander communities.

The “Living Is For Everyone” (LIFE) Framework is the strategic plan of the NSPS. It aims to foster strategic partnerships and to position suicide prevention effort across all sectors. The LIFE documents were developed by the National Advisory Council on Youth Suicide Prevention, guided by consultation with key groups and evidence that suicide prevention requires a multi-faceted approach involving collaboration between all levels of government and the community.

2.2 Indigenous policy context

The extreme disadvantage of Indigenous people is a direct result of colonisation, and particularly of past government practices and policies. A major concern of many Indigenous communities, cooperatives and organisations is the health and wellbeing of their young people, particularly those who are homeless with substance use and/or mental health issues

(Berry, MacKenzie, Briskman, Ngwenya 2001). It has been reported that the private rental market generally will not house Aboriginal young people and that even caravan parks will only house them if a support worker is attached and rent is paid in advance (Berry et al. 2001). The scarcity of stable housing for Indigenous young people makes them particularly vulnerable to physical and social dangers. These young people are frequently marginalised from family and community, forced to live in dire poverty, suffering multiple barriers to accessing basic services due to their age, gender and Aboriginality, with little hope for the future.

It is now well recognised in the literature that the high incidence of mental health problems, substance use, family violence and social dislocation among Indigenous young people is of serious concern. Severe levels of depression and suicidal behaviour within many Indigenous communities are grim reminders of the dire situation faced by Indigenous young people.

Taking into account the already exacerbated socially and politically disadvantaged position within which Aboriginal young people function, as well as factors that undermine their Indigenous cultural and spiritual roots, it seems tragically inevitable that suicide or attempting suicide is an option.

(Berry et al. 2001)

The policy direction of the Australian Government and the State and Territory Governments for Aboriginal and Torres Strait Islander people’s health sits within a number of interlinking frameworks and policy initiatives. There are four key reports, produced over the past two decades, which have contributed significantly to the development of social and emotional wellbeing policy:

- The National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health “Ways Forward” (1995);
- The Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan (1996–2000);
- The Evaluation of the Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan (1996–2000); and
- The National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003).

Current policy initiatives relevant to this research include: the National Strategic Framework for Aboriginal and Torres Strait Islander Social and Emotional Well Being and Mental Health (ATSI SEWB Framework); and the National Drug Strategy Aboriginal and Torres Strait Islander Peoples’ Complementary Action Plan.

National Strategic Framework for Aboriginal and Torres Strait Islander Social and Emotional Well Being and Mental Health (2004–2009) Consultation Paper

The development of the SEWB Framework sits within the policy context of two other important initiatives: the National Strategic Framework for Aboriginal and Torres Strait Islander Health; and the National Mental Health Plan (NMHP) 2003–2008.

The Aboriginal and Torres Strait Islander Health Framework articulates strategic direction in Indigenous health, agreed to and binding on all Australian Governments. It endeavours to ensure a cross-sectoral approach to improving and enhancing Indigenous health services including mental health, suicide, substance use, family violence and child abuse. The NMHP (2003–2008), discussed earlier in this Chapter, has identified five key directions for improving access to services for Indigenous people including: enhancing partnerships between Indigenous services and mental health services; involving Indigenous people in policy-making and planning; improving access for Indigenous people to mental health services; improving the cultural appropriateness and safety of mental health service options for Indigenous people; and improving linkages between mainstream mental health, GP's, alcohol and drug services and Indigenous health services.

Authored by the Social Health Reference Group, the SEWB Framework aims to provide a broad national Strategic Framework for action to improve social and emotional wellbeing and mental health service delivery to Indigenous people and communities. The SEWB Framework is currently pending final approval by the Australian Health Ministers' Advisory Council. It specifically targets the key result area of "Social and Emotional Well Being" identified in the National Strategic Framework for Aboriginal and Torres Strait Islander Health.

The SEWB Framework identifies nine priority "Key Result Areas" (KRA) for future directions and efforts. While all nine themes are relevant to this research, of particular importance are the KRA's that refer to improving the capacity of mainstream mental health services in delivering services to Indigenous people, enhancing resilience and protective factors in children and young people and enhancing the role of "Social Health Teams". The Framework includes a focus on responding to the recommendations derived from the Evaluation of the Emotional and Social Well Being Action Plan and addresses a number of key issues such as socio-economic status, racism and the role of other sectors such as employment, education, housing, justice, Indigenous Affairs, family and children's services.

National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan (2003–2006)

The NDS Aboriginal and Torres Strait Islander Peoples Complementary Action Plan responds to the range of issues facing Indigenous people in the area of licit and illicit substance use. The plan identifies six areas for future action and, in summary, includes:

- enhancing the capacity of Indigenous people to address substance use issues;
- providing a whole-of-government response;
- improving access for Indigenous people to appropriate services;
- implementing a range of holistic approaches including prevention, treatment, and continuing care;
- enhancing the capacity of relevant organisations through work-force initiatives; and
- creating sustainable partnerships in research, monitoring, evaluation and information dissemination.

(For a full version of these six KRA's see Appendix 3.)

The issue of comorbidity for Indigenous people is taken up in the KRA of "holistic approaches including prevention, treatment and continuing care" (Objective 4.1) and states that appropriate responses should:

Provide a full range of approaches to ATSI peoples to address the impact of the use of alcohol, tobacco and other drugs and social and emotional wellbeing and issues related to comorbidity.

Importantly, the action plan recognises that efforts aimed at addressing issues of licit and illicit substance use within Indigenous communities cannot operate in isolation from broader patterns of social disadvantage. In order to achieve meaningful outcomes the action plan highlights the need to address these broader disadvantages that commonly underpin problematic substance use and its related individual and community harms.

It is difficult for communities to focus on prevention or health promotion when many are living in a crisis situation. A range of parallel interventions may be required before a community can realise the long-term benefits of broader strategies.

(NDS ATSI Complementary Action Plan 2003–2006)

2.3 Prevention and early intervention

Risk and resilience

The literature on risk and resilience clearly illustrates the impact that pro-social bonds have

on young people who are marginalised or at risk of developing a range of individual and social problems. Fuller (1998:75) describes resilience as “... the happy knack of being able to bungy-jump through the pitfalls of life”.

Resilience is often thought of as the basic capacity of an individual to recover from adversity, life's tragedies, difficulties or harmful events. Included in this is the notion that resilience encompasses the skill to defend or protect oneself from these occurrences where possible (Fuller 1998). Key domains of personal skills or resources required for resilience have been outlined by a range of writers, including Withers and Russell (1998) and Benard (1991), who site the following four areas:

- Social competence – includes responsiveness, flexibility, empathy and caring, communication skills, a sense of humour and any other pro-social behaviour;
- Problem-solving skills – the ability to think critically, abstractly and reflectively and to develop alternative approaches to cognitive and social difficulties;
- Autonomy – derived from the capacities of self-esteem, self-efficacy, internal locus of control and adaptive distancing; and
- Sense of purpose and future – encompassing attributes of health expectancies, goal directedness, success orientation, achievement motivation, educational aspirations, persistence, hopefulness, hardiness, belief in a bright future, a sense of anticipation, a sense of a compelling future and a sense of coherence.

Underpinning this ideology is the requirement for an individual to possess a sense of “connectedness” or “belonging” to their family, peers, friends or community and for young people, their school. The ability of an individual to form bonds or attachments to others is usually achieved through socialising processes that include:

- a range of perceived opportunities to participate in activities within the social unit;
- the amount of interaction and involvement with others;
- the extent of positive reinforcement of involvement and interaction; and
- the emotional, cognitive and behavioural skills for involvement and interaction, which enhance reinforcements and perceptions of reinforcement (Withers and Russell 1998:32).

These socialising processes encourage the individual to seek and achieve significant bonds and attachments to others in their family and community,

which are based on the values, norms and behaviours of these people in their various environments.

For young people, the establishment of pro-social bonds to family and school are primarily seen to be predictive of pro-social behaviour (Withers and Russell 1998:33). Such attachments are noted as “protective” factors that inhibit the development of antisocial or “at-risk” behaviours. Past research indicates that young people clearly benefit when they experience significant emotional ties that are consistent and positive, have reasonable regulation and boundaries applied to their behaviour and are supported in expressing their own thoughts and emotions.

Policy directions in prevention and early intervention

Although there is ongoing debate among experts in regard to the distinction between prevention and early intervention, current and past research indicates that risk factors in children and young people that are predictive of early and heavy substance use in later adolescence and early adulthood are closely associated with risk factors for other conditions and difficulties (LIFE 2000). For example, risk factors associated with suicide and self-harm in young people (such as physical or sexual abuse, parental substance use/mental health or mood disorder, impaired parent-child relationship, domestic/family violence, socially disadvantaged background, low educational achievement etc.), are clearly associated to those that have been identified for early uptake of substance use and early indicators of mental health problems and/or mental illness (LIFE 2000).

The practical application of reducing risk and increasing resilience among young people at risk has been adopted by the Australian Government and some States and Territories in an array of policy and programmatic areas. A clear understanding of risk and protective factors allows for effective preventative initiatives to be targeted and implemented. For example, the National Drug Strategy 2004–2008 (Consultation Draft 2004) highlights the need to take a preventative approach to reducing the uptake and harmful effect of substance use. Similarly, the National Mental Health Plan 2003–2008 and the National Comorbidity Project also features early intervention and prevention as key priority themes. Policy initiatives that address Indigenous health, social and emotional wellbeing and mental health are also significantly focused on prevention initiatives and methods by utilising community capacity building approaches. The National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complimentary Action Plan define the phases of preventative

approaches in terms of health promotion, prevention, harm reduction and early intervention.

2.4 Issues of definition and meaning

Research by Mather et al. (1999) found that young people with co-existing mental health and substance misuse problems tend to fall into two distinct groups:

- those with clinically significant mental illnesses such as schizophrenia, bi-polar disorder and major depression who self-medicate with alcohol and illicit drugs to lessen the distressing symptoms of their illness; and
- those with borderline personality and anti-social personality disorders or anxiety exacerbated by excessive use of substances such as alcohol, marijuana, amphetamines, cocaine and heroin (Mather et al. 1999).

The National Mental Health Plan (2003–2008) acknowledges that mental health is a “complex domain where diverse views exist and where terms are used in different ways, which can sometimes lead to misunderstandings”. The plan refers to mental health problems and mental illness as a variety of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people. The difference in definitions between a mental illness and a mental health problem are explained further:

A mental illness is a clinically diagnosable disorder that significantly interferes with an individual’s cognitive, emotional or social abilities... mental health problems also interfere with a person’s cognitive, emotional or social abilities, but to a lesser extent than a mental illness. Mental health problems are more common mental health complaints and include the mental ill health temporarily experienced as a reaction to life stressors. Mental health problems are less severe and of shorter duration than mental illnesses, but may develop into mental illness. The distinction between mental health problems and mental illness is not well defined and is made on the basis of severity and duration of symptoms.

(National Mental Health Plan 2003–2008)

For the purposes of this report the terms “mental illness” and “mental health problem/issue” will be used in accordance to the above definition.

2.5 Comorbidity and young people

Young people with co-occurring mental health and substance use disorders ... can present such perplexing, often obnoxious, and sometimes

alarming behaviour that it “sets a practitioner’s teeth on edge”.

(Noble 1999)

Although comorbidity affects a range of age groups and crosses gender barriers, young people have been identified as at significant risk of poor treatment outcomes and considerable social disability as a result of suffering from comorbid conditions (National Comorbidity Project 2001). They also tend to have histories of poor educational achievement, family breakdown and child abuse, domestic violence and involvement with statutory agencies including child protection and juvenile justice (Tickell 1999).

Many have experienced a lack of engagement at school with early departure, increasingly through exclusion and parallel involvement in crime. This culminates either in leaving home at an early age or receiving a custodial sentence with little or no assistance with resettlement on discharge. This in turn triggers periods of insecure housing or homelessness and a ratcheting up of problems as a result.

(Tickell 1999)

In Australia, a study by Mather et al. (1999) found that 90% of the burden of disease (i.e. the instances of illness) in 15–24-year-old males and 80% of the burden of disease in 15–24-year-old females is related to substance misuse disorders or mental disorders.

According to Dadds (2000) the critical period for developing emotional and substance use problems is from late childhood through adolescence. In Mark Dadds (2000) article, prepared for the National Comorbidity Project, the author refers to a number of longitudinal studies that show two clear pathways in the development/onset of comorbidity. First, anxiety problems in late childhood lead to depression in adolescence, and both then contribute to early onset and persistence of substance use disorders. Second, conduct problems in childhood and adolescence also predict early onset substance use disorders and the presence of comorbid anxiety and depression facilitates this risk (Dadds 2000).

Young people are ill-equipped to deal with the series of traumatic events that have been happening to them. They are often suffering from great stress, manifesting all the symptoms that run alongside this – suicidal tendencies, panic attacks, depression and so on. Often they are self-medicating using illicit drugs or drinking to reduce their anxiety and feelings of being out of control. They are mistrustful and sometimes aggressive to people in authority.

(Tickell 1999)

2.6 Comorbidity and youth homelessness

Sometimes all you want to do is just talk to someone. You don't expect them to give you the solutions or answers, but it just helps a lot to just talk and get it all off your chest.

(Dianne aged 20)

Homelessness amongst young people occurs because of a range of interlinking and complex conditions that are both personal and political. The Burdekin Report (1989) made note that any analysis of the causes of youth homelessness might be viewed from two different but interlinking perspectives. The first looks through the eyes of the individual, with a focus on problems with social relations and issues apparent in the family unit. The second view relates to the structural problems of society, its political platforms and public policy implications.

When adolescence and homelessness is added to the mix of mental health and substance abuse, the result can be baffling for service providers as well as traumatic and distressing for the individual. The impact of homelessness on young people with co-existing disorders is significant and despite the best efforts of the current service system, the needs of this group of young people remain largely unmet. Some researchers and practitioners attribute this to the implementation of de-institutionalisation in the late 1980's along with the introduction of services with specific or specialised focus. Young homeless people with complex dual disorder issues often fall between services and, remaining unsupported, will become further marginalised and increasingly at risk of greater levels of depression and suicide, violence, incarceration, exploitation and STD's (Tanti 1998).

The interrelatedness of comorbidity and homelessness was recently emphasised by a Melbourne comorbidity worker. Sarah Marriman and her colleagues argued that homelessness is not incidental to comorbidity in young people but is frequently an integral part of the disorder. They observed that:

Many of the potential complexities associated with dual diagnosis (such as breakdown of family relationships, decreased access to paid employment and increased exposure to illegal activity) can contribute to the young becoming homeless. Conversely, a young person already homeless may be more likely to be exposed to high levels of life stress and traumatic events which may precipitate onset of mental health problems ...once homelessness becomes part

of the dual diagnosis picture, service provision becomes even more difficult.

(Marriman et al. 2003)

2.7 Comorbidity, youth suicide and self-harm

Life sucks, that's why I use and why most of my friends take drugs too. It makes you not care about things... It's something to hold on to. Kids do it because they can't communicate what they feel, they can't face life and nobody listens. Things make you feel so alone and the drugs block out those feelings.

(Michelle aged 16)

There are many factors that have been suggested as contributing to suicide and self-harming behaviour in young people. These include mental health problems, harmful drug use, anxieties about sexuality and gender, breakdown in relationships, family issues, social and cultural dislocation, unemployment and low socio-economic status, homelessness, delinquency and incarceration in custody, prison or the juvenile justice system (Success Works 2001).

Though there is debate over the relative importance of different risk and protective factors in suicidal behaviour, some review studies suggest a range of factors that are associated with increased suicide risk for an individual. The most important of these is a history of mental illness (notably depression), particularly where more than one mental illness is present, or a mental illness is combined with harmful drug use.

(LIFE 2001)

Current understandings of suicide risk factors and protective factors in young people indicate that suicide is not a simple response to a singular difficulty. Rather, it is a result of a range of issues, factors, history and stresses suffered by a young person, often at a particularly vulnerable life stage.

Our best understanding suggests that suicide is the tragic outcome of a build-up of stresses and risk factors in a person with relatively few protective factors and whose resilience, perhaps, is poor.

(LIFE 2001)

Likely indicators of suicide risk include a history of previously attempting suicide or self-harm, with one study estimating that young people who had previously attempted suicide as thirty times more likely to die by suicide than that of their general population counterparts (Silburn et al. 1990). The LIFE series publication (2001) summarised the

most common risk factors from a range of social commentators and writers and included:

- family history of suicide or suicidal behaviour and child abuse (Beautrais 1998);
- socio-economic disadvantage, including low educational achievement (Beautrais 1998; De Leo et al. 1999; Taylor et al. 1998); and
- legal problems, imprisonment or conflict with the law (Royal Commission into Aboriginal Deaths in Custody 1991).

In 1997 the Victorian Suicide Prevention Task Force undertook an intensive public investigation into the nature and extent of suicide in Victoria. The focus

was primarily on young people and the subsequent impact on the family and community in general. A range of issues and concerns were identified as part of the investigation, including the following points:

- Medical models for responding to suicide and self-harming behaviour in young people are limited, as too are the sociological perspectives that often ignore mental illness as a significant risk factor.
 - The current service system is fragmented and compartmentalised which particularly affects those young people who suffer combinations of risk factors that cut across sectoral boundaries.
-



Mapping of current practice

The best is when you can go to one person you trust for all your problems. [Youth A & D] workers can help you get all the things you need...are easy to get on with and really friendly. My outreach worker helped me get into detox.

(Fiona aged 18)

This section outlines information gathered from the range of consultations undertaken within all States and Territories during the period November 2003 to March 2004.

Consultations covered a range of services and service types including: youth accommodation; generalist youth counselling and support; Indigenous youth services; specialist services such as mental health, alcohol and other drugs and dedicated comorbidity services. While it is acknowledged that there is considerable cross-over of service types (i.e. youth housing and residential youth drug and alcohol; adult housing and mental health services; alcohol and drug rehabilitation services etc.), the research indicated significant differences between key service sectors and their respective intervention paradigms, particularly in those programs and services that were youth focused and those that were non-youth focused.

Consultations with young people focused on those who had been identified by service providers as suffering co-occurring mental health and substance

use problems and had some experience as service users. A significant proportion of young people interviewed were current service users, some had only recently entered the service system while others were able to recount many years experience with a range of services and support agencies.

The findings of these consultations are presented in this Chapter in identified areas of key themes and include the views and perspectives of young people with comorbid disorders who have been or were (at the time of interview), service users. These themes are: Levels of Demand for Services; Engaging Dual Diagnosed Young People in Services; Utilising a Strengths-Based Approach; Working Across Service Sectors; and issues for Indigenous Young People and their Communities.

3.1 Levels of demand for services

Service providers were asked to estimate the degree to which their program or service came into contact with young people suffering dual diagnosis. The result was a range of estimates that varied considerably. However, many in the youth accommodation and drug and alcohol field were unclear about what exactly defined comorbidity, particularly if a mental health problem rather than a mental illness was present. For example, some youth accommodation services estimated extremely high

rates (up to 70%) of current clients that were either previously diagnosed with a mental health problem and were partaking in significant substance use or who were displaying symptoms of dual diagnosis but had not undergone a psychiatric assessment. Other youth services reported between 10%–40% of clients who presented or were assessed with a comorbid disorder. Brisbane Youth Services indicated that almost all young people they assist are homeless and at least 70% of their client group have presented with symptoms of comorbidity (primarily referring to mental health problems). Just over half of their client group (53%) were known to be chronic with many more suffering severe depression, self-harming and suicide behaviour. The “Link” program in Tasmania also cited increased levels of demand for services, noting that over the last eight years the numbers of young people presenting with comorbid mental health and substance use issues had increased acutely. Furthermore, they stated that 100% of current comorbid clients were either homeless or extremely transient.

Youth specific alcohol and drug services also indicated significant variation in their estimated contact with dual diagnosed young people. Many cited that between 40%–90% of clients accessing their programs and services were suffering dual diagnosis; however a considerable majority of these young people had not undergone a formal psychiatric assessment.

Mental health workers in most States and Territories noted early in the consultations that demand, particularly on child and youth mental health programs, was high. A proportion of these programs subsequently tended to focus on the acute end of the continuum although programs are also meant to target moderate mental health issues (such as for many CAMHS programs). In some States and Territories, such as the ACT, there are a few services that provide limited counselling for young people (i.e. The Junction Youth Health Service and the Bungee Project), however, it was noted that these services are not able to meet the high demand currently being experienced in the sector.

Limited number of resources and services

In rural areas in some States and Territories (i.e. Northern Territory including Darwin and Alice Springs; Albury/Wodonga) there is a significant lack of youth accommodation and youth generalist services. For example, Darwin participants noted that although there exists some youth SAAP and JPET programs there was no generalist youth services at all within the capital or surrounding areas. This was seen as having a significant impact on the ability of other services (such as drug and alcohol and mental health

agencies) to first identify and then engage young people in relevant services. Youth specific alcohol and drug services were also not necessarily a feature in every State and Territory. Even when present, residential youth alcohol and drug programs are frequently limited in numbers and scope. Those States and Territories that have a lack of youth specific drug and alcohol service were also the same States and Territories that reported either few or no youth (general or issue specific) services.

In Tasmania, the situation is of particular concern. Participants noted that there are no youth specific alcohol and drug detoxification services and no dedicated adolescent psychiatric mental health units. The situation of the housing and accommodation sectors in Tasmania was also noted by participants as in need of significant resources.

A number of informants recalled a range of brief case histories to illustrate the dire situation in accommodation for many young people at risk.

Accommodation issues for homeless young people are critical. A month ago a service was handing out tents. One young person pitched his tent too close to a public toilet block and was taken off category 1 housing because he had access to amenities. A 17-year-old girl who was homeless for 6 weeks was also taken off category 1 housing because they [Housing Tasmania] said she had “adjusted to homelessness”. It’s got to the point where they’ll say almost anything to reduce the demand.

(Tasmanian Youth Worker)

Dedicated comorbidity services

In 2002 The National Comorbidity Project (NCP) identified a total of forty-four dedicated dual diagnosis specialist services throughout Australia. Of these, only three services are specifically targeted toward young people and none dedicated to the Indigenous community:

- **Young People Prevention and Early Intervention (YPPI)** Central Coast Area Health Service (NSW); an early intervention home-based mobile treatment service for young people aged 12–24 with early presentation of psychosis.
- **Youth Off The Streets** Dunlea Adolescent Alcohol and Other Drugs Program (NSW); an alcohol and drug 2–4 week residential treatment program. Clients who have a history of mental health problems or are in need of assessment are referred to the local community mental health centre.

- **Cannabis and Psychosis Project** Early Psychosis Prevention and Intervention Centre (EPPIC) (Vic); an outpatient community-based intervention specifically designed for young people with early psychosis.

The remaining forty-one services cited by the NCP are a combination of adult treatment programs (primarily outpatient orientated), research initiatives and education, training and community development projects that aim to improve the relationship and partnerships between mental health and alcohol and other drug services. The Western Australian Joint Services Development Unit is an example of such a service funded by the Office of Mental Health with strong support from the Drug and Alcohol Office with the aim of providing direct clinical support to mental health and alcohol and drug agencies in their work with comorbid clients.

3.2 Engaging dual diagnosed young people in services

For young people, accessing and attempting to navigate the complex service system can be a frustrating and confusing experience. In Australia there have been a number of studies that have documented the views and experiences of marginalised homeless and difficult to engage young people (i.e. Success Works 1998 and 1999; Hirst 1989, 1995; Burrows 1994; Burdekin 1989). A consistent theme emerging from these studies over the past five to ten years indicates that young people view the service system as one which is primarily interested in “telling them how to feel, what to do, how to do it and when they should do it”.

It's like me telling you how you like to have your coffee. You say “white with three”, I say “yeah, O.K.”, but I don't really listen because I think I know better, coz I make coffee all the time and I'm expert at it. So I give you black with none, because that's what I think you should like. How frustrating is it for you?

(Michelle aged 16: Success Works 1999)

The international literature on best practice notes that dual diagnosis clients “often experience themselves as system misfits, unwelcome, unwanted, and blamed for the complexity of their difficulties” by a service system not designed to address the complexity of their needs (Canadian Co-occurring Mental and Substance Disorders (Dual Diagnosis) Panel (CMHASD) 1998). In recognition of this, service standards developed in the United States emphasise the need for programs to be “culturally competent and linguistically appropriate” and workers to be “welcoming” and empathetic to the needs of clients

in order to reduce the number and rate of treatment “drop-outs” (CMHASD Panel 1998).

As mentioned earlier in this Chapter the findings from the consultations indicated there were significant differences between key service sectors and their respective intervention approaches. Programs that delivered a service specifically targeting and designed for young people, whether it pertained to accommodation, counselling, crisis response, alcohol and drugs or basic support and assistance, were generally more likely than other services to focus on appropriate engagement strategies. Services and programs that offer treatment and support to dual diagnosed young people aged between 18 and 25 years in addition to a significant adult population were generally less focused on “engagement” as a key factor in service provision. This was most apparent in adult drug and alcohol services, adult accommodation and crisis services and mental health services.

Targeted youth services

The focus of service provision in the majority of youth accommodation services and other youth services visited or interviewed for this research was primarily on effectively engaging young people, building rapport and developing a trusting relationship. This practice emphasis is underpinned by the knowledge that it is often critical to gain a young person's willing participation in the helping relationship before assistance and support for deeper issues (such as comorbidity) are accepted by clients. This is particularly pertinent as research into the nature of comorbidity (for example, Brady et al. 1996; Drake et al. 1990, 1993; Lehman, Herron, Schwartz and Myers 1993; Loneck 2002) clearly indicates that denial of one or both conditions is common among young people and their families, especially when self-medication is perceived as a helpful strategy by clients toward alleviating negative or unpleasant feelings. The use of a youth-friendly environment that helps young people to feel comfortable and accepted was also a feature of many youth focused services as part of their engagement strategy.

Some youth services and youth drug and alcohol services employed creative ways in which to engage and maintain young people's participation in the service. For example, Brisbane Youth Services (BYS) involves clients in the running of their drop-in centre as well as performing other appropriate duties around the office. Similarly, Queensland's Adolescent Drug and Alcohol Withdrawal Service (ADAWS) employs a dedicated worker to implement their client exit and follow-up service in order to maintain young people's engagement with the program following

their treatment exit. This program utilises creative arts and recreation activities to achieve meaningful participation from young people who have exited the service and to promote the established relationships that have developed between workers and clients.

Perspectives of young people

Young people consulted for this research however, noted that there exists a fine line between effective engagement and what they called “false confidence building”. A number of young people interviewed defined this as workers attempting to engage them through reassurance and building their confidence in a manner that was perceived as patronising.

*I come to see my worker here and she's like “Oh, Shaun how **are** you? How are you **feeling**?” I'm like “yeah, O.K.” but I know she doesn't mean it – she's just saying it as though she does because that's what she thinks is good. She treats me like I'm stupid and that that's all I need to open up and tell her everything. When workers do that it makes you believe that they don't really care, they're just pretending to because it's their job.*

(Shaun aged 15)

Others reported the assistance and interest from staff as important in gaining confidence to take a positive step toward accepting assistance and treatment for their mental health and substance abuse issues.

I have only got my act together since I met Andrew (youth worker). He's helped me a lot.

(Peter aged 20)

Mental health and adult treatment services

Consultations revealed that many youth specific workers were critical of the approach frequently adopted by mental health practitioners and relevant adult focused services to working with dual diagnosed young people. A significant proportion of mental health practitioners interviewed for this project, also agreed that mental health services desperately needed to adopt more appropriate models of engaging young people in referral, assessment and treatment as well as improving the current “clinical” physical environment which is characteristic of many mental health services. Adult housing and crisis services that provide support and/or treatment to young people aged 18–25 were reported by youth workers as “generally not interested” in engagement as a foci for the provision of services. This, it was claimed, was underpinned by the perception that young people in this “young adult” age group were, primarily “adult” in essence and therefore treated as such.

Workers also commented that lack of engagement would often result in a young person declining to return to the service for treatment, exacerbate the young person's sense of denial and in some cases cause a “set back” in their progress and attitude toward treatment. These outcomes proved frustrating for many youth/alcohol and drug workers who had spent considerable time and effort in “convincing” their client to access these needed services. Accessing mental services (including some child and adolescent mental health programs) was perhaps the most pertinent and common example provided by informants:

It almost seems as if they [mental health workers] will do anything to avoid taking these kids on, because they don't know what to do with them. These kids are often non-compliant, want more say in what happens to them and are more resistant than adults to being medicated as a treatment option.

(Northern Territory Worker)

Perspectives of young people

Young people consulted as part of this research were perhaps the most vocal in regard to the issue of engagement by mental health services. In respect to this issue, mental health services appear to have a considerably poor reputation among young people:

They're useless. They're too busy trying to tell you what to do rather than listening. I was assessed by this guy when I was 17 and he had this real arrogant look on his face as if he had all the answers and I was just this stupid kid. They think that we can't pick up on their little subtleties, like their enormous ego or their arrogance. They don't want to meet you halfway and don't recognise that they don't have all the answers and that the patient may have some insight.

(David aged 19)

Although seemingly harsh, this view was prevalent among many young people who also stated that they were less likely to continue to access a service if they could not establish a rapport with a worker.

Although a proportion of those who participated in the consultations described negative experiences with mental health services and programs primarily targeting the eighteen and over age group, others had a very different point of view. Consultations in Western Australia, for example, revealed that there are some significant exceptions to the views expressed above. For example, the two youth specific services Youthlink and Next Step provide multi-disciplinary and long-term interventions for dual diagnosed young people that are focused

directly on engagement and on staying with the young person for as long as necessary to assist them to address their various issues.

3.3 Utilising a strengths-based approach

A significant proportion of services and practitioners interviewed for this research commented that service provision to dual diagnosed young people was based on a strengths-based, solution-focused model. Past research indicates that strategies for intervention that are underpinned by a strengths-based approach are found to be effective in engaging young people who have a range of complex issues. The literature on solution-focused, strengths-based interventions in engaging and working with young people defines this approach with the following key components:

- a shift in focus of treatment and intervention from deficits or problem-based approaches to emphasising and validating strengths, talents and existing protective factors that the young person currently employs to cope with life stressors;
- encourages and promotes the involvement in treatment of significant others (where appropriate) such as immediate and extended family members, family/individual social networks, friends, carers and relatives;
- is based on the literature and framework of risk and resilience;
- looks to realise goals and solutions that are achievable, manageable and practical;
- frequently involves peer-support and peer education models; and
- is responsive to the changing and unique needs of each individual.

The Schizophrenia Fellowship (2004) defines strengths-based approaches to working with young people as promoting mental health wellbeing in young people through:

...a variety of peer-support, life skills development, and leisure activities. These activities are facilitated within a strengths-based (in other words, building on people's strengths and resources), peer-support framework (enabling people to feel connected to other people who they can relate to and learning from each other). This compassionate, innovative and empowering approach provides young people with opportunities to recognise and further develop their resilience.

Harm minimisation

All services indicated a strong commitment to the principles of harm minimisation in their work with dual diagnosed young people. This was seen as a critical factor in the success of interventions.

Harm minimisation has remained the foundation for national alcohol and drug policy in Australia through successive governments since 1985. Alternative approaches have been rejected by policy makers on the basis of the evidence that such approaches:

- don't stop the alcohol or drug use;
- drive problematic drug and alcohol use underground;
- fail to take into account underlying causes such as past trauma or self-medication for underlying mental health issues, or the perceived benefits of drug use;
- increase harms for individuals and the community (including increased costs for governments);
- create barriers for people seeking help with alcohol and drug problems; and
- are contrary to a duty of care (Success Works 2004).

3.4 Working across service sectors

Some services, such as Queensland's "The Hot House" (a youth alcohol and drug counselling service) were based within a mental health service and worked with both voluntary as well as involuntary clients. Another example was Western Australia's Joint Services Development Unit that has the specific role of linking mental health and drug and alcohol services to address the needs of comorbid clients. However, this service is not youth specific.

In general, services for young people were willing and enthusiastic to work with each other to address the needs of young people with comorbidity. However, there is a strong perception that the mental health sector is not as aware of the need to work together or to recognise the need for a multidisciplinary and multi-sectoral approach in working with dual diagnosed young people whose needs may span a number of areas beyond their mental health and drug and alcohol presentation.

Workers within youth accommodation, alcohol and drug sectors indicated a high degree of willingness to participate in joint case management and to utilise other resources and agencies within the community to fulfil the needs of their clients. They felt that this desire to work collaboratively was not generally reciprocated by mental health services.

3.5 Indigenous young people and services

The part that breaks our hearts is just before they become teenagers. Up till then, they have the light in their children's eyes. When they turn 11, 12 and 13 we see that light go out – they are the walking dead, their spirit has died because they can see the reality of their situation.

(Indigenous Elder)

Evidence from international studies on Indigenous populations in English-speaking countries indicates that Indigenous people's health is considerably worse than that of their non-Indigenous counterparts. However in countries such as New Zealand, the United States and Canada, the health outcomes of their Indigenous populations has been noted as significantly better than that of Australian Aboriginal and Torres Strait Islander peoples (Matheson 2000; Scrimgeour 1994 cited in NSF for ATSI Health 2003). Factors that have been noted to contribute to the improved health of Indigenous people include:

- improved environmental health;
- provision of good quality and comprehensive primary health care that is supported by adequate resources over a substantial period of time;
- public health care approach that has a prominent role for education, promotion and development of strong community involvement;
- pro-active workforce strategies that focus on training Indigenous people; and
- attention given to developing the capacity of the health care system to collaborate with agencies outside of the health sector (National Strategic Framework for Aboriginal and Torres Strait Islander People 2003).

In Australia, mortality and morbidity rates indicate that the health of the Indigenous population is the worst of any other population (ABS 2003; AIHW 2003). Rates of non-fatal injuries, self-harming behaviour, mental illness and substance use have been noted as significantly higher than that of the non-Indigenous population (Swan and Raphael 1995). Indigenous people are also noted to live in conditions that the general Australian population would consider unacceptable including overcrowding, poorly maintained housing structures, high cost housing; and lack of basic infrastructure such as sanitation, water supply and safe housing (NSF for ATSI People 2003).

Site visits to a range of Indigenous services and communities during the consultation phases of this research found that many Indigenous communities (particularly those in rural and remote locations) continue to suffer in conditions that are clearly

unacceptable. For example, in Alice Springs there are a number of Indigenous communities that live on the outskirts of the main population, many of which have little or no basic infrastructure such as electricity, adequate sanitation or water supply. Young people in these communities are known to wear containers (such as paint tins) usually filled with petrol, secured around their neck by string. Other young people wear a cloth or handkerchief pinned to their clothing that has been soaked in petrol, allowing easy and convenient use for inhaling.

Consultations in other Indigenous services and communities revealed that there are few services for Indigenous young people. In Western Australia, for instance, there is only one Indigenous drug and alcohol service for adults and young people in Perth and none south of Perth. There is no Indigenous detoxification service. Dual diagnosed young people are referred between the Indigenous drug and alcohol service and mental health services and mainstream services do not employ Indigenous staff. As a direct result Indigenous clients do not access these mainstream services.

Service providers within Indigenous services expressed concern about their inability to manage clients with comorbidity. This was particularly pertinent given the very high levels of demand for services. Most Indigenous services are not youth specific but some (such as the Noongar Alcohol and Substance Abuse Service in Western Australia) employ dedicated youth officers to work with young people and provide outreach support to juvenile justice centres and schools.

Indigenous services and clients indicated that mainstream services are only accessed by Indigenous clients in rare and extreme circumstances (such as at the order of the courts). Referrals are not usually made to mainstream services meaning that Indigenous clients are cut off from many support options.

In terms of youth accommodation services, informants indicated that most young Indigenous people with substance abuse and mental health issues may refuse to access needed support, for a variety of reasons, frequently remaining homeless and at risk.

3.6 Summary

Current practice in the delivery of services for young people with comorbidity is characterised by:

- different interpretations of the level of comorbidity between service types ranging from 10%–40% for some services to 70%–90% in others and lack of understanding and clarity of the definitions of comorbidity;

- high levels of demand in all services with comorbid clients presenting a significant source of demand;
 - lack of youth specific services in some jurisdictions and lack of youth-focused comorbidity services generally;
 - varying levels of understanding of the need to focus on engagement with young people with youth specific services more likely than others to see this as a priority and to make efforts to achieve it;
 - lack of appropriate models in the mental health system and in some adult-oriented services to work effectively with young people with comorbidity leading to high levels of referral failure as services are unable to cope with or tolerate non-compliant behaviour;
 - strength-based, solutions-focused approaches in many successful services, particularly those with a focus on young people. A strong commitment to harm minimisation by most services;
 - willingness on the part of many youth accommodation, housing and drug and alcohol services to work together in addressing the needs of dual diagnosed young people with a perception that mental health services have a lesser commitment to multi-sectoral approaches; and
 - poor socio-economic conditions for Indigenous people and little or no access to mainstream services for Indigenous young people with few youth specific Indigenous services.
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4 Barriers to service provision

Cameron is 14 years old, homeless and on the run from local authorities. He has been charged with numerous counts of break and enter and burglary and was bailed to a local rehabilitation centre for the four months leading up to his court case in June. He left the rehab because an older boy threatened him with physical and sexual violence. Cameron has been diagnosed with ADHD and often erupts in bursts of outrage and anger, particularly when his level of frustration exceeds his capability of handling stressful situations. As a result, he has been excluded from a number of services, although his access to services and support in the first place is limited by his age. There have been two workers Cameron has liked and connected with during his brief teenage years, however both have moved on in their careers. The police have physically and emotionally abused him while he has been in custody, the rehabilitation centre refused to respond to his complaints about being threatened and he has been excluded from accommodation services because of his age, violent and angry outbursts, reluctance to comply with rules and regulations and his lack of ability to appropriately respond to authority. He spends most of his time "stoned" as it calms his mood considerably and he has resorted to crime to support himself and his substance use.

Cameron faces an array of complex issues and barriers to accessing support and assistance, the least of which is the consequences of his criminal activity. The most likely outcome for Cameron at this point is youth detention, where his father is fearful he will not survive the ordeal due to his age, small stature and introverted personality. Cameron's father has been instrumental in gaining treatment support for his son so far, and was the key person to organise his stay at the rehabilitation centre.

They just want to lock him up but they don't understand that will most likely kill him. He's treated by the police like an adult criminal and junkie, they make no consolation that he's still a kid and needs help. The judge does not want to lock him up, but he needs reasons not to. If I can have everything organised, like accommodation, school and such and take it to the judge then there is a chance that Cameron won't see the inside of a jail cell – at least not until his court case. The problem is there are few services out there that can or are willing to help. For the most part he is too young or too violent. Add a mental health problem and drug use into the mix and the services run a mile.

4.1 Barriers identified through the literature

In April 2004 the draft report of the “Barriers and Incentives to Treatment for Illicit Drug Users” research project was completed. The research was funded by the Australian Government Department of Health and Ageing (DoHA) and comprised of a consortium that included the lead consultants Lance and Meriel Schultz (LMS Consulting), the National Centre in HIV Social Research and the Australian Injecting and Illicit Drug Users League (AIVL). A key aspect of the project was the full participation and involvement of the AIVL that provided a clear and meaningful perspective of drug users into the research. The purpose of the study was to investigate the barriers and incentives to treatment for substance users and develop appropriate recommendations for future policy and program directions.

The preliminary findings from the DoHA study indicated that barriers to treatment for illicit drug users (of all ages) included *personal factors* (such as negative attitudes towards particular treatment options and/or difficulties in organising practicalities like childcare and transport); *interpersonal factors* (such as family or sub-culture opposition to treatment); *organisational factors* (such as lack of treatment places, long waiting lists, financial costs, inappropriate rules and regulations); and *societal factors* which primarily included the social stigma associated with being labelled a substance user. Although the study was targeted to all age groups, the authors acknowledge the different and extended need of specific population groups:

A review of studies examining barriers specific to population groups, such as women and youth, rural and remote communities, people from cultural and linguistic diverse backgrounds and Aboriginal and Torres Strait communities, indicated that there are particular sets of problems relating to these populations in addition to the barriers illicit drug users face in general...he particular treatment needs of these groups are not well known or documented.

(DoHA 2004)

The study also comments on the incidence of comorbidity, making note that individuals who suffer co-occurring mental health and substance use experience far greater difficulties in accessing treatment services and are generally thought of as “very difficult to treat”.

In 2001 the American Federation of Families for Children’s Mental Health mapped existing dual diagnosis services and concluded that “it is most

difficult to find fully integrated treatment in which one team deals with all the client’s treatment and support needs”. The US study found that young people with co-occurring disorders, too often find themselves in the criminal or juvenile justice system and that relapse rates following incarceration are very high if the individual is released without adequate supervision, support, housing, educational opportunities, and vocational opportunities (Blamed and Ashamed: the Treatment Experiences of Youth with Co-occurring Substance Abuse and Mental Health Disorders and Their Families). The paper ended with a call for young people entangled in the criminal justice system to be “diverted-to-treatment”.

With few exceptions the literature on barriers to services for those with co-occurring mental health and drug and alcohol disorders is focused primarily on the needs of adults. The lack of available literature in the area of young people’s experience with comorbid disorders and the subsequent barriers they may experience in accessing services highlights the importance of this research. For the purposes of this research the information pertaining to the barriers to services specifically experienced by young people has been largely drawn from the consultations with service providers, service users and other experts interviewed as part of this research.

A significant area of inquiry for this research is the consideration of support services that extend the integrated care delivered to young people beyond the articulated general practice/mental health/drug and alcohol service systems. The focus of this research project is on the broader social supports that young people with dual diagnoses or undiagnosed dual disorders require (such as housing, education and training, income support etc.) and on the linkages (or lack thereof) between those services and the increasingly integrated medical-psychiatric system.

A range of individual and structural barriers to accessing services for comorbid clients (of all ages) has been the point of some research and investigation over the past decade (see for example: Brady et al. 1996; Drake et al. 1990 and 1993; Lehman, Herron, Schwartz, and Myers 1993; Loneck 2002). As young people also suffer these general difficulties when attempting to access and maintain support through the service system, it is worth summarising these findings briefly.

Individual barriers

Individual barriers to accessing services and support for those suffering comorbidity include:

- Denial and minimisation:
This refers to the frequency with which many clients and their families often deny or minimise

their substance abuse problem, their mental health problem, or both, making it difficult to engage them in treatment.

- **Lack of information about comorbidity:**
Clients and their families rarely have good information about comorbidity and appropriate services and “family members are often unaware of substance abuse, blame all symptoms on drug abuse, or attribute symptoms and substance use to wilful misbehaviour” (Drake et al. 2001).
- **Self medication:**
Many clients were found to self-medicate in order to relieve the effects and distress of one or other of the disorders. This makes accurate diagnosis difficult as “the illnesses interact with and exacerbate one another” (US Department of Health and Human Services 2003).
- **Lack of family/community support:**
Family conflict and family breakdown are often significant factors that can influence clients to either seek treatment or exit treatment.
- **Complex Nature of Comorbidity:**
The complex needs of people suffering from comorbidity are frequently not taken into account by those in the helping professions. Some researchers have criticised the use of the terms “comorbidity” or “dual diagnosis” as people with these illnesses “...are heterogeneous and tend to have multiple impairments rather than just two illnesses” (Drake et al. 2001).

Structural barriers

Research has found that there are structural deficits that support many of the identified individual difficulties suffered by comorbid clients. These include: a complex system of programs and services that is difficult to navigate; lack of appropriate treatment frameworks; and lack of appropriate training for mental health, alcohol and drug professionals as well as youth work and housing practitioners. The international literature indicates such barriers additionally include:

- lack of service integration (lack of agreement and theoretical frameworks between sectors);
- policy and program barriers (organisational structures and program policies that effectively mitigate against the functional integration of services); and
- clinical barriers (lack of expertise in comorbidity identification, assessment and treatment).

National and international research highlights the correlation for many communities between low socio-economic status and higher rates of disorders and diseases such as mental health problems, self-

harming behaviour and communicable diseases (ATSI NDS 2003). In particular, poor childhood health and childhood abuse has been linked to mental health problems, substance use and the development of chronic health issues in later adolescence and early adulthood (NSF for ATSI People 2003).

The US report “Blueprint for Change” identifies some specific system-level barriers to effective integration of services. The list identifies professional and service turf issues, funding limitations, lack of technology and resources to link agencies and support integration, lack of available services, size and complexity of the service system and lack of political will. As noted by Australian researchers Allen et al. (2003) in their research on developing a best practice model for dual diagnosis treatment:

Treatments for those “dually diagnosed” have historically focused on sequential or parallel service provision (Health Canada 2002), often with a focus on one particular treatment modality (e.g. cognitive behavioural theory) over others. These models typically offer treatments from both the alcohol and other drug (AOD) and Mental Health service systems independently, either at the same time (parallel), or one after the other (sequentially). Such approaches typically “share” clients between the two service systems, but unfortunately they have traditionally failed to share a common language, set of values, or theoretical framework(s) by which to work with clients. This has resulted in confusion for clients who are required to move between two service systems that often have competing demands.

(Allen, Lubman, Bonomo, Cementon, and Rogers 2003)

The most noted barrier identified in the literature that prevents clients receiving satisfactory treatment is the frequent failure of clinicians to agree amongst themselves. As argued by Australian researchers Mueser and colleagues:

The difficulty in dealing with dual problems within separate specialised services results in many of these individuals “falling through the cracks” or having their problems ignored. As a result, their care is often suboptimal.

(Mueser et al. 1995, quoted in Kavanagh et al. 1998)

A major report conducted for the National Comorbidity Project found that this structural legacy presents:

“...particular challenges for treatment settings, not the least of which is that effective management and care requires collaboration across two separate sectors of the health system, which traditionally

have different underpinnings. This situation presents significant service system and service delivery difficulties which if not addressed may result in poorer outcomes for clients.

(Donald et al. 2003)

4.2 Themes emerging from the consultations

The following discussion brings together the available information in the literature on service system barriers along with the findings emerging from the consultations including those key issues identified by service providers and young people. The literature identifies the barriers for dual diagnosed young people attempting to access services as: difficulties in attending appointments (particularly at multiple services); confusion and contradiction between differing treatment and program philosophies; and the failure of services to assertively and consistently reach out to engage clients (NAAH 2003). As well, this study reveals that homelessness is the most significant barrier preventing young people suffering comorbidity from accessing appropriate treatment and support. As illustrated in the case study described at the beginning of this Chapter, involvement in the juvenile justice or criminal justice system frequently occurs as a result of homelessness and illicit substance use. Furthermore, consultations highlighted the complex and sometimes violent or volatile behaviour of these young people which can mean that their access to services is further limited through being prevented from having entry to, or being expelled from, services for certain behaviours, particularly from accommodation and residential treatment services.

Consultations with service providers revealed six major themes in barriers to accessing services by young people with comorbidity. These key areas of concern are: homelessness; challenging, volatile or violent behaviour; appointment-based service provision; defining comorbidity; lack of specialist services and dedicated resources; and conflicting interests in service provision.

Homelessness

The Supported Accommodation Assistance Program (SAAP) is often the agency of first (and last) resort for many young homeless people. As part of their input to the recent SAAP IV Evaluation (part of which was undertaken by Success Works), SAAP agencies reported that an increasing proportion of their clientele have complex problems including co-occurring mental illness and substance use disorders. In describing their linkages with other

sectors, SAAP agencies noted the most significant as “mental health”, “alcohol and drugs” and “housing”, followed by “health” and the “criminal justice system”. As pressure has been put on each of these sectors, the levels of support expected from SAAP have increased.

A recurrent theme in the SAAP IV evaluation consultations was the heavy and unsupported load that SAAP services are required to carry in dealing with clients with comorbidity, and the inability of SAAP services to produce positive outcomes for such clients. Of particular concern in several consultations was the reported use of SAAP services as an exit point for other government-funded services (particularly residential youth services, prisons and mental health).

The evaluation report noted that:

According to providers, the non-complex client, the client who is still connected with employment, education and/or family, the client who was experiencing domestic violence, young singles and the client who can access private rental accommodation is most likely to achieve good outcomes, including independent living. For the more complex clients, such as those who behave violently, have dual diagnoses or are Indigenous, the outcomes are not as good.

(Success Works 2004)

Consultations for this project identified the lack of suitable and appropriate accommodation for young people with comorbid disorders as the most significant barrier to the access and provision of services. Youth work practitioners commented that without some form of reasonable stability, it was difficult, if not impossible, to address the non-crisis and deeper issues (such as comorbidity) that young people present with. Alcohol and drug professionals noted that it was an uphill battle to treat and assist young people to deal with a substance use problem whilst they remained transient or homeless. Homelessness frequently contributed to further complexities and barriers such as involvement in the juvenile and criminal justice systems. Mental health workers stated that while extreme environmental factors remained active in young people’s lives, it was difficult to accurately diagnose their mental health condition with any confidence.

In summary, the lack of access to homelessness services and the lack of ability of homelessness services to work effectively with young people with comorbidity is a significant barrier. The barrier exists not only in relation to young people’s access to accommodation and housing services, but, because

other services are dependent on client stability and their access to a range of other service supports.

Challenging, volatile or violent behaviour

The SAAP IV evaluation consultations revealed that while SAAP services did not have specific exclusion policies for clients with comorbidity, these clients were more likely than others to be excluded as a result of behavioural issues (Success Works 2004). Consultations for this research also found that young people's access to a range of services and supports was largely dependent upon their "reasonable and good behaviour". As noted earlier in this Chapter, the complex nature of people suffering from comorbidity is frequently not taken into account by those in the helping professions. This is perhaps most relevant to the youth sector as the complex nature of comorbidity is exacerbated by a range of other issues unique to young people, least of which can be the often volatile developmental stage of "adolescence". As noted by Tickell (1999) in Chapter One of this report:

Young people are ill-equipped to deal with the series of traumatic events that have been happening to them. They are often suffering from great stress, manifesting all the symptoms that run alongside this – suicidal tendencies, panic attacks, depression and so on. Often they are self-medicating using illicit drugs or drinking to reduce their anxiety and feelings of being out of control. They are mistrustful and sometimes aggressive to people in authority.

(Tickell 1999)

Over the years SAAP has tended to become a repository for people excluded, for various reasons, from other services sectors. Clients who are demanding and violent may in turn be excluded from SAAP services because workers do not have the specialist expertise or resources to adequately and safely care for such clients.

Early in 2001 Queensland SAAP undertook a survey of "exclusion" in SAAP services to determine how many people were "turn(ed) away for reasons other than no vacancy or capacity". It found that just over half of the 53% of Queensland SAAP services that participated in the survey had an exclusion policy. The ten most common reasons for exclusion in descending order were found to be:

- violence (past or present);
- criminal conduct (past or present);
- intoxication (especially if associated with violence);
- substance abuse (past and present);
- physical disability;
- age and/or gender of accompanying children;

- perception of mental illness;
- no long-term income;
- past debt to the service; and
- other.

Service providers consulted for this study noted that young people suffering dual diagnosis may present with at least one of these behaviours, and frequently will meet multiple aspects of these exclusion criteria. As reported in previous Chapters, dual diagnosed young people are also highly likely to perceive their drug use as "helpful", deny the existence of a mental health condition, have no income and often a history of exclusion from a previous service. Furthermore, non-SAAP housing services as well as other service supports, such as counselling services, were also reported by youth workers, drug and alcohol workers, mental health practitioners and young people as exercising similar exclusion criteria, particularly when it came to violent and volatile behaviour.

Exclusion policies go right to the heart of SAAP's lack of capacity in as much as some of those who are excluded may well constitute the most incorrigibly homeless through no fault of their own. The Queensland report concludes that:

The legal and financial requirements of management in SAAP services means that services cannot afford to take risks which would leave them exposed to legal action.

(Ministerial Advisory Arrangement (MAA) for SAAP/CAP 2001)

Appointment-based service provision

*We have what we call a six week rule. That is, in our experience it takes at least six weeks of reminding, cajoling and encouraging a kid to attend a **regular** appointment, let alone one-off appointments. To expect these young people to attend appointments on time is impractical and unrealistic. They just can't do it.*

(Tasmanian Youth Worker)

Peter Norden, Director of Jesuit Social Services (Melbourne) noted in 2001 that "the existence of a mental disorder is an often unidentified factor in the complex task of responding to the health needs of young people using illicit drugs, especially heroin". Norden further argued that:

Formal clinical settings, with fixed role relationships and appointment schedules that demand consistency and punctuality, are limited in their ability to engage young people ...

(Norden 2001)

The views of youth service providers gained during the consultations for this study also highlighted the difficulty young people with complex needs have in living up to the expectations of appointment-based services. Youth focused services, particularly crisis and some counselling services, noted that an understanding and acceptance of adolescent development in the context of the complexities surrounding homelessness and dual diagnosis contributes to an appreciation of young people's psycho-social ability to meet adult expectations (i.e. failing to arrive at appointments on time, acting out behaviour etc.). Counselling practitioners at one youth counselling service commented:

There is no limited time on counselling for clients, they can leave and return to the service at any time. We don't penalise missed appointments, lateness or acting out behaviour because this is part of working with this sort of difficult client group. Doors hanging off broken hinges are not exactly uncommon, but they can be easily repaired.

(Youth Psychologist)

Informants from a broad range of services expressed concern about the steady increase in young people presenting with co-occurring mental health and substance use problems. Workers in youth accommodation, generalist youth services and youth crisis services made note that dual diagnosed young people will tend to seek assistance for a variety of "other" complicating issues such as homelessness, ill-health, income support problems, legal problems and relationship/family issues (Labad 2003).

Often, these young people's lives are in a perpetual state of chaos as they try to grapple with these issues ... as well as coping with mental illness/disorder and a substance use disorder. Throw "normal" adolescent issues into the mix and it shouldn't be a surprise that appointments are missed and behaviour is sometimes less than "socially acceptable".

(Labad 2003)

Defining comorbidity in young people

As was mentioned in Chapter One, past research has identified two distinct groups of young people suffering co-occurring mental health and alcohol and drug problems. These are:

- those with clinically significant mental illnesses such as schizophrenia, bi-polar disorder and major depression who self-medicate with alcohol and illicit drugs to lessen the distressing symptoms of their illness; and

- those with borderline personality and anti-social personality disorders or anxiety exacerbated by excessive use of substances such as alcohol, marijuana, amphetamines, cocaine and heroin (Mather et al. 1999).

The distinction between "mental illness" and "mental health problems" is a complex one and appears to be not well understood by practitioners in the field in regard to the identification of comorbidity in young people. As was noted in Chapter Two, Australia's National Mental Health Plan (2003–2008) acknowledges both the complexity and diversity of views in defining mental illness and mental health problems. In addition, the frequent use of different terminologies, such as "mental health disorder", "mental illness", "mental health problem" and "mental health issue" to explain a range of conditions, also serves to exacerbate confusion as to what exactly is defined as a valid mental health condition that can then be diagnosed as comorbidity when placed alongside problematic substance use.

Consultations for this project revealed that many youth service workers stated that 100% of their clients could be thought of as having a mental health issue if post-traumatic stress disorder, a past history of abuse, suicide or self-harming behaviour, depression and anxiety are accepted as "mental health issues". Many youth housing and drug and alcohol workers noted that these conditions, alongside substance abuse, were the rule rather than the exception.

Interestingly, these conditions are in fact "mental health problems", according to the definition cited in the National Mental Health Plan (2003–2008). However, what is not well understood by those outside the mental health sector is that "mental health problems" are not necessarily mandated conditions for intervention by mental health services, at least not to the extent that mental illness is a mandated condition for intervention. It is worth noting at this point that youth practitioners who had a psychiatric training background frequently reported that they were able to gain access and support to mental health services where previous attempts by a generalist youth worker (with no psychiatric training background) had been unsuccessful. Some youth specific services stated that where possible, they would employ practitioners with a psychiatric training background for this sole purpose.

Consultations with clinicians within the mental health sector, found that the focus of many (although not all) child, youth and adult mental health programs was on identifying clinical mental illness or an acute mental health problem, as a determinant for both a diagnosis of comorbidity and entry into treatment. Even so, clinicians stated that an accurate

diagnosis was often difficult, if not impossible whilst the substance abuse problems were both active and interfering with symptoms of a possible mental health illness. This factor appears to explain the importance mental health clinicians place on determining which of the co-occurring conditions (i.e. mental health or substance use) is the primary condition, whereas practitioners outside the mental health field generally perceive this distinction as a moot point. Moreover, mental health clinicians in some States cited the considerable lack of resources coupled with the high demand for services as a major reason for mental health practitioners to actively discourage those with mild or non-critical mental health problems to access services and receive treatment. One clinical mental health practitioner and former member of CATT stated:

Mental health workers will jump on the opportunity to shunt D&A/mental health clients over to alcohol and drug services. We just don't have the capacity to deal with them. We are so under-resourced with patients who suffer mental illness without substance abuse problems that the prospect of doing these clients as well can't really even be entertained.

(State Manager)

It is worth noting that during the consultations with mental health practitioners and clinicians only a few participants referred to the distinction between “mental illness” and “mental health problem” as a diagnostic issue when working with drug and alcohol or youth services. Similarly, it would appear that many youth housing workers, alcohol and drug practitioners and those working in sectors outside the mental health field do not understand this definitional difference and frequently expect mental health clinicians to respond to mental health problems as they would for mental illness. This is often the point of frustration for those working with young people who are suffering a co-occurring mental health problem and substance use issue.

The stigma that is frequently associated with mental health conditions was also reported as a significant barrier to service access, insofar as young people were extremely reluctant to access mental health services for fear of being labelled a “mental case”. In addition, there was also consensus from professionals in all sectors consulted that there is a lack of trust from young people toward government or mandated services, particularly mental health services. Services consulted stated that this issue is often exacerbated when mental health service environments are clinical in appearance and approach.

The third barrier then is about the definition of mental health issues and mental illness and the lack

of understanding between sectors and the impact this has for referrals and expectations of support in working with comorbid clients.

Lack of specialist services and dedicated resources

Specialist services and dedicated resources for young people with co-occurring disorders were reported as “thin on the ground”. As mentioned earlier, the National Comorbidity Project found that of the forty-four dedicated comorbidity services in Australia, only three focused exclusively on young people. Consultations also revealed that it was both inappropriate and unsuccessful to attempt to treat young people in an environment or program that primarily targeted adults. Young people frequently felt intimidated, uncomfortable and “out of place” when forced to access adult services. Many young people will be unwilling to then return to the service. The lack of youth focused specialist services was also reported as having resulted in the need for extended waiting lists, particularly for services of a residential nature. Alcohol and drug practitioners noted that due to these waiting times many young people are not placed as the window of opportunity has often passed and potential clients fall through the gaps.

Lack of expertise and dual skills

Lack of expertise and appropriate skills in the identification, engagement and treatment of co-occurring disorders in young people was also reported in the consultations as a critical barrier. Mental health professionals stated that alcohol and drug practitioners and youth work practitioners were lacking the appropriate skills and expertise to determine potential comorbid disorders through accepted assessment processes. Alcohol and drug workers along with their youth worker counterparts commented that mental health professionals lacked knowledge, skills and expertise in drug and alcohol issues and best practices for working with young people. Consultations revealed that allied health and primary care professionals also lacked skills in identifying potential comorbid conditions in young people.

Lack of education and training to the broader service sector (including allied health and primary care workers), secondary schools and general practitioners about comorbidity was seen to inhibit preventative work and the chance of early detection and intervention.

Conflicting interests in service provision

Conflicting interests and understandings of the nature and definitions of comorbidity between all

key sectors was seen by those consulted as a major barrier to the provision of services and resulted in fragmentation of service provision and a significant contributor to inhibiting access to appropriate services for young people. Young people already in the system were seen as “caught in the middle” of these conflicting interests, with mental health services often insisting on a medicated treatment regime, while drug and alcohol services would emphasise the need for abstinence. For young people attempting to access services, it was reported that treatment and support from the housing sector, mental health and drug and alcohol services would often be denied due to varying conflicting aspects of the comorbid condition. For example, housing services are reluctant to take on dual diagnosed young people due to the complex nature of their condition and lack of appropriate skills, time and resources of housing workers. Drug and alcohol services frequently viewed young people with severe mental health conditions and substance use issues as mental health clients and mental health services were reluctant to treat young people with substance use problems. This is commonly known among practitioners as the “ping pong effect”.

Consultations also revealed that the apparent severity of a young person’s comorbid disorder would

also impact on their ability to receive appropriate services. Alcohol and drug services noted that where a young person’s mental health issue was assessed by mental health practitioners as not of a severe nature, clients would often be denied mental health intervention. According to the consultations this was most evident with young people who were assessed by youth/alcohol and drug services as displaying depression, anxiety, suicidal or self-harming behaviour.

4.3 Barriers to services by service type

Other barriers to services identified through the consultations were particularly pertinent to different service types. For example, mental health services commented that their ability to maintain client confidentiality was severely limited for young people less than 16 years of age. In a similar manner, drug and alcohol services made note that there was a lack of continuity of care for young people in the housing sector. Figure Three below, illustrates the range of identified barriers described through the consultations with key sector organisations and practitioners.

Figure Three: Barriers to services by service type

	General youth services	A&D	Mental health	Comorbid services
Exclusive program entry criteria	•	•	•	
Separation b/w mental health and alcohol and drug services		•		•
Homelessness	•	•	•	
Complexity of dual diagnosis	•	•	•	
Lack of policy planning and implementation	•	•		•
Confidentiality for young people aged under 16 years			•	
Lifestyle issues and conflicts (i.e. family conflict/peer group)		•	•	
Developmental issues (i.e. level of maturity, social competency)	•	•	•	
Lack of evidence-based approaches		•	•	
Lack of NGO’s			•	
Lack of skills, continuity of care		•		
Attitudes of mental health clinicians toward A&D services	•	•		•
A&D practitioners lack of knowledge about mental health			•	•

As can be seen in the above Table, identified barriers common to youth, alcohol and drug and mental health services include: complexity of the comorbid condition, developmental issues such as level of maturity, age and social competency,

homelessness and the exclusive nature of program entrance criteria. Dedicated comorbidity services reported the separation between alcohol and drug services and mental health services was particularly evident in current practice and the lack of policy

planning/implementation (principally at the local level) was of major concern.

Interestingly both mental health services and alcohol and drug services were in agreement on many of the identified barriers they reported during the consultations. These include: the impact of lifestyle issues and conflicts on treatment options; complexity/severity of the condition; the impact of homelessness; and lack of an evidence-based approach to interventions.

4.4 Barriers to services for Indigenous communities

The National Strategic Framework for Aboriginal and Torres Strait Islander Health (Context Paper 2003) identified a range of reasons for the inadequate provision of health system services to Indigenous people. These included: locations that are difficult to access; low levels of Medicare enrolment; financial cost of private and community-based health care; unwelcoming and unfriendly service environments and attitudes of providers; poor inter-sectorial linkages; poor performance of the system to meet complex and multiple needs; inadequately target health promotion approaches; and a largely non-Indigenous workforce.

The correlation between low socio-economic status and higher rates of disorders and diseases mentioned earlier in this Chapter, are far more pronounced for Indigenous communities. As a particularly vulnerable population, Indigenous young people have a far greater risk of developing mental health problems, severe and harmful substance use, homelessness and coming into conflict with police. As noted in the National Strategic Framework for Aboriginal and Torres Strait Islander Health Consultation Paper (2003) these social determinants do not occur independently of each other, rather the cumulative effect of disadvantage clearly multiplies risk factors which, in turn, lead to high need and complex conditions.

In 1999 the Australian National Audit Office found that Indigenous presentations for clinical services reduced considerably following the successful implementation of programs that aimed to improve housing and environmental health in Indigenous communities.

Improving housing, water, sewerage, power and waste services to the same standards enjoyed by the broader Australian population can significantly improve Aboriginal and Torres Strait Islander health status.

(National Strategic Framework for ATSI Health Consultation Paper 2003)

Similarly, there is also significant evidence that links higher educational achievement with lower use of alcohol and other substance use among Indigenous young people (ABS 2003; AIHW 2003).

In 2001 a study on Indigenous homelessness in Victoria was conducted by a group of RMIT researchers. The final report noted that although the circumstances and causes of Indigenous peoples health had been well documented over the past five to ten years, an understanding of the impact and construction of culture in respect to the diversity of the Indigenous community was not so well understood (Berry, et al. 2001). The research highlighted that “Indigenous people comprise a vigorous, distinct community of communities”. In other words, there are distinct communities of Indigenous people who identify with different locations, clans, language, culture and traditional practices. Although these diverse communities share some common issues and problems, their needs are not necessarily the same. Key themes identified in the RMIT final report that are particularly pertinent to this research included the following:

- **Indigenous culture** – particularly the notion of “extended family” and its fundamental role in the Aboriginal way of life. Acknowledgment of the Indigenous extended family has been frequently denied in policy and practice and what is seen by government policy as “overcrowding” within some Indigenous households is the provision of extended family support in the community. However, it is also noted that overcrowding situations can also mask the levels of Indigenous homelessness and is not always appropriate for some young people.
- **Poverty** – extended family obligations were also noted to have a significant impact on income in that Indigenous family and communities observe family obligations and sharing of income amongst family members as a way of life.
- **Complex Service Systems** – the categorisation of needs into separately-funded streams such as “youth”, “single male”, “women”, “substance user”, “mental health” etc. clearly does not recognise the interplay between complex and underpinning factors and fails to acknowledge the holistic approach to “social and emotional wellbeing” that is preferred by Indigenous communities and organisations.
- **Inadequate Housing Provision** – the severe shortage of housing stock in both the private and public sectors was identified as a key issue and significant contributor to overcrowding. The design and make-up of housing stock was also noted as not appropriate as housing for

many Indigenous extended families needs to comprise of at least six bedrooms with large living areas in order to accommodate high numbers of family members.

Throughout the consultations a number of issues and themes emerged that correlate strongly with existing research on Indigenous populations, service approaches and the barriers that are commonly experienced by Indigenous people in attempting to access appropriate services. For young people in particular, barriers identified in the consultations included:

- a general lack of services both geographically and Indigenous (or Indigenous youth specific);
- homelessness and inappropriate overcrowding in unsafe and unacceptable conditions;
- inadequate access of families and communities to basic infrastructure, such as sanitation, waste disposal, power, water supply etc;
- high levels of distrust in mainstream services and workers and associated stigma and shame in relation to mental illness;
- high levels and use of inhalants such as petrol, among young Indigenous people, particularly in rural and remote communities;
- high levels and frequency of conflict with police and other law enforcement agencies as well as resulting incarceration;

- lack of holistic, Indigenous “extended” family-based approaches for young people to social and emotional wellbeing; and
- lack of Indigenous role models.

4.5 Summary

Barriers to service provision for young people with comorbidity include:

- chronic levels of homelessness and the incapacity of the SAAP sector to cope with the issues presented by dual diagnosed young people or to assist them to achieve positive outcomes;
- challenging, volatile and violent behaviour and the lack of resources and capacity of service providers to effectively deal with complex behaviours;
- lack of a clear definition of comorbidity and consequent misuse of referrals and lack of understanding between sectors;
- lack of access to specialist comorbidity services for young people;
- stigma, particularly in relation to mental illness;
- fragmentation of service provision and conflicting requirements (e.g. in relation to medication); and
- lack of access to Indigenous specific services for Indigenous young people.



Strategies to overcome barriers

The majority of States and Territories have recognised the issue of comorbidity and are actively engaged in various policy and program initiatives that aim to improve service provision and client outcomes in this area. Although attention to the issue of co-occurring mental health and substance use has only recently been adopted by State and Territory Governments there are a number of pilot projects identified through both consultations and the literature across the country that are currently being implemented, tested and evaluated. For a clear majority of these State responses to comorbidity, the plight of young people suffering comorbidity has not yet been highlighted. However, these projects and policy initiatives form the basis of current practice knowledge in Australia and illustrate a variety of approaches and strategies that are being trialled in order to overcome the barriers that comorbid clients face in accessing support and treatment.

The National Comorbidity Project (2002) recognised that the broad social service system “should function in an integrated way and respond to comorbidity as common practice in all services across health, corrections, education and primary care” (Teesson and Byrnes 2002). Participants in the 2001 National Comorbidity Workshop endorsed the need for “whole-of-government” partnerships to develop functional linkages between the multifocal health system and “housing, income, welfare, health,

criminal justice, education and training” systems in relation to comorbidity (Teesson and Byrnes 2002). Ideally, young people suffering co-occurring disorders should be able to enter “the system” at any point and be guided seamlessly through a support grid that correctly identifies and adequately meets all their needs.

The purpose of this Chapter is to outline the most relevant initiatives currently being undertaken by service providers as well as State and Territory initiatives in relation to comorbidity, particularly those that have recognised dual diagnosed young people as a high needs and critically disadvantaged group.

5.1 From the consultations

As a key aspect of this study, the research team posed a range of questions to service providers about how they manage and strategically address the barriers that arise for many of their comorbid young clients. Responses were varied across service sectors and included implementing approaches that were “strengths-based” and “solution orientated”, focusing on early intervention and/or prevention, working within a framework of “risk” and “resilience”, working intensively with families (where appropriate and possible), trialling integrated case management and assertive outreach, and relying on the “goodwill”

and “friendships” formed as part of a practitioners professional network with key support services. When it came to housing and accommodation issues however, many informants were at a loss to identify effective practices:

You can't give what you haven't got. I can get some of my clients into some programs just by pushing the friendships and alliances I've built over years of being in the sector. Most [clients] I can do little for in terms of housing – it's just not there.

(Tasmanian Youth Worker)

Similarities in strategies employed by workers and organisations to overcome some of the more common barriers were in the key areas of: improving access; collaboration and cooperation; managing difficult or disruptive behaviour; and reaching agreement on diagnosis and treatment. Tasmania's Colony 47 Program (along with the Link Youth Health Service) also notes these as common areas where workers employ a number of strategies to overcome identified barriers. The following has been adapted from Colony 47's “Collaboration for Change” resource package produced in 2003 for practitioners working with comorbid clients.

Improving access

- **Assertive outreach** – to link young homeless people suffering comorbidity with relevant workers and encourage them to access services.
- **Effective engagement** – including motivational interviewing and ensuring that a young person receives a service that is helpful on their first visit, and encourages them to return.
- **Flexibility** – offering services on a “walk-in basis” and at times and places that will suit young people rather than services.
- **Non-appointment-based** – allow young people to access support and treatment when it is suitable to them (i.e. avoiding early morning appointments).
- **Follow-up and reminders** – for necessary appointments by contacting young people by phone (if possible) or meeting with them prior to the appointment to assist with organising time and transportation.

Improving collaboration and cooperation

- Proactively making contact with other service providers to ensure consistency of care.
- Creating links with legal entities including courts, juvenile justice and criminal justice systems.

- Fully utilising networks and professional friendships.
- Ensuring more than one worker in the organisation is familiar with the client so that if the primary worker falls ill, leaves the service or cannot meet with the client there is someone else who is “in the know”.
- Utilising case conferencing on a regular basis.
- Avoiding unproductive over-servicing (where different agencies are working in often incompatible ways unaware of what others are doing).

Managing difficult and/or disruptive behaviour

- Utilising a whole team approach so that the message is consistent.
- Allowing clients to return to the service once they have calmed down.
- Negotiating more appropriate access times to the service for the client (i.e. when the service is quiet and full attention can be paid to them).
- Considering “banning” clients as an absolute last resort.

Reaching agreements on diagnosis and treatment

- Joint training initiatives on comorbidity between sectors and service providers.
- Joint case assessments between mental health and primary worker outside of the mental health sector (i.e. drug and alcohol or youth worker).
- Developing common referral and assessment tools between local key services.

5.2 State and Territory initiatives

SAAP building links

Recent advances made towards the building of links between the SAAP homelessness network and other service systems are of particular interest. SAAP representatives in the ACT for example, reported some progress in the provision of service responses to people with comorbidity through expanded service networking and improved working relationships between SAAP agencies and other community agencies. They also reported that the increasing complexity of needs of many clients along with a reduction in the number of exit points due to a lack of public housing, medium-term accommodation options and high private rental costs has led to a reduction in actual client numbers serviced. A Complex Needs Project has been commissioned by SAAP ACT to review services for CALD users and a Mental Health

worker has been engaged to support services to assist the growing number of clients with mental illness, including comorbidity. The need to train SAAP workers to assist clients with mental illness has been recognised as a key priority.

SAAP Tasmania has developed a first contact assessment tool that allows services to identify the most appropriate interventions for a client and to find those in an integrated “continuum of support” model. However, the evidence suggests that integration has only partially been achieved with many jurisdictions continuing to report difficulties in providing linked-up services to homeless people or people at risk of homelessness with comorbidity due to a lack of integrated service delivery with those sectors responsible for assessment and treatment (Success Works 2004).

Western Australia and Victoria both have State Homeless Strategies that have integrated programs that provide accommodation options for people with mental health issues and who use SAAP services. The Victorian model outlined in the State-wide Assessment and Referral in Homelessness Services Project (2001) recommended the development of enhanced referral processes that would enable clients who entered the homelessness system at any point to have their global needs identified and be guided through an integrated support system. Models of integrated support proposed by the report call for the development of service and referral protocols between homelessness entry points and with “other program areas” and for the development of “front door” agencies that are either co-located with, or have active referral pathways to, other services including health and employment/income support services. Although the document makes no mention of “dual diagnosis” or comorbidity, it is specifically designed to identify and address the needs of homeless clients with “complex needs”.

Western Australian SAAP has drug and alcohol workers co-located with many SAAP services (Success Works 2003). SAAP in Western Australia has also signed a series of protocols similar to that of Tasmania, which aim to integrate homelessness services into a whole-of-government response to young people with complex needs. Separate protocols link SAAP with other government services including the Health Department’s Mental Health and Drug and Alcohol Divisions, and Departments of Community Development, Justice, Education, Housing, Police, Centrelink and Crisis Care. These protocols aspire to enable SAAP to operate as a key triage point for young people with complex needs. It remains to be seen whether SAAP is equipped to take up a role that moves beyond its original brief.

The protocol signed jointly with the Mental Health Division and with Community Development specifically notes the needs of “shared clients” who are “homeless or at risk of homelessness where this is directly or indirectly linked to the state of their mental health” and to disorders associated with alcohol and other drug use. It is intended that a collaborative relationship between these departments and SAAP will “ensure that common issues and any overlap or gaps in agency response can be dealt with effectively to enhance the service required by clients” so that clients do not continue to fall through the safety net.

The document commits all parties to effective collaboration at policy and planning, program planning and management and service delivery levels (WA SAAP). Protocols focus on the need for timely information exchange; joint input into new service planning and development; combined learning and coordinated purchasing or establishment of services. They also detail commitments to undertake collaborative service delivery and case management, provide mutual feedback, plan and deliver continuing care and undertake service and case reviews. The protocols emphasise each party’s commitment to provide services closely aligned to individual client need, and to ensure that the needs of joint clients in both services are taken into account.

SAAP linking strategies

In 2002, SAAP released the findings of its enquiries into the effectiveness of existing linking strategies between mental health agencies, SAAP and other relevant agencies, including outreach and case management programs, for meeting the needs of the homeless. The review found that in some areas there was an overall lack of services, but in others, existing services are:

...insufficiently flexible and coordinated and insufficiently accessible and responsive to the needs and experiences of homeless people, particularly those with dual diagnoses and multifaceted and complex needs.

It also found “a lack of support services including clinical, disability and tenancy critical to preventing homelessness...for people with mental illness”, a lack of capacity for early intervention with children whose parents experience homelessness and/or mental illness, and with young people in the early stages of psychosis and/or living with the effects of abuse. It particularly noted the need to coordinate and integrate homelessness and psychosis/mental health early interventions and to include a focus on the support needs of families (SAAP 2002).

The SAAP Linkages report identified a wide range of agencies that should be included in consultations to develop a coordinated response for homeless people with mental illness, but did not identify specific barriers to cooperation and integration, or focus on comorbidity. The project researchers argued indeed, that at the same time as mental health services came under community pressure to provide a broad range of services and to develop strategic alliances, recent national policy initiatives, viz. The Second National Mental Health Plan (1998) and The Mental Health Promotion and Prevention National Action Plan have “driven the change from the provision of whole-of-life services for people with a mental illness to providing specialist mental health services...[so that] mental health is no longer responsible for the provision of services such as housing and residential support” (SAAP and Mental Health Linkages 2002).

The report concluded that there is a need to integrate responses delivered by housing, clinical, income support, family, employment and training support services, for the development of locally-based service agreements and protocols and for the development of shared or common assessment and referral tools. It also highlighted the need for the exploration of models for integrated responses to Indigenous communities, but as yet no details have been formulated.

Colony 47 “Collaboration for Change” Resource Package

The Collaboration for Change Resource Package project was funded by the Community Support Levy from the Tasmanian Government. The aim of the project was to develop a resource package that would support the creation of an infrastructure to enable workers to further develop skills in working with clients who have complex needs. Due to the considerable involvement of the Link Youth Health Service, located in Hobart, the package has a significant youth focus. The project also intended to challenge services to begin communicating with each other about ways to improve service delivery to comorbid clients who frequently “fall through the gaps” of the current service system.

South Australia’s Social Inclusion Initiative

South Australia’s Social Inclusion Initiative is a whole-of-government response and recognises that “issues such as poor health, crime rates, problem drug use, poverty and decreased social cohesion are interrelated and their causes are often traced to social exclusion” (SA Drugs Summit 2002). The Social Inclusion Board is overseeing the Government’s response to the South Australian Drug Summit,

held in 2002. The Drugs Summit identified “services appropriate to people with dual diagnoses” as a specific deficit in the health maintenance and treatment sector. It called on government to fund an integrated initiative between mental health and alcohol and other drug services for young people with comorbidity. It prescribed a pathway that would move from early intervention through crisis care to long-term support and identified young people as a particular client group in need of outreach services. South Australia has already begun to develop integrated mental health/drug and alcohol responses for adults but is yet to include a specific focus on young people under 18 with comorbidity.

As the Drug Summit communiqué noted, comorbidity is complex, difficult to manage and requires long-term individual treatment plans to prevent people “falling through the gaps”. The communiqué recognised that integrated support was not yet being provided. It called for the development of service linkages to provide “joint assessment and case management” across integrated medical, mental health and drug and alcohol services so that “clients would have to tell their story only once”.

However, given that there was a limit placed on the number of recommendations that each working group could present, the SA Drugs Summit did not specifically call for the integration of accommodation, education or income support services into the comprehensive support system for young people with comorbidity (SA Drugs Summit Communiqué 2002).

ACT Youth Suicide Prevention Strategy

The ACT Youth Suicide Prevention Strategy (1998–2001), which as of 2001 had not been integrated into the Australian Government suicide prevention framework, was associated with a related initiative on comorbidity about which no detail was available at the time of publication. The report noted that this, and other ACT suicide prevention initiatives, “operated from within a mental health oriented framework”. More recent SAAP initiated coalitions between mental health and homelessness services may result in a reorientation of that approach.

It appears that no other State’s or Territory’s suicide strategies had actively identified comorbidity as a specific risk factor associated with increased suicide, or put in place specific programs to meet the needs of young people with comorbidity.

Australian Government Department of Health and Ageing

In 2001–2002 Success Works undertook a research

project to identify ways of rationalising the linkages between the National Suicide Prevention Strategy and related Australian Government and State and Territory Government initiatives (Review to Identify Priorities for Rationalisation between the National Suicide Prevention Strategy and related Commonwealth and State and Territory initiatives, SuccessWorks January 2002). The report found that comorbidity is increasingly significant amongst people presenting at drug and alcohol services, mental health services, general practitioner services and homelessness services. It also found that “people suffering from co-existing disorders are at a far greater risk of suicide as the risk factors associated with each condition increase their vulnerability and often reduce their capacity to “cope” with life events and stressors” and that service providers recognise the need for effective collaboration. The Australian Government’s National Suicide Prevention Strategy entailed a shift of focus from previous initiatives that were youth specific to a universal suicide prevention strategy.

The research report provided a table of existing funded government initiatives on a State-by-State basis. The NSW State Suicide Strategy includes a comorbidity program that the researchers found was not well integrated into with other initiatives under the strategy. The strategy also supported and funded a School-Link initiative designed to enhance the identification, management and prevention of depression and related disorders in secondary school-aged children and adolescents, and a range of other programs directed at young people and at the training of health and mental health practitioners who come into contact with young people. Programs have a strong emphasis on adolescent mental health, on early intervention and on post-ventive follow-up.

Dual Diagnosis Model Project (NSW)

In 1999 the Richmond Fellowship of NSW (RFNSW), an organisation with a long history of providing comprehensive support in group accommodation settings to young people with mental health disorders, combined with the South Sydney Youth Services (SSYS) to undertake the Dual Diagnosis (model) Project. It was evaluated in 2002 at the end of its four-year funding period. The project had a non-medical, youth work focus and aimed to address service system gaps, including the lack of youth specific services, lack of accommodation for youth with comorbidity, the lack of ongoing counselling, lack of tolerance from Community Health Centres where substance abuse is seen as self-inflicted, and the lack of tolerance from drug and alcohol services if the young person is non-compliant with medication. During the project, the team refined processes of

initial contact, case management and goal setting, crisis work, social and therapeutic group work, therapy and counselling, education and information provision, outreach and family support, and kept abreast of best practice in comorbidity responses in other domains. The project found that there is a dearth of comprehensive models to compare to the RFNSW–SSYS program.

A total of 173 individuals, many of whom were otherwise outside the existing governmental income support system and were without stable accommodation, were assisted during the four-year period, with consistently positive outcomes in terms of program completion, medication management and compliance, capacity to interact with other people, self-esteem, identification and achievement of personal goals. Only one in four of the project’s clients had previously accessed mental health or alcohol and other drug services before contacting the Dual Diagnosis Project. This finding emphasises the inefficacy of relying on such services to provide the primary support to young people with comorbidity.

The report indicated that funding and resourcing of the project was insufficient to meet the demand that the successful project attracted, and that the project was hamstrung by the lack of housing options for clients. The issue of how to work with other services also remained unresolved. Of significance for this project is the finding that other services reported that “the Dual Diagnosis Project has had little impact on their service delivery”. Thus, despite the success of the Richmond Fellowship–SSYS model, other services have not responded to the barriers their own services put in the way of young people with comorbidity. A requirement of later stage evaluations will be to assess the accuracy of the perception that those services remained unchanged and to consider the reasons why services have not been more responsive to the needs of young people with comorbidity.

The Richmond Fellowship–SSYS project’s literature review, and our own, places this model project at the leading edge of international responses to working with young people with comorbidity. They found supporting evidence from Teesson (2000), Kavanagh (2000), Drake (2001) that treatment models that deal with mental health and substance misuse sequential or in parallel substantially fail to address the complexity of client needs, leading many sufferers to disengage from treatment altogether, or to be excluded from one or both services (RFNSW–SSYS pp. 29–30). The review also concludes that most of the available literature is focused on the integration of mental health and drug and alcohol services, and largely ignores the integration of those medical services into the broader social support safety net.

The Richmond Fellowship–SSYS project drew some reinforcement for the design of program elements from the “5 stages of change” model developed by Prochaska, DiClemente and Norcross (1992), work by Carey (1996), Walsh (n.d) and Drake (2001) on assertive outreach, motivational interventions, and from Mueser and Noordsy (1996) on counselling (RFNSW–SSYS pp. 30–32).

The RFNSW–SSYS evaluation reviewed two Australian case studies of programs for young people with comorbidity (RF–SSYS), both of which provided pointers to best practice for the RFNSW–SSYS initiative. The programs are Connexions (Jesuit Social Services, Collingwood, Victoria), and Young People with Psychiatric Illness – Intervention and Assessment program (YIPP–IA) (Central Coast NSW). YIPP–IA found that “addressing environmental factors greatly improves treatment effectiveness”. Both of these projects moved beyond the medical system and directed efforts at enhancing young people’s ability to develop social skills, self-esteems, social support, to maximise time spent in a drug-free environment, to foster practical life skills and to address the “void left when drug-related activities are abandoned”. The program also combined SSYS programs like the “Links to Learning” program with housing support, and income support access.

NSW Association for Adolescent Health

In August 2002 young people in the Richmond Fellowship–South Sydney Youth Services dual diagnosis project participated in focus groups, and along with their parents and representatives from almost thirty organisations concerned with the health and wellbeing of young people, joined in a forum on comorbidity organised by the NSW Association for Adolescent Health. The report confirms our finding that there “is a paucity of literature specifically on young people and comorbidity or on subgroups of this population such as young people of non-English speaking background, Indigenous Australians, and same sex attracted youth.

The forum addressed the now well recognised association (e.g. Drake and Wallach 2000, Drake and Mueser 1996) between comorbidity in young people and homelessness or unstable housing arrangements, psychological stress and demoralisation, youth

prostitution and criminality, contact with police and justice systems, social isolation and marginalisation, lack of employment and educational achievement, income insecurity, and so on. The forums took up Drake’s repeated call to “create safe and protective environments along with the development of opportunities for educational, social and vocational success” (Drake and Wallach 2000). The forum also foregrounded survival and recognised that dealing with, and living with, comorbidity is “also about pluck, innovation, counterculture, outrageousness, and a belief in the human spirit” (Cohen and Lewis 1992, quoted in NSW Association for Adolescent Health 2003).

The Caught in the Gap report provides a list of best practice components for integrated treatment programs that combine treatment of disorders by the same, comprehensively-trained clinician, assertive case management, group work designed to build supportive community, individual and family counselling and housing support. It also notes the Victorian-based SUMITT program which, while not a youth specific service, does provide services to people aged 16–64 with comorbidity that integrate psycho-medical clinical treatment with family support and interventions, income security support, nutrition, day programs and vocational support and advocacy. Recommendations from the forum included calls for:

- the development of pro-active service entry points which are visible, have an assertive outreach capacity rather than being crisis-driven;
- the use of family focused interventions;
- services to be client-focused rather than geographically-focused;
- the development of youth-specific services;
- improved communication, collaboration and integration between services;
- joint training of workers; and
- improved and expanded accommodation options and services.

The NSW Association for Adolescent Health has called on NSW Health to fund a three-year trial of a State-wide integrated treatment facility based on these recommendations.

6 Best practice

Both national and international research supports the experience in both drug and alcohol and mental health services that those suffering comorbidity have poorer outcomes across multiple domains, as well as being difficult to serve in traditional treatment service environments (see for example, Teesson and Byrnes 2002; Drake et al. 1991; Cuffel et al. 1994). Specifically, young people are more likely to relapse and be re-hospitalised, to be treatment resistant and non-compliant, medically involved (e.g. HIV, Hepatitis B/C infected), criminally involved, and homeless, as well as impulsive, suicidal and violent (Cuffel et al. 1994). In addition, studies in managed-care systems have identified these young people as being over-represented in populations of high utilisers of scarce systems resources, such as housing, State care systems, juvenile justice and criminal justice (Teesson and Byrnes 2002).

In order to increase effectiveness in dealing with dual diagnosed young people, the broader social service system “should function in an integrated way and respond to comorbidity as common practice in all services across health, corrections, education and primary care” (Teesson and Byrnes 2002). Teesson et al. (2002) also argue that integrated “whole-of-government” partnerships are needed which achieve functional linkages between the multifocal health system and “housing, income, welfare, health, criminal/juvenile justice, education and training”

systems in relation to comorbidity (Teesson and Byrnes 2002).

While there is a dearth of literature that focuses on the plight of young people in regard to comorbidity, there is even less when attempting to trace best practice programs or initiatives. Again, the focus in the literature (particularly the international literature) is largely dedicated to the adult population and consideration for sub-populations such as young people, Indigenous people and those from a non-English-speaking background is virtually non-existent.

For the purpose of this research the focus for the international literature on good practice was on guidelines and the development of policy in the United States (US), the United Kingdom (UK) and Canada, particularly where they relate to young people or may offer potential insight to best practice in working with young people with comorbidity.

6.1 Overview of the international literature

The most popular approach to developing best practice on the international stage has been the design and development of practice and policy standards and guidelines. For example, in the United States a national panel of comorbidity experts that included consumers, family members and service

providers, convened to undertake an extensive review of the published and unpublished literature with a view to developing a set of standards for dealing with comorbid clients. The result was a set of standards developed around five key themes:

- consumer and family needs;
- system design;
- guidelines for assessment, treatment and rehabilitation and psychopharmacology;
- competencies required of clinicians in areas of attitudes, values, knowledge and skills; and
- training curricula to enable staff to meet the standards of care required.

In 2003 the US Substance Abuse and Mental Health Services Administration (SAMHSA) released its final report titled “Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and/or Co-Occurring Substance Use Disorders”. The Blueprint is intended for use as a manual for service planning and delivery. It specifically recognises the circularity of causality between comorbidity and homelessness and focuses on the integration of mental health/substance disorder services with mainstream resources that serve people who are homeless.

In the United Kingdom the Department of Health appointed a Dual Diagnosis Steering Committee to oversee the development of the Dual Diagnosis Good Practice Guide by the Sainsbury Centre for Mental Health in partnership with Alcohol Concern and Dr Alison Lowe of the Barnet, Enfield and Haringey Mental Health Trust. The Dual Diagnosis Good Practice Guide was published by the Department of Health in 2002.

The UK practice guide adopted a “mainstreaming” policy of delivering comorbidity responses through existing local mental health services supported by dual diagnosis outreach teams. The guide recommended that all agency workers receive base level dual diagnosis training, while designated dual diagnosis team workers receive more advanced training. The guidelines called on services to come together with local stakeholders to identify target populations and develop programs that meet the specific dual diagnosis needs of their own locality. Dual diagnosis responses were seen to be best initiated by small and time limited “Local Implementation Teams” incorporating mental health and substance misuse specialists working to develop care pathways, risk assessment processes and clinical governance guidelines (UK Department of Health 2002).

In Canada the Canadian Centre for Addiction and Mental Health appointed an Expert Panel to review and to provide advice on dual diagnosis work. Compared

to the US standards and the UK guide, the Canadian guidelines do not consider the extension of integrated practice beyond the clinic in any detail. The scope of the best practice advice was significantly limited and only focused on screening, assessment, treatment and support. It called for “concurrent treatment” of mental health and substance disorders, rather than the development of “integrated” treatment models (CAMH 2002). Moreover, the Centre for Addiction and Mental Health chose to consider only generic individuals rather than make any recommendations, or devise any processes, to meet the needs of client sub-groups such as young people, the elderly, the homeless or cultural groups such as Aboriginal people. Interestingly the Centre for Addiction and Mental Health has developed best practice advice for specific concurrent disorders to mental health sub-group levels. This approach differs significantly from that adopted in the US and UK as well as Australia. The sub-groups considered by the Centre for Addiction and Mental Health were:

- co-occurring substance abuse and mood and anxiety disorders;
- co-occurring substance abuse and severe and persistent mental illness;
- co-occurring substance abuse and personality disorders; and
- co-occurring substance abuse and eating disorders.

Perhaps the most significant development in recent dual diagnosis service delivery is the “integrated” model originally developed by Drake and Noordsy (1994–1995) in the US. Integrated models of treatment aim to synthesise substance use and mental health treatment frameworks and practice in order to ensure that clients receive “comprehensive, consistent and integrated treatment to their presenting needs” (Health Canada 2002).

The essential distinction here is that while integrated treatments offer concurrent treatment in terms of concepts, personnel, programs and facilities, sequential or parallel treatments each retain the philosophy and practice base of their distinct service system.

(Dual Diagnosis Resource Centre 2000)

Although there has been some criticism that the trend toward developing integrated models of treatment for dual diagnosis clients is moving significantly faster than the evidence can support it, there appears to be some consensus that integration offers the best solution to an effective treatment approach that is currently viable (Dual Diagnosis Resource Centre 2000; Ley et al. 1999; SAMHSA 1997; Parker 1998; Sitharthan et al. 1999).

Alternatives to the integrated model, such as sequential or parallel approaches have been shown to be ineffective in addressing dual disorders . . . However, debate continues over the optimal nature of service integration.

(Dual Diagnosis Resource Centre 2000)

6.2 Best practice – the Australian experience

Significant initiatives in the field of comorbidity have also been undertaken within Australia by the Australian Government and the State and Territory Governments. Among these is the National Comorbidity Project which identified a national policy approach to comorbidity as well as a number of priority areas for action including: prevention and early detection; carers and consumers; research and evaluation; education and training; integration/collaboration of services; and a whole-of-government approach.

In comparison with international efforts, Australia has or seeks to address a similar and substantial range of issues and aspects. Consultations from the field in regard to best practice principles in the identification and treatment of young people with comorbid disorders were comparable with the findings in the literature. The principles identified through the National Comorbidity Project, for example, indicate the need for a long-term perspective to be taken and that consideration is given to both brief and long-term interventions. It was also noted that an effective relationship between practitioners and clients should be based on honesty, trust and respect, and that active listening and a client-centred approach should be used to establish rapport, develop a common understanding and to reach an agreement of the management plan.

There are some notable initiatives that have been implemented in Australia and which have addressed the issues specifically for young people suffering dual diagnosis. One of these is the NSW Dual Diagnosis Project which was a joint initiative between South Sydney Youth Services (SSYS) and the Richmond Fellowship of NSW and funded by the Australian Government's National Illicit Drug Strategy for a four-year period. The project was established to assist in the treatment options for dual diagnosed young people; in particular there were three key aims:

- to reduce the harm associated with illicit drug use and the trauma associated with dual diagnosis;
- to increase young people's skills and knowledge about illicit drugs and their impact on mental health; and

- to expand the availability and effectiveness of appropriate treatment options.

The final report (Synnott and Laurie 2002) identified a range of good practice strategies and approaches to working with dual diagnosed young people. For example, the approach utilised by the project was developed and informed by young people and based on the gaps in services that the SSYS and Richmond Fellowship had identified through their own experience. The strategy adopted by the project was characterised as a "non-medical, youth-work focused approach to assisting young people in a holistic and integrated way" (Synnott and Laurie 2002). Key service aspects from the project involved: individualised case management; crisis work; group social and therapeutic work; counselling; education and information; outreach; and family support. The evaluation of the project after four years of implementation noted that:

Despite the increasing complexity of issues for young people being assisted, the Dual Diagnosis Project has been able to reduce the number of young people exiting the program because of non-compliance (not taking their medication). Similarly the Team has been able to reduce the numbers leaving before they have completed the program.

(Synnott and Laurie 2002)

Indicators of the project's positive impact on young people's lives were also cited in the evaluation and included:

- the project worked with a significant proportion of young people for more than twelve months;
- young people stayed with the project and achieved personal goals;
- young people demonstrated improved skills in managing their medication;
- stakeholders from other services provided testament about the impact of the project on their clients capacity to deal with substance abuse and mental illness; and
- young people identified personal goals that they believed had only been achieved through their involvement with the project.

Another Australian initiative that warrants mention is the NSW Association for Adolescent Health "Caught in the Gap" research into dual diagnosis and young people (Davis 2003). The study focused on obtaining the views and opinions of young people and their experiences of services. In regard to improving services to better meet the needs of young people suffering dual diagnosis Davis (2003), concludes:

In summary, they felt education about dual diagnosis in schools, particularly on mental health issues and the consequences of drug use, was needed. Also education of family members and police to be more understanding would help. In relation to hospital care, participants suggested providing structured activities and healthy food, along with not placing young people in the same ward as “very mad, crazy people”. Finally they recommended that health services work more collaboratively, provide better information on treatment and show respect to individuals with a dual diagnosis.

(Davis 2003)

In line with the findings of this research, the “Caught in the Gap” report notes that most young people interviewed as part of their focus group methodology, stated that their experience with youth workers were by far the most positive as they were “treated with respect and in a non-judgemental way”.

6.3 Best practice working with Indigenous communities

Best practice for working with Indigenous young people must sit within a holistic framework and approach to working with Indigenous families (including extended family) and communities. Such an example is the model of Social Health Teams (recognised within the Aboriginal and Torres Strait Islander SEWB Framework) that work with Indigenous communities from within Aboriginal Health Services:

- Wuchoperren Health Service (Qld);
- Central Australian Aboriginal Congress (NT);
- Winnunga Nimmityjah Aboriginal Health Service (ACT);
- Nunkuwarrin Yunti of SA Inc. (SA); and
- Port Lincoln Aboriginal Health Service (SA).

These Social Health Teams and services offer both mental health and drug and alcohol workers or access and referral into appropriate services as needed.

This section primarily draws on recent work undertaken by Success Works on a range of projects with Indigenous communities including work on the Evaluation of Government Responses to *Bringing Them Home*: The Stolen Generations Report (Success Works 2003). The BTH final report identified the following good practice principles for working with Indigenous communities:

Elements of good organisational practice with Indigenous communities –

- **The impact of past policies:** Understanding and recognising the impact of past policies

on the Indigenous community through: raising awareness; identification and acknowledgment of losses; identification and acknowledgment of emotional legacies; and reclaiming unrecognised emotional losses such as a sense of identity or power/trust, confidence, self-esteem and safety (Wanganeen 2001).

- **Holistic healing:** Focusing on holistic healing which views wellbeing in its totality. Addressing grief in Indigenous young people is not simply about individual wellbeing but collective community wellbeing, supported by community development approaches.
- **Clear directions, planning, leadership and vision:** A clearly defined organisational vision, encompassing planning and direction, is an essential base for good Indigenous practice. Sound leadership, which enables these processes to be developed, passes on confidence, pride and commitment to workers. Organisations which display their vision and values publicly, as a snapshot, engender transparency and accountability.
- **Integration** of relevant services to ensure ease of access and efficient use of resources.
- **Teamwork and a high quality skilled workforce:** Staff training demonstrates the value placed by the organisation on the quality of their workers. Expecting staff to work in sensitive areas without training support and supervision sets them up to burn out or fail. The range of accredited opportunities must take into account different levels of staff needs. Opportunities for debriefing among colleagues and as part of professional supervision reduces staff turnover, due to stress-related conditions. The quality of the workforce often contributes to the success of a project.
- **Flexibility and responsiveness to clients:** The nature of an organisation determines flexibility. An organisation which encourages ways of working which suit the client group – in this case in a culturally appropriate manner of working – are more likely to achieve positive outcomes.
- **Established networks, and a commitment to collaboration and partnerships with other key organisations:** Evidence is that good links with other like-services enhances quality outcomes for service users. Memoranda of Understanding, collaboration and partnerships between organisations which provide similar and complementary services, underlines their commitment and provides a solid base for workers to operate together.

- **An integrated, holistic approach:** Services which address client needs through a variety of available services, which link in together, offer the user the opportunity to receive assistance from one central point.
- **Effective communication systems** (for example by ensuring appropriate language is used): This involves not only sound and effective internal communication but also regular meetings with similar workers from other parts of the State, Territory or country, to showcase their projects, styles and models. Workers demonstrating good practice have good communication skills. They are aware of using language appropriate to the person they are talking to; the significance of body language and the ability to pick up on it; and the importance of respectful listening.
- **Commitment** from all levels of the organisation to the successful outcomes of the project.
- **Sound organisational policies and procedures:** Organisations with sound policies and procedures provide clarity and credibility to workers and service users, which encourage people to use the services with confidence.
- **Making a demonstrated difference in the lives of those being engaged in the process/project:** Actually making a difference to Indigenous peoples' lives is crucial to good practice. Ways in which this difference can be measured are through verbal feedback and observation as well as demonstration through increased participation in activities.
- **Building trust:** This takes time and it can't be assumed that it will just happen. Trust means that people are willing to reveal personal information and pain, in the belief that something will change as a result. This means that workers must provide a safe and comfortable environment in the physical sense as well as in the emotional sense.

6.4 Findings from the consultations

Consultations with service providers from accommodation, youth, alcohol and drug services, mental health and dedicated dual diagnosis programs, revealed a range of key aspects that are effective in engaging young people in access and treatment and which promote positive outcomes. Of most significance, was the need to appropriately adapt services to meet the unique needs and characteristics of the youth population, primarily engagement strategies, non-confrontational and non-judgemental approaches and working within a framework focused on strengths and practical solutions.

Achieving a youth-friendly focus

As discussed earlier in Chapter Four (4.6) young people consulted as part of this research reported that they valued the opportunity to be able to talk openly and honestly about their situation and issues of concern with workers. All young people, without exception, stated that having a trusting relationship with a practitioner(s) was the primary factor that they found most helpful in accessing (and maintaining involvement) with services. In addition, young people also stated that they felt most comfortable in an environment that was relaxed and welcoming, where they could witness other young people in attendance and where they could access appropriate information about a range of issues that they found of interest.

Services that were achieving this aspect in working with young people were youth services and youth specific drug and alcohol services. As was noted in Chapter Four (4.1.3) youth services were primarily focused on achieving effective and meaningful engagement with young people as part of their intervention approach. Youth specific drug and alcohol services (such as YSAS in Victoria and Next Step in WA) also had a major focus on engagement strategies and providing a youth-friendly/client-centred approach to intervention and treatment. Mental health services and dedicated comorbidity services acknowledged the importance of a youth-friendly approach to intervention with some practitioners commenting that their own service setting environment was clinical and inappropriate for young people.

A range of strategies were recommended by informants, including young people, and primarily centred on services employing experienced workers and clinicians who acknowledge that there are specific skills that are needed to work with dual diagnosed young people. Practitioners who have a thorough knowledge and understanding of adolescent development and particularly who understand the relationship between adolescent mental health issues and past trauma, such as childhood sexual abuse, abandonment, domestic violence and parental drug use, are needed in this field.

Appointment-based services were criticised by many in the youth-work field who noted that many dual diagnosed young people are subject to punitive consequences for missed appointments and non-compliant behaviour. As one service provider noted:

Appointments for these kids are a farce. More often than not they are unable to get their act together in time. They will then feel dejected and angry because they missed what may have been an important appointment. Many services are really unforgiving about this. Their expectations

of these kids is unrealistic – they expect them to behave like responsible adults, which if they were, they probably wouldn't need the appointment in the first place.

(Victorian Youth Worker)

Non-appointment-based services were seen by informants as the best way in which to achieve positive participation and outcomes for dually diagnosed young people. Where appointments are necessary, then workers and practitioners need to be mindful of appropriate times (i.e. outside of school hours, staying away from early morning appointments) and transport related issues. Participants noted that best practice often involved “holding hands” with young people in order to get them to key appointments. Assertive outreach was also cited by many service providers as an extremely effective method for engaging young people and getting them to necessary services on time.

Other aspects that were highlighted in the consultations as characteristic of a youth-work focus were as follows:

- appropriate responses to crisis-driven situations that provided concrete supports to meet young people's basic needs such as material aid, food vouchers, accommodation etc., and which encourages young people to return to the service allowing for the possibility of further engagement over time;
- flexible and assertive outreach service provision which aims to keep in touch with young people while they are waiting for services, provides appointment reminders (phone calls on the day, pick-up services, providing pre-prepared cab charge vouchers) and following up missed appointments;
- a holistic approach that is dedicated to working with the whole person and not just an aspect of “the issue”.

Inter-sectorial partnerships and integration

As was identified in the literature, the gap between mental health services and alcohol and drug services has significant implications for the effective treatment and management of those suffering a co-occurring disorder. Historically, mental health services developed separately to substance abuse services and as such have different underpinning principles, goals as well as priorities and treatment approaches. These competing interests have been found to contribute significantly to poorer outcomes for dual diagnosis clients and their families.

Consultations with service providers clearly indicated that a “seamless service” that involved the

expertise, skills and knowledge of both alcohol and drug practitioners as well as mental health clinicians was a key factor for best practice in the identification and treatment of dual diagnosis. However, consultations also highlighted the critical need for these services to adopt a youth-work and youth-friendly approach in working with young people, as adult approaches to engaging and maintaining young people's participation in treatment failed dismally. In addition, all service providers consulted agreed that assertive mobile youth outreach programs, consisting of appropriately-trained mental health and alcohol and drug practitioners, were highly-effective strategies for identifying and engaging dual diagnosed young people who also suffered extreme marginalisation.

Services that appeared to achieve the best outcomes for young people were those who viewed comorbidity as part of their core business, and therefore had considered the best ways in which to work alongside other relevant and key services such as mental health, accommodation and drug and alcohol services. The development of inter-agency protocols for sharing client cases was common within these programs and often had resulted in extended training initiatives between substance abuse services and mental health services.

Another significant marker in best practice strategies was the effort some service providers dedicated to the housing needs of their clients. For example, one service in Western Australia noted that the provision of active and assertive support for youth housing placements which involved engaging landlords, neighbours and other tenants was highly-effective in assisting security of tenure. Another service provider commented that if possible a variety of housing options should be considered for dual diagnosed young people, as standard approaches frequently do not work.

Another aspect that was raised by participants as part of an integrated approach was the need for relevant and appropriate assessment and diagnosis as well as shared referral and assessment tools.

All services consulted agreed that thorough assessment and accurate diagnosis of comorbidity in young people often occurred over a period of time and via a range of treatment interventions. Most mental health clinicians stated that there were difficulties in accurately diagnosing mental health issues in dual diagnosed young people, often due to the impact of environmental factors (such as homelessness, substance use and family difficulties) upon the young person's behaviour and presentation. Youth service practitioners commented that the establishment of a trusting and caring relationship with a young person

was often the only way to elicit the information and history needed to make a clear assessment. Workers also noted that many young people were practiced in concealing relevant details about their current situation until they were more confident about the parameters of their relationship with workers.

In respect to shared referral and assessment tools service providers noted that young people will often refuse to “tell their story” multiple times and tend to communicate different accounts to different services and workers. As one worker commented:

They are not idiots. Many of them have had to learn how to manipulate the system to meet their needs – when trying to get into a drug service they will minimise or deny their history of mental health involvement and to get into housing services they will conceal their drug use...

(NSW Youth Drug and Alcohol Worker)

Practitioners and workers from all sectors agreed that (when appropriately selected) common referral and assessment tools between like services encourage and support continuity of care, allow for improved streamlining of service integration and support long-term assessment processes and diagnosis.

Extended (long-term) flexible support

As was found in the literature on best practice, the provision of quality care and treatment for comorbid clients was seen to need a long-term perspective. Drake et al. (2001) stated that:

Effective programs recognise that recovery tends to occur over months or years and... effective programs therefore take a long-term, community-based perspective that includes rehabilitation activities to prevent relapses and to enhance gains.

(Drake et al. 2001)

All participants in the consultations, including young people, clearly stated that current interventions were commonly short-term with little, if any, follow-up support. Services noted that they were generally not funded to provide quality follow-up and their programs primarily designed to achieve short-term goals. Youth service providers were more likely to provide long-term involvement with young people who accessed their services, however they lacked the resources, specialist’s skills and training to effectively address and support young people with co-occurring disorders. Participants also noted in the consultations that long-term treatment should be focused on a strengths-based model that sought to achieve realistic and practical solutions in the young person’s life. Patience and tolerance were also cited as key approaches as well as:

- developing a long-term focus on treatment and support which is accepting of the nature of relapse and allows young people to return repeatedly to the service if necessary;
- the provision of a variety of creative approaches to working through issues such as art therapy, peer support and music rather than only talking therapies;
- a commitment from practitioners and services to continually restructure treatment interventions to be responsive to young people’s changing needs;
- ongoing assessment which is reviewed at regular intervals;
- that treatment should not be based on the client’s participation or fulfilment of program criteria;
- an awareness of the incidence of relapse and a knowledge of relapse prevention strategies;
- a willingness to address the range of crisis issues that often accompany comorbidity in young people (i.e. homelessness, family breakdown, lack of income, lack of participation in education etc.); and
- a commitment to treating both substance use and mental health problems as dual primary issues.

These factors are also supported in the literature, particularly best practice guidelines developed in the United States and UK.

6.5 Summary

Best practice in working with young people suffering co-occurring mental health and substance use problems has been identified through both the national and international literature. Consultations performed as part of this research provided further detail and meaningful insight on the practical application of strategies and approaches currently utilised in the Australian context, that are considered effective and achieving positive outcomes for these young people. Common elements of best practice can therefore be summarised as follows:

- Integrated models of intervention have proven more effective over parallel or sequential models.
- In working with young people suffering dual diagnosis it is essential for interventions to be youth focused and youth-friendly; non-judgemental; non-punitive; and cognisant of developmental issues, the impact of past trauma, and the tendency of clients to be non-compliant

with treatment (particularly medication regimes) and anti-social in behaviour.

- Non-appointment-based approaches to service provision offer higher rates of youth participation.
 - Assertive outreach models for accessing and engaging marginalised and disconnected dual diagnosed young people in services and treatment are most effective.
 - Implementation of common referral and assessment tools effectively limit the number of times a young person needs to “tell their story”.
 - Practitioners need to have a thorough understanding of relapse and relapse prevention strategies that are designed for young people.
- Intervention, assistance and treatment for dual diagnosed young people need to occur over the long-term, commonly over years rather than months.
 - A willingness to address the range of crisis issues that often accompany comorbidity in young people (i.e. homelessness, family breakdown, lack of income, lack of participation in education etc.).
 - A commitment to treating both substance use and mental health problems as dual primary issues and development of inter-agency protocols and procedures to facilitate shared case interventions.
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7 Recommendations

As has been reported in this study, comorbidity in young people is an issue that currently presents considerable difficulties across the health and community service sectors. Dual diagnoses has been reported as prevalent in up to 50% of people with mental health problems, and are particularly common among homeless young people. It has been established through this research and the current literature that young people with comorbidity receive inadequate clinical care (Davis 2003; Bradley and Toohey 1999), and that treatment costs for comorbid clients are disproportionately higher than other mental health treatments (Dual Diagnosis Resource Centre 2000). It has also been reported that young people suffering comorbidity are more likely to be homeless, disconnected from school, family and community and involved in the juvenile and/or criminal justice system. These factors, along with a rise in the general availability and potency of both licit and illicit drugs has had a significant impact on demand for services as well as damaging consequences for those most at risk (Dual Diagnosis Resource Centre 2000; Davis 2003; Bradley and Toohey 2000). Indigenous young people suffering comorbidity also face an array of further complex issues including intergenerational substance use and mental illness, difficulties in accessing mainstream services and, frequently, abstract poverty.

7.1 Policy level recommendations

Rationale

It has been well established and acknowledged throughout this research that there is a need for mental health and alcohol and other drug treatment services to overcome the conceptual and practice barriers that inhibit effective identification and treatment of young people with co-occurring disorders. This study has also highlighted the need for well-informed and effective youth-friendly approaches to sit alongside mental health and drug treatment strategies in order to successfully engage, maintain and re-engage (when necessary) young people's participation in the treatment process. Current best practice in Australia has included the development of protocols between sector services that are based on an ongoing, consistent working relationship. These protocols generally aim to ensure that service professionals are fully informed about the priorities and treatments that participating agencies are willing to provide, prior to the referral being made. Also highlighted in this report is that young people suffering co-occurring disorders respond favourably to long-term engagement and non-appointment-based services, particularly those who are homeless or otherwise marginalised from their family and community.

Recommendations:

1. That the Australian Government extend its efforts in the area of co-occurring mental health and substance use issues to include and highlight **young people** and **Indigenous young people** as a priority “at-risk” population for comorbidity. Such efforts should extend to relevant national initiatives such as the third NMHP, the NDS/NDSF, the National Suicide Prevention Strategy, the National Homeless Strategy and relevant National Indigenous strategies/policy directions. As each of these National Strategies has a pre-determined life, including timeframes for review and evaluation, it is recommended that consideration be given to the issue of comorbidity in young people as each strategy is reviewed.

2. That the Australian Government strongly encourage other relevant national strategies that currently extend a relationship to high risk or marginalised young people (i.e. Partnerships Against Domestic Violence, Stronger Families and Communities, the MCEETYA Ministers Declaration: *Stepping Forward – improving pathways for all young people etc.*) to ensure the issue of comorbidity in young people is recognised and appropriately addressed.

3. That governments ensure that funded mental health and alcohol and other drug services that provide treatment and assistance to young people (aged 12–25 years) suffering dual diagnosis, implement protocols for dual case management. In particular, the occurrence of a mental health problem (as well as mental illness) should be included in definitions of comorbidity in young people. Services should be strongly encouraged to work with such young people.

4. That governments review youth specific SAAP services to identify their allocated resources and their role in housing young people suffering comorbidity. In addition, SAAP services working with young people need to be encouraged to develop appropriate protocols with local drug and alcohol agencies as well as mental health services.

5. That national policy and funding acknowledge the important role of a youth specific focus in development of best practice in treatment approaches to assisting dual diagnosed young people.

6. That future funding of services for dual diagnosed young people acknowledge that such services frequently need to be long-term (i.e. twelve months duration), non-appointment-based, flexible in access times and venues, and adopt a non-punitive response to anti-social, volatile or aggressive behaviour. Such services need to have in place appropriate and sound policies, procedures and protocols for dealing with difficult to engage young people, based on current national and international best practice standards.

7. That the Australian Government further support and encourage the role of the National Comorbidity Project in addressing the range of policy issues apparent in the area of comorbidity in young people.

7.2 Service provider level recommendations

Rationale

As has been highlighted in this study, a client-centred approach to the provision of treatment and assistance to dual diagnosed young people proposes better treatment outcomes (particularly when the approach is of a long-term nature) and is considered best practice on both the national and international stage. A client-centred approach has been defined as a strategy that takes a client’s point view of the world and works within it.

...effective health treatment services are “client-centred”, in that they take individuals’ characteristics into account ... the unstable living circumstances and treatment histories of many dual diagnosis clients... dictates that effective and appropriate treatment be available at any point in the service delivery framework, regardless of the location or type of service involved.

(Dual Diagnosis Resource Centre 2000)

Recommendations:

8. Comorbidity should be seen by service providers in youth accommodation, drug and alcohol and mental health as a common occurrence rather than an “exception”. Drug and alcohol, mental health and youth accommodation services need to be funded and measured accordingly (currently there is duplication between services and a tendency to shift demand between each sector).

9. Drug and alcohol, youth accommodation and mental health services need to implement screening tools that appropriately cover dual diagnosis as part of general assessment processes for all young people accessing these services.

10. That service providers be supported and encouraged to adopt a youth-friendly, client-centred approach to working with young people in this target group. This includes meaningful involvement of young people in developing services, creating a youth-friendly environment and adopting a non-punitive approach to anti-social behaviour and/or non-compliance in treatment (particularly non-compliance in medicated therapy).

7.3 Early intervention

Rationale

The practical application of reducing risk and increasing resilience among young people at risk has been adopted by the Australian Government and some States and Territories in an array of policy and programmatic areas relating to families and young people at risk. In addition, many of the services consulted as part of this research had adopted a “strengths-based” and “solution-focused” approach to working with dual diagnosed young people and other high risk adolescent populations. The case for early intervention has also been cited by a number of specialist mental health services such as EPPIC in Victoria. Early identification of co-occurring mental health and substance use problems in young people is a key to reducing the risk that later adolescent years will almost certainly promise if a dual diagnosis condition goes unchecked and unidentified.

Recommendations:

11. That the Australian Government and the State and Territory Governments support prevention and early intervention initiatives in educational settings (including primary and secondary schools, TAFE and institutes of higher education) for the prevention and early identification and support for young people suffering co-occurring disorders.

12. That professional development for teachers, particularly secondary school year level coordinators is provided on the prevalence and indicators for comorbidity along with information for secondary consultation and referral services.

7.4 Intervention

Rationale

Currently, service provision in Australia has favoured an “integrated” treatment model for dual diagnosis (Drake and Noordsy 1995) in addition to the “parallel” or “sequential” service provision model. Recent efforts in Australia have been focused on the integration of mental health and drug and alcohol services; however the case for addressing the specific and unique issues for young people has largely been ignored. In particular, researchers such as Drake et al. (2001) note that services for comorbid people have traditionally been specialised, intensive and expensive over the short-term. However this is not the recommended pathway for addressing comorbidity in young people, rather a less intensive, longer-term perspective with a more generalist approach should be utilised, at least in the early stages of assessment and treatment. In addition, there has been some research to suggest

that approaches that favour dual diagnosis specialist workers within treatment teams “run the very real risk of overloading the specialist worker with ‘problem’ clients and of effectively deskilling other team members” (Dual Diagnosis Resource Centre 2000). In fact, the reality is that evidence-based treatment and intervention approaches to comorbidity are still in their infancy. For dual diagnosed young people, evidence-based interventions are virtually non-existent, however there is much to be learned from current work with high risk adolescent programs as well as recent Australian research (such as Davis 2003; Synnott and Laurie 2002; The Coffs Harbour Project; and the Victorian Dual Diagnosis Teams), which appears to be in the forefront of contemporary investigation in this area.

Recommendations:

13. That the Australian Government and the State and Territory Governments fund a range of youth-specific pilot treatment and intervention models for comorbidity that draw on and further test the findings of recent projects and research such as the partnership between South Sydney Youth Services and the Richmond Fellowship, NSW Caught In the Gap (NAAH); and the Victorian Connexions Project and Youth Dual Diagnosis Strategy (DHS).

14. That these pilot models are funded for at least a three-year period and operate alongside a separately-funded comprehensive formative and action-research evaluation plan. The findings of the evaluations would inform future evidence-based models for treatment and intervention for dual diagnosed young people.

15. That homelessness services receive further resources to adequately support the increased demand for housing and accommodation options for vulnerable and at-risk young people suffering comorbid disorders.

16. That all services working with young people suffering comorbid disorders adopt best practice standards which focus on appropriate and effective engagement strategies, tolerance for anti-social and volatile behaviour, provide an holistic approach (treating the whole person rather than the issue) and have a long-term focus.

17. That government, through the Commonwealth State Housing Agreement undertake a review into short, medium and longer-term accommodation options for dual diagnosed young people which include halfway housing, sole occupancy, and shared households – all with appropriately skilled and trained youth worker support.

18. That crisis services, including crisis youth accommodation services and SAAP services,

review their entry criteria and policies and procedures on exclusion, as it relates to dual diagnosed young people.

7.5 Continuing care and recovery

Rationale

As noted earlier in this report, there are few programs in operation that include a follow-up and/or exit component which aims to keep young people engaged in treatment and support services. Of those that are currently operating they are most commonly under-funded, lacking appropriate resources and skilled staff.

Recommendations:

19. That government look to increasing resources for programs and projects that work with dual diagnosed young people as a core business target group and dedicate resources for continuing care, recovery and follow-up services. Such services would be required, as part of a funding agreement, to design and develop appropriate tracking mechanisms which would add to the current knowledge base on dual diagnosed young people exiting services.

20. That services working with dual diagnosed young people look to integrating continuing care, recovery and follow-up strategies as part of their program services. This would include the involvement of immediate and/or extended family, friends and carers (where appropriate) in supporting the recovery process.

7.6 Law enforcement and police

Rationale

The Coffs Harbour Project was an Australian rural health and police interagency crime prevention initiative that sought to bridge the gap between mental health services and law enforcement when dealing with substance-using mentally ill people who are violent. Although the project did not focus on the plight of young people, the project investigated ways to develop health and police interagency cooperative management initiatives in dealing with comorbid clients. Following initial discussions the main problems identified were confusions and misunderstandings between police and their day-to-day dealings with mental health services. It was decided that these problems would be best addressed in the design, development and implementation of training sessions between police and mental health workers. The subsequent training initiative rated highly among law enforcement participants:

...we can conclude that the training content, format and presentation across different police and ranks was experienced by them consistently as beneficial in dealing more effectively with the dually disordered population they meet in the course of their policing duties.

(Bradley and Toohey 1999)

Highlighted in this research are the instances of young people with co-occurring disorders entering the juvenile justice or criminal justice systems. Frequently, young people suffering dual diagnosis find themselves disconnected from family, school and their community. They may become homeless, involved in the youth drug culture and subsequently participating in criminal activity. Both national and international research indicates that these young people need to be diverted into treatment rather than face criminal charges and punitive consequences. In addition, juvenile and adult justice systems commonly operate on an appointment-based system (particularly for community-based orders) and show consistently high rates of failure and non-attendance at these services by young people. This often results in worsening outcomes for young people including incarceration and hospitalisation.

Recommendations:

21. That juvenile and adult justice systems reconsider the appropriateness of appointment-based systems for young people who are suspected of suffering co-occurring substance use and mental health problems.

22. That young people, particularly those aged less than 18 years of age, who are offenders and have a substance use issue, are appropriately assessed for a co-occurring mental health problem and/or mental illness.

23. That governments develop appropriate training packages for police, juvenile justice and adult justice workers, loosely based on the Coffs Harbour Police Liaison Training Program and which reflect best practice standards in the identification and treatment approach for dual diagnosed young people.

7.7 Indigenous services

Rationale

As highlighted throughout this report the issues faced by Indigenous young people are largely set within their families and communities. In many Indigenous communities consulted as part of this research, young people with substance use and/or mental health problems are living within a setting that is characterised by a lack of basic infrastructure. Research clearly indicates

that the social and emotional health of these young people will be improved if their living environment is brought up to a standard that most non-Indigenous Australians enjoy. Further, there are many Indigenous communities where intergenerational substance use and mental health issues are extremely prevalent (i.e. Alice Springs and rural areas of the Northern Territory and Western Australia). These issues frequently sit alongside other critical issues such as extreme poverty, high rates of incarceration and parental substance use.

The provision of dedicated comorbidity services to Indigenous young people is not supported by this research and clearly does not fit within the best practice framework of Indigenous social and emotional wellbeing.

However, as noted in Chapter Six of this report there are a range of elements of good organisational practice within Indigenous communities. Services that are culturally appropriate for Indigenous communities and their young people are needed urgently.

Recommendations:

24. That government address the basic health needs of Indigenous communities in rural and remote areas, particularly in regard to the provision of basic and adequate infrastructure to improve the environment health of such communities.

25. That government continue to support, adequately maintain and increase (where needed) culturally appropriate dedicated resources to Indigenous social and emotional health policy and implementation initiatives.

26. That the issue of co-occurring substance use and mental health problems in young Indigenous people is set with current frameworks of social and emotional wellbeing and considered the responsibility of government departments implementing policy that address broader health issues within Indigenous families and communities.

27. That government increase funding to key Indigenous services that are currently working with populations and communities where substance use and mental health problems are prevalent so that youth specific Indigenous services can be developed and provided, where appropriate. Funding for these services must sit within an Indigenous framework of social and emotional wellbeing and be subject to the advice and directions of the Indigenous community.

28. That governments increase funding and support to the provision of Indigenous workers within mainstream services to increase potential access points for Indigenous young people with co-occurring disorders.

7.8 Education and training

Rationale

The Dual Diagnosis Resource Centre (2000) notes that traditionally there has been a low profile accorded to substance abuse issues in the education and training of mental health professionals. Research indicates that many mental health clinicians lack formal training, knowledge and expertise in dealing with drug and alcohol issues even though a considerable proportion treat such patients (Aanavi et al. 1999). This is also apparent in the training curricular for medical staff and general practitioners. Similarly, substance abuse workers lack training, knowledge and expertise in the identification of mental health issues, and as reported earlier in this study, many do not understand the definitional separation of a mental health problem and mental illness.

Consequently, the knowledge and skills of workers in mental health and substance abuse settings about each other's fields of practice has been insufficient to ensure effective treatment of dual disordered clients in either setting.

(Dual Diagnosis Resource Centre 2000)

Research from Australia and the international stage indicates that there are some problems in translating training knowledge into practice. Many training practitioners argue that skills that are gained during training are frequently lost if they are not practiced or utilised in real life situations (Jenner et al. 1998). In addition it has also been reported that there is some resistance, particularly by senior mental health clinicians, to further training. Furthermore, the complex language and competing agendas among clinical services make it difficult for non-clinical service sectors to access clinical services for on behalf of their clients. Earlier in this report it was noted that some youth agencies will hire workers with a psychiatric training background as a strategy to access clinical mental health services for particular clients.

Recommendations:

29. That mental health services acknowledge that substance use among clients with a mental illness or mental health problem is "the norm" rather than the exception. Training for mental health workers needs to cover the indicators, circumstances, issues and best practice strategies for engagement and relapse prevention in working with dual diagnosed young people.

30. That governments implement a well-planned, coordinated training program for NGO's and government-run mental health and alcohol and drug services, that takes account of the diversity of the

health care and community services systems and which is informed by best practice standards for working with young people.

31. That funding is provided as part of a professional development package for current services and staff in the non-government sector, on the issues and current best practice for working with dual diagnosed young people. Such training needs to be updated regularly to reflect new and emerging data and information.

32. That government provide funding for the design, development and implementation of training on comorbidity in young people for juvenile justice and criminal justice systems.

References

- Allen N, Lubman D, Bonomo Y, Cementon E, & Rogers N (2003) *Developing a Best Practice Dual Diagnosis Model for Young People Presenting at a Youth Drug Treatment Service*. Published on the Infoxchange website: <http://www.healthnews.infoxchange.net.au/group/noticeboard/items/20031006003.doc>, accessed April 2004.
- American Federation of Families for Children's Mental Health (2001) *Blamed and Ashamed: the Treatment Experiences of Youth with Co-occurring Substance Abuse and Mental Health Disorders and Their Families*.
- Aanavi M, Taube D, Ja D, and Duran E, (1999) 'The status of psychologists' training about and treatment of substance-abusing clients' in *Journal of Psychoactive Drugs*. 31(4):441-44.
- Australian Bureau of Statistics (August 2003) *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples: Ill Health*. ABS Catalogue No. 4704.0.
- Australian Government Department of Health and Ageing (2000) *LIFE: Living Is For Everyone: A framework for Prevention of Suicide and Self-Harm in Australia*.
- Australian Government Department of Health and Ageing (2003) *National Drug Strategy*.
- Australian Government Department of Health and Ageing (2004) *Barriers and Incentives to Treatment for Illicit Drug Users*. LMS Consulting, National Centre in HIV Social Research (University of New South Wales), Australian Injecting and Illicit Drug Users League.
- Australian Institute of Health and Welfare (2003) *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2003*.
- The Australian National Audit Office (1999) *National Aboriginal Health Strategy – Delivery of Housing and Infrastructure to Aboriginal and Torres Strait Islander Communities*, Audit Report No 39, 1998-99.
- Beautrais A, Joyce P & Mulder R (1998) 'Youth Suicide Attempts: A Social and Demographic Profile' in *Australian and New Zealand Journal of Psychiatry*. 1998, 32: 349-357.
- Benard, B (1991) *Fostering Resilience in Kids: Protective factors in the family, school, and community*. Western Regional Centre for Drug-free schools and communities. NWREC, USA.
- Benfer B (2002) 'Dual Diagnosis: An Integrated Model for the Treatment of People with Co-Occurring Psychiatric and Substance Abuse Disorders in Managed Care Systems' in *Journal of Psychosocial Nursing & Mental Health Services*. Vol. 70(11):49.
-

- Berry M, MacKenzie D, Briskman L & Ngwenya T (2001) *Victorian Indigenous Homelessness Study: Final Report*. Aboriginal Housing Board of Victoria.
- Bijl R, de Graaf R, Hirpi E, Kessler R, Walters E, Kohn R, Offord D, Ustun B, Vicente B, Vollebergh W, Wittchen H & Planck M (2003) 'The Prevalence of Treated and Untreated Mental Disorders in Five Countries' in *Health Affairs*. Vol. 22(3):122-133.
- Bradley A & Toohey B (2000) *The Coffs Harbour Project: A Violence Prevention Program For Substance Misusing Mentally Ill*. Commonwealth Department of Human Resources and Health – Drug Crime Prevention.
- Brady S, Hiam C, Saemann R, Humbert L, Flemming M & Dawkins-Brickhouse K (1996) 'Dual Diagnosis: A Treatment Model For Substance Abuse and Major Mental Illness' in *Community Mental Health Journal*. Vol. 32(6):573-8.
- Burdekin B (1989) *Our Homeless Children: Report of the National Inquiry into Homeless Children*. HREOC, Canberra.
- Burrows D (1994) *Contradictory Strategies: HIV and Drugs*. Australian Federation of AIDS Organisations, Canberra.
- Canadian Department of Health (2002) *Best Practices: Concurrent Mental Health and Substance Use Disorders*; Centre for Addiction and Mental Health, Ottawa, Ontario.
- Carey K (1996) 'Treatment of co-occurring substance abuse and major illness' in Drake R and Mueser K (eds) *Dual Diagnosis of Major Mental Illness and Substance Abuse*. Vol 2:19-31 San Francisco.
- Co-occurring Mental and Substance Disorders (Dual Diagnosis) Panel (CMHASD) (1998) *Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice guidelines, Workforce Competencies, and Training Curricula*. Centre for Mental Health Services, Rockville.
- Cuffel B & Chase P (1994) 'Remission and Relapse of Substance Use Disorders in Schizophrenia – Results from a One-Year Prospective Study' in *Journal of Nervous Mental Disorders*. Vol 182: 342-348.
- Dadds M (2000) *The Comorbidity of Substance Use and Emotional Disorders: Potential for Innovative Prevention Strategies*. Prepared for the National Comorbidity Project Workshop, March 6&7.
- Davis, C, (2003) *Caught in the Gap: Dual Diagnosis and Young People. A report of the issues, August 2003*. NSW Association for Adolescent Health.
- De Leo, D. et al. (1999) *Aging and Suicide: A Report to the Commonwealth Department of Health and Aged Care*. Australian Institute for Suicide Research and Prevention, Griffiths University, Queensland.
- Department of Health (2002) *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide*. Department of Health, London.
- Donald M, Dower J & Chen L (2003) *Literature Review in Current Practice in the Management of Clients with Comorbid Mental Health and Substance Use Disorders in Tertiary Settings*. Australian Government Department of Health and Ageing, Canberra.
- Drake R, Osher F, et al (1990) 'Diagnosis of alcohol use disorders in schizophrenic patients' in *Schizophrenia Bulletin*. Vol 1(16):57-67.
- Drake R and Wallach M (1993) 'Moderate drinking among people with severe mental illness' in *Hospital and Community Psychiatry*. 44(8):780-782.
- Drake R and Wallach M (2000) 'Dual Diagnosis: 15 years of progress' in *Psychiatric Services*. Vol 51(9):1126-9.
- Drake R Essock S, Shaner A, Carey K, Minkoff K, Kola L, Lynde D, Osher F, Clark R & Rickards L (2001) 'Implementing Dual Diagnosis Services for Clients With Severe Mental Illness' in *Psychiatric Services*. Vol. 52:469-476.
- Drake R, Mercer-McFadden C, Mueser K, McHugo G & Bond G (1998) 'Review of Integrated Mental Health and Substance Abuse Treatment for Patients with Dual Disorders' in *Schizophrenia Bulletin*. Vol. 24(4):589-608.
- Fuller A (1998) *From Surviving to Thriving – Promoting Mental Health in Young People*. ACER Press, Melbourne.
- Jenner L, Kavanagh D, Greenaway L, Saunders J, (1998) *Dual Diagnosis Consortium: 1998 Report*, Dual Diagnosis Consortium, Brisbane.
- Hirst C (1989) *Forced Exit*. Salvation Army, Melbourne.
- Holmwood C (2003) *Comorbidity of Mental Health Disorders and Substance Use in General Practice: A brief guide for the primary care clinician*.

- Australian Government Department of Health and Ageing, Canberra.
- Kavanagh D (2000) *Treatment of Comorbidity*. National Workshop of the National Comorbidity Project, Canberra.
- Kavanagh D, Young R, Boyce L, Clair A, Sitharthan T, Clark D & Thompson K (1998) 'Substance Treatment Options in Psychosis (STOP): A New Intervention for Dual Diagnosis' in *Journal of Mental Health*. Vol. 7(2):135-143.
- Labeled J (2003) *Collaborating for Change: Building Blocks for Working with People who have Mental Health and Substance Use Issues*. Tasmanian Community Advisory Group on Mental Health (TasCAG).
- Lehman, Herron, Schwartz, & Myers (1993) 'Rehabilitation for Adults with Severe Mental Illness and Substance Use Disorders – A Clinical Trial' in *Journal of Nervous & Mental Disease*. Vol.181(2):86-90.
- Ley A, Jeffrey D, McLaren S, Siegfried N, (1999) *Treatment programmes for people with severe mental illness and substance misuse*. Cochrane Review, Vol 3, Oxford.
- Loneck B, Banks S, Way B & Bonaparte E (2002) 'An Empirical Model of Therapeutic Process For Psychiatric Emergency Room Clients With Dual Disorders' in *Social Work Research*. Vol. 26(3):132-144.
- McCabe D & Holmwood C (2003) *Comorbidity of Mental Health Disorders and Substance Use in General Practice*; Australian Government Department of Health and Ageing, Canberra.
- Marriman S, Herman A, Stewart S, Arbel-Itzhari L & Woolfe B (2003) 'Dual Diagnosis: Implications for Young People' in *Parity*.
- Matheson D (2000) *Keynote Presentation to Second International Primary Health Care Conference*. Melbourne.
- Mather C, Vos T & Stevenson C (1999) *The Burden of Disease and Injury in Australia*. Australian Institute of Health and Welfare, Canberra, AIHW cat no PHE 17.
- Ministerial Council on Drug Strategy (2003) *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan, 2003-2006*. Background Paper, Commonwealth of Australia.
- Minkoff K (2001) 'Developing Standards of Care for Individuals with Co-occurring Psychiatric and Substance Use Disorders' in *Psychiatric Services*. Vol. 52(5):597-599.
- Mueser K, Bennett M & Kushner M (1995) 'Epidemiology of Substances Use Disorders Among Persons With Chronic Mental Illness' in Lehman A & Dixon L (eds) *Double Jeopardy: Chronic Mental Illness and Substance Use Disorders*; Chur, Switzerland, Harwood Academic.
- Mueser K, and Noordsy, D (1996) 'Group Treatment of Dually Diagnosed Clients' in Drake R and Mueser K (eds) *Dual Diagnosis of Major Mental Illness and Substance Abuse*. Vol 2:19-31.
- National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003) *Consultation Paper*. NATSIHC, Canberra.
- Noble D (1999) 'Lives at Risk: Understanding and Treating Young People with Dual Disorders' in *Families in Society*. Vol. 80(1):102-103.
- Norden P (2001) 'Heroin Use as a Form of Self-Medication' in *Parity*. September.
- New South Wales Association for Adolescent Health (2003) *Dual Diagnosis and Young People*. NSW Association for Adolescent Health.
- New South Wales Health Department (2000) *The Management of People with a Co-existing Mental Health and Substance Use Disorder – Service Delivery Guidelines*. NSW Health Department, NSW.
- Parker S (1998) 'More isn't always better for dual diagnosis' in *Clinical Psychiatry News*. Vol 26(5):26.
- Prochaska J, DiClemente C, Norcross J, (1992) 'In search of how people change: Applications to addictive behaviors' in *American Psychologist*. Vol. 47:1102-1114.
- Ryglewicz H, & Pepper B (1996) *Lives at Risk: Understanding and Treating Young People with Dual Disorders*. The Free Press, New York.
- Robinson S, Gomes A, Pennebaker D, Quigley A & Bennetts A (2001) *Co-occurring Mental Illness & Substance Abuse – A Service Review*. The Centre for Mental Health Services Research Inc., Perth.
- Royal Commission into Aboriginal Deaths in Custody: Overview and Recommendations* (1991). Canberra, Australian Government Printing Service.
- Schultz L, Schultz M (2004) *Barriers and Incentives to Treatment for Illicit Drug Users* (Draft Report; unpublished). Australian Government Department

- of Health and Ageing (DoHA) National Centre in HIV Social Research and the Australian Injecting and Illicit Drug Users League.
- Scrimgeour D (1994) 'Community Involvement in Health Services for Indigenous Peoples of Canada, Norway and New Zealand' in *Occasional papers/Menzies School of Health Research*. Vol. 2:95. Alice Springs, N.T.
- Siggins Miller Consultants (2003) *Current Practice In The Management Of Clients With Comorbid Mental Health And Substance Use Disorders In Tertiary Care Settings*. Australian Government Department of Health and Ageing, Canberra.
- Silburn S, Zubrick S and Hayward L (1990) *Completed Suicide in Western Australian Youth: A Study of 96 Cases Aged 15-24 Years*. Paper presented at 1990 conference – Preventing Youth Suicide, Australian Institute of Criminology, Adelaide.
- Sitharthan T et al (1999) 'Integrated drug and alcohol intervention: Development of an opportunistic intervention program to reduce alcohol and other substance use among psychiatric patients' in *Australia and New Zealand Journal of Psychiatry*. Vol.33(5):676-683.
- Sloboda Z (1999) *Problems for the Future? 'Drug Use among Vulnerable Groups of Young People' in Drugs: Education, Prevention and Policy*. Vol. 6(2):195-201.
- Social Health Reference Group (2003) *Consultation paper for Development of the Aboriginal and Torres Strait Islander National Strategic Framework for Mental Health and Social and Emotional Well Being 2004 – 2009*. Australian Government Department of Health and Ageing, Canberra.
- State Task Force on Dual Diagnosis (2002) *Final Report and Recommendations*. Dual Diagnosis Recovery Network, Tennessee.
- Steele D & Rechberger E (2002) 'Meeting the Treatment Needs of Multiply Diagnosed Consumers' in *Journal of Drug Issues*. Vol. 32(3):811-824.
- Success Works (1998) '*Living is the Best Option: Young Women's Project*' – Evaluation of Youth Suicide Prevention Initiative for the National Youth Suicide Prevention Strategy. Commonwealth Department of Health and Family Services.
- Success Works (1999) *Health Services Framework for People Experiencing Homelessness*. Royal District Nursing Service.
- Success Works (1999) *Involving Families in the Treatment of Young People with Problematic Substance Use*. 2001) *Evaluation of the High Risk Adolescent Quality Improvement Initiative*. Department of Human Services Victoria, Aged and Community Mental Health Division, Drug Treatment Service.
- Success Works (2001) *Evaluation of the High Risk Adolescent Quality Improvement Initiative*. Department of Human Services, Victoria.
- Success Works (2003) *Evaluation of Responses to the 'Bringing Them Home' Report*. OATSIA.
- Success Works (2004) *Development of a Harm Minimisation Policy Framework*. Department of Human Services, Victoria.
- Swan P & Raphael B (1995) *Ways Forward – National Consultancy report on Aboriginal and Torres Strait Islander Mental Health*; National Mental Health Strategy, AGPS, Canberra.
- Synnott E and Laurie G (2002) *Mental Health and Substance Use Treatment Services for Youth at Risk: Evaluation of a four year partnership*. Richmond Fellowship of NSW and South Sydney Youth Service.
- Tanti C (1998) 'Why SUMITT?' in *Parity*. Vol.11(8):8-9.
- Taylor R et al (1998) 'Suicide in NSW, Australia, 1985-1994: socio-economic and migrant interactions' in *Social Science and Medicine*. Vol. 47(11):1677-1686.
- Teesson M (2000) *Background Paper – National Workshop of the National Comorbidity Project*. Canberra.
- Teesson M & Byrnes L (2002) National Comorbidity Project, National Drug Strategy and National Mental Health Strategy. Commonwealth Department of Health and Aged Care, Canberra.
- Tickell C (1999) 'Comorbidity – The Social Implications' in *Drugs: Education, Prevention and Policy*. Vol. 6(2):175-179.
- U.K. Department of Health (2002) *Dual Diagnosis Good Practice Guide*.
- U.S. Department of Health and Human Services (2003) *Co-occurring Mental and Substance Abuse Disorders: A Guide for Mental Health Planning and Advisory Councils*. Washington.
- U.S. Department of Health and Human Services (2003b) *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental*

Illness and/or Co-occurring Substance Use Disorders. Washington.

Wanganeen R (2001) 'Spiritual Healing Using Loss and Grief' in *Aboriginal and Islander Health Worker Journal*. Vol. 25(5):12-13.

Withers G and Russell J (1998) *Educating for Resilience – Prevention and Intervention Strategies for Young People at Risk*. Melbourne, Catholic Education Office, MacKillop Family Services and DHS Victoria.

Wray D (2003) *Adapt Program – Discussion Paper*. Published on the internet: www.swsahs.nsw.gov.au. Accessed April 2004.

Appendices



Appendix One: List of organisations consulted

ACT

Youth Justice Services (Donna Castledine, Toni Kuschert)
Youth Coalition of the ACT (Susan Pellegrino)
Intensive Support Program (Mark Baldwin)
Mental Health ACT (Steve Hartnett)
YWCA Youth Services (Kevin Ruddick)
Diversion Service, Alcohol and Drug Program (Glenda McCarthy)
Winnunga Nimmityjal AHS (Lee-Anne Daley, Harold Chatfield)
Youth in the City (Carrie Fowlie)
Junction Youth Health Service (Joanne Brown)

New South Wales

Rivendell Child and Adolescent and Family Psychiatric Services (Charles)
Nepean Hospital Drug and Alcohol Services (Steve)
NSW Association for Adolescent Health
Yaeralla Youth Services (Mary)
Crossroads Youth Service
NSW Association for Adolescence Health (Abigail Elliot)
Wentworth AHS (Stephen Ward)
Wentworth Area D&A (Hermann)
NSW Health (Giles Barton, David McGrath)
Drug and Alcohol Community Youth and Adult Teams (Miriam O'Toole)
Salvation Army, Endeavour Hills (Heather Drew, Graham Drew, Maxine Marquez, Tony Santos, Major Alan Dreyton)
Waverley Action for Youth Services (Jisela Gootmann, Amanda Webster)
Dual Diagnosis Program for Youth at Risk Services (Suzie Walker, Julie-Ann Glades, Karen Wells, Amanda Middleton)
The Coffs Harbour Project (Barry Toohey)

Northern Territory

Early Intervention of TEMHS, Tamarind Centre (Ruth O'Brien)
Anglicare Youth Programs, (Tony Forrester, Sam Herry and Anant Kaur)
Central Aus Alcohol and Other Drug Service in Alice Springs (Phillippa Galligan)

Queensland

Adolescent Drug and Alcohol Service, Brisbane (Michelle Kerr and staff)
Queensland Health, Brisbane (Tania Murray and Ian Young)
Aspley Community Health Centre (Kelly and Margaret Ness: Psychologists with The Hot House, organised by Vanessa Winchester)
Brisbane Youth Service (Robyn Bolden)

South Australia

Department of Human Services (Kim Petersen)

Streetlink Youth Health Service (Andrew Drummond)

Shopfront Youth Health and Information Service (Deb Odgers and Sharon Wright)

Marion Youth Centre (Ben Smith)

Northern Area Community and Youth Services (Jeremy Stone and Kirk Jones)

Mission Australia – Hindmarsh Sobering Up Centre (Leonne Karlsson and Dave Porter)

DASC (Eva Betz)

Youthlink (Ann Crago)

CAMHS (Ian Dobson Gidgetta Salmone Violi)

Womens and Childrens Hospital – Mental Health Services (Cheryl Green)

The Second Story (Lyn Matthews)

Child and Youth Health (Jane Carlisle)

Tasmania

Department of Health and Human Services (Tony Law and Jerry Lambersona)

The Link Youth Health Service (Lianne Barden and Staff)

Colony 47 (Danita Sherrin)

Victoria

SHARC – Self Help Addiction Resource Centre (Gordon Storey)

The Buoyancy Foundation of Vic (Deborah Honburg)

The Youth Substance Abuse Service (David Murray)

Department of Psychiatry, University of Melbourne (Kathryn Elkins)

Odyssey Institute (Neos Zavrou and Miranda Manning)

Western Australia

Youth Link (Denise Follett and staff)

Next Step (Tania Towers)

Ruah-in-Reach (Megan Roseworn)

NASAS (Noongar Alcohol and Substance Abuse Service) (Danny Penny)

Mission Australia (Carmen Acosta and staff)

Joint Services Unit (Richard Bostwick)

WANAADA (Jill Rundle)

CAMHS – South West Metro Area (Patrick Marwick)

Appendix Two: Questionnaire pro-forma's Focus group background questionnaire

Your Name: _____

Your Position: _____

Your Service/Program: _____

State/Territory: _____

What does your Service/Program do? *(Please give a brief description)*

What are the primary target groups of clients of your Service/Program?

Is your Service/Program specifically for people with comorbidity? Yes/No

If so, approximately what proportion would be aged between 15–24 years?

If not, approximately what proportion of your client base would have comorbidity?
Of these how many would be aged between 15–24 years?

Focus group moderator's guide

Success Works has been commissioned by the Department of Family and Community Services with the National Youth Affairs Research Scheme (NYARS) to undertake an ad hoc research study about the barriers to service provision for young people with presenting substance misuse and mental health problems. The three principle objectives of the study are:

1. To map current practices and structural, cultural and other barriers in youth accommodation and other services that impede access by an appropriate service provision to clients with substance misuse and mental health problems.
2. To identify what strategies could be utilised to overcome these barriers.
3. To identify models of good practice in working with these clients.

Current practices

- Q1. How do clients access your service/program? (*i.e. Referral by self/family/health professional etc.*)
- Q2. What happens after clients access your service? (*i.e. Assessment process, referral to another service, provision of information etc.*)
- Q3. How and when are clients moved from assessment to treatment?
- Q4. What is your treatment philosophy?
- Q5. What are the main features of your treatment program?

Tick where appropriate:

• Integrated	• Longitudinal	• Building of rapport/re'ship
• Motivation Interviewing	• Phased interventions	• Family/other included
• Treated as dual disorders	• Treated in one setting	• Individualised
• Outreach	• Trained in comorbidity	• Intervention/s evaluated
• Engage all client issues including those outside usual boundaries (<i>e.g. homelessness</i>)	• Client's social networks considered	• Clinicians are welcoming, empathetic, empowering and hopeful
• Quality management (outcome measures, practice guidelines, training materials, consumer/carer evaluation)	• Other (<i>please specify</i>)	• Other (<i>please specify</i>)

- Q6. What is a "typical" client treatment pathway?

Q7. What is the process for follow-up and exit?

Barriers

Q8. What are the barriers for people with comorbidity in accessing services/programs?

Tick where appropriate:

• Cultural	• Gender related	• Policy/Program related
• Complexity	• Skills/training of clinicians	• Denial
• Minimisation	• Clinical	• Family
• Age related	• Education related	• Other (<i>please specify</i>)

Q9. What are the barriers that specifically relate to *young people* with comorbidity in accessing services/programs?

Good strategies and practices

Q10. What are good strategies and practices for working with people with comorbidity?

Q11. What are good strategies and practices for working specifically with *young people* with comorbidity?

Q12. Please describe and name any service, which you consider is implementing effective strategies and practices for young people with comorbidity?

Conclusion

Q13. If there was one thing you could implement to improve services for young people with comorbidity, what would it be?

Individual services

Success Works has been commissioned by the Department of Family and Community Services with the National Youth Affairs Research Scheme (NYARS) to undertake an ad hoc research study about the barriers to service provision for young people with presenting substance misuse and mental health problems. The three principle objectives of the study are:

1. To map current practices and structural, cultural and other barriers in youth accommodation and other services that impede access by an appropriate service provision to clients with substance misuse and mental health problems.
2. To identify what strategies could be utilised to overcome these barriers.
3. To identify models of good practice in working with these clients.

Name/Position of people met: _____

Service/Program Name: _____

State/Territory: _____

Current practices

- Q1. How do clients access your service/program? (*i.e. Referral by self/family/health professional etc.*)
- Q2. What happens after clients access your service? (*i.e. Assessment process, referral to another service, provision of information etc.*)
- Q3. How and when are clients moved from assessment to treatment?
- Q4. What is your treatment philosophy?
-

Q5. What are the main features of your treatment program?

Tick where appropriate:

• Integrated	• Longitudinal	• Building of rapport/re'ship
• Motivation Interviewing	• Phased interventions	• Family/other included
• Treated as dual disorders	• Treated in one setting	• Individualised
• Outreach	• Trained in comorbidity	• Intervention/s evaluated
• Engage all client issues including those outside usual boundaries (<i>e.g. homelessness</i>)	• Client's social networks considered	• Clinicians are welcoming, empathetic, empowering and hopeful
• Quality management (outcome measures, practice guidelines, training materials, consumer/carer evaluation)	• Other (<i>please specify</i>)	• Other (<i>please specify</i>)

Q6. What is a "typical" client treatment pathway?

Q7. What is the process for follow-up and exit?

Barriers

Q8. What are the barriers for people with comorbidity in accessing services/programs?

Tick where appropriate:

• Cultural	• Gender related	• Policy/Program related
• Complexity	• Skills/training of clinicians	• Denial
• Minimisation	• Clinical	• Family
• Age related	• Education related	• Other (<i>please specify</i>)

Q9. What are the barriers that specifically relate to *young people* with comorbidity in accessing services/programs?

Good strategies and practices

Q10. What are good strategies and practices for working with people with comorbidity?

Q11. What are good strategies and practices for working specifically with *young people* with comorbidity?

Q12. Please describe and name any service, which you consider is implementing effective strategies and practices for young people with comorbidity?

Conclusion

Q13. If there was one thing you could implement to improve services for *young people* with comorbidity, what would it be?

Client interview guide

Success Works has been commissioned by the Department of Family and Community Services with the National Youth Affairs Research Scheme (NYARS) to undertake an ad hoc research study about the barriers to service provision for young people with presenting substance misuse and mental health problems. The three principle objectives of the study are:

4. To map current practices and structural, cultural and other barriers in youth accommodation and other services that impede access by an appropriate service provision to clients with substance misuse and mental health problems.
5. To identify what strategies could be utilised to overcome these barriers.
6. To identify models of good practice in working with these clients.

First Name: _____

Age: _____

Gender: _____

Service: _____

State/Territory: _____

- Q1. How did you come in contact with this service?
 - Q2. Could you tell me a little bit about yourself?
 - Q3. How long have you been coming here?
 - Q4. Did you try any other places?
 - Q5. What do you think of mental health services?
 - Q6. What do you think of drug and alcohol services?
 - Q7. What sorts of things have you found to be helpful? Why?
 - Q8. What sorts of things have set you back? Why?
 - Q9. What sorts of the things would have helped or supported you?
 - Q10. If you could change one thing about the system, service or program to improve it, what would it be?
-

Sector focus groups or individual interviews

Community Health Centres, Employment Agencies, Homeless Accommodation Services

Names of people met: _____

Name of Service: _____

Type of Service: _____

State/Territory: _____

Q1. What is your role?

Q2. What does your organisation do?

Q3. What is your client target group(s)?

Q4. Do you see clients with mental health issues? _____ YES/NO

Q5. Do you see clients with drug and alcohol issues? _____ YES/NO

Q6. Do you see clients with both mental health and drug and alcohol issues? _____ YES/NO

Q7. Do you see young people aged between 15 and 24 years? _____ YES/NO

Q8. Do you see young people with both mental health and drug and alcohol issues? YES/NO

Q9. If YES

Q9.1 What proportion of your client group would be young people with mental health and drug and alcohol issues?

Q9.2 How have they come to access your service?

Q9.3 What do you think are the barriers that may prevent or inhibit them from accessing your service?

Q9.4 What does your service do to assist and support young people with mental health and drug and alcohol issues?

Q9.5 What else could be done by your service to assist and support young people with mental health and drug and alcohol issues?

Q10. If NO

Q10.1 Why not?

Q10.2 Do you think there are barriers for young people with mental health and drug and alcohol issues accessing your service?

Q10.3 What could be done about these?

Q11. If UNSURE

Q11.1 How come?

Appendix 3: NDS Aboriginal and Torres Strait Islander peoples complimentary action plan (2003–2006) key result areas

The action plan is structured around six key result areas.

Enhanced capacity of Aboriginal and Torres Strait Islander individuals, families and communities to address current and future issues in the use of alcohol, tobacco and other drugs and promote their own health and wellbeing.

Whole-of-government effort and commitment, in collaboration with community controlled services and other non-government organisations, to implement, evaluate and continuously improve comprehensive approaches to reduce drug-related harm among Aboriginal and Torres Strait Islander peoples.

Substantially improved access for Aboriginal and Torres Strait Islander peoples to the appropriate range of health and wellbeing services that play a role in addressing the use of alcohol, tobacco and other drugs.

A range of holistic approaches from prevention through to treatment and continuing care that is locally available and accessible.

Workforce initiatives to enhance the capacity of Aboriginal and Torres Strait Islander community-controlled and mainstream organisations to provide quality services.

Sustainable partnerships among Aboriginal and Torres Strait Islander communities, government and non-government agencies in developing and managing research, monitoring, evaluation and dissemination of information.

Each key result area contains a number of objectives, key action areas and examples of actions. The objectives are structured around actions that apply to the whole result area: control of supply, demand management, harm reduction, early intervention and treatment.

