Comorbidity framework for action

NSW Health Mental Health/Drug and Alcohol

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SHPN (MHDAO) 080017
ISBN 978 1 74187 220 0

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April 2008

Contents

Acknowledgements ... 2

Executive summary ... 3

Section 1. Introduction ... 4

Definition of comorbidity ... 4

Context ... 4

Section 2. Nature of the document ... 6

Governance ... 6

Implementation ... 6

Evaluation ... 7

Section 3. Action areas ... 8

Action area 1. Workforce planning and development ... 8

Action area 2. Infrastructure and systems development ... 11

Action area 3. Promotion, prevention and early intervention ... 13

Action area 4. Priority clients and settings ... 15

Appendix 1. Development of the framework for action ... 19

References ... 24

Contact ... 24

Acknowledgements

The development of this Framework for Action has been supported by the advice and input of many individuals and organisations.

This includes the Australian College of Emergency Practitioners, NSW Alliance of General Practice, Aboriginal Health and Medical Research Council, Network of Alcohol and other Drug Agencies (NADA).

The development of the Framework has also only been possible with the guidance of the NSW Health Comorbidity Subcommittee (a subcommittee of both the NSW Health Drug and Alcohol Council and the NSW Health Mental Health Program Council), including representation from Mental Health Coordinating Council Network of Alcohol and other Drug Agencies (NSW) representatives from the Area Health Services, Justice Health, and the NSW Department of Health.

Executive summary

NSW Health has created this Framework for Action to respond to issues posed by comorbidity in the State's health settings. It has been developed around four key areas that are our agreed immediate priorities for action.

The four priority areas for action will:

1. Focus on workforce planning and development
2. Improve infrastructure and systems development
3. Improve response in priority settings for priority clients
4. Improve promotion, prevention and early intervention strategies.

These four priority areas will make immediate and targeted action possible by forming the basis for change and the strategic direction for managing it. In addressing gaps of concern, these priorities will lead to improvements in our response to comorbidity of mental health and drug and alcohol substance misuse.

The priorities for action are not limiting. Health care sectors and local areas will retain autonomy in how they address the unique issues they face. But, in instigating change and improving response, we will support appropriate participation and adhere to the principles of partnership.

While more can be done to address comorbidity, this Framework for Action highlights the responses that NSW Health and its partners will undertake in the immediate future. As our responses are further developed, key stakeholders and partner agencies will continue to be consulted.

In identifying our priorities for action, NSW Health sought clinical and expert advice. We investigated how comorbidity appears in clinical populations and how health services currently respond.[1]

Where specific activities to address the action areas were identified during the research and development of this Framework, they are currently being developed or being considered for future development in the context of other activities.

SECTION 1

Introduction

This Framework for Action was developed by the Mental Health and Drug and Alcohol Office within the NSW Department of Health. It is the basis for immediate action in addressing the unique and challenging issues comorbidity of problematic drug and alcohol and concurrent mental health concerns[2] presents to our health services. The Framework effectively identifies four priority action areas and outlines key activities that demonstrate our commitment to achieving positive change.

The Framework for Action is supported by a Statewide Table of Activities, which identifies the range of activities currently being undertaken by NSW Health and its partners in addressing comorbidity.

Together, the Framework for Action and the Statewide Table of Activities provide specific and targeted responses and the strategic direction that is needed to address comorbidity in NSW.

Definition of comorbidity

The definitions for comorbidity in relation to drug use and mental illness used by clinicians in existing data collections are:

> *Those clients who are drug dependent or using drugs at a level that is harmful to the stability of their mental illness, and whose drug use precipitates relapse of the psychiatric condition, increases the risk of suicide, or complicates management and retards progress.*
>
> *Those clients (usually drug dependent) who present in a psychotic state subsequent on their drug use, and those clients who have a psychotic illness, are drug dependent, and present at treatment services in a psychotic state or are suicidal.*

There has been considerable debate around the appropriate terminology for the coexistence of substance use and mental health. Comorbidity is a term used more broadly in health and refers to a client who has two or more concurrent health concerns. For the purposes of this document, comorbidity refers to the definition below. As outlined in the Siggins Miller Systems Analysis report[3], the term 'comorbidity' has been selected rather than 'dual diagnosis' following the rationale described by Williams and Cohen (2000)[4]: "*Comorbidity is a general term, which delineates the co-occurrence of symptoms or disorders. Dual diagnosis is appropriately used to identify a closer relationship between the two conditions, perhaps including cause or effect*". They indicate their preference for the term 'comorbidity' as it does not distinguish the level of substance use/misuse or imply a causal relationship between the conditions.

Context

The Framework for Action should be considered in conjunction with a number of complementary NSW documents, because the implementation and guidance of these complementary documents will have outcomes for people with comorbidity.

These documents include:

- NSW: A new direction for Mental Health[5]
- The drug and alcohol plan 2006–2010
- The NSW State Plan[6]
- The interagency action plan for better mental health[7]
- The planned NSW Aboriginal Drug and Alcohol prevention and treatment plan
- The Council of Australian Governments' (COAG) National action plan on mental health 2006–2011 (NAP)[8]

In recognition of mental health as a national priority, COAG has agreed to a National Action Plan on Mental Health. The agreement involves a joint package of measures and significant new investment by all governments over five years that will promote better mental health and provide additional support to people with mental illness, their families and their carers. The Plan sets out agreed outcomes and specific policy directions for action that emphasise coordination and collaboration between government, private and non-government providers in order to deliver a more seamless and connected care system. The Plan outlines how all jurisdictions; including New South Wales, will improve their mental health services. Through the Plan and attached funding, both the commonwealth and state governments will be working toward improving the management of comorbidity.

The management of comorbidity requires a whole of government approach. Policy development and implementation of programs require the engagement and support of government and non-government agencies. Multi agency approaches will ensure appropriate management of the broad needs of people with comorbidity. Initiatives such as the Joint Guarantee of Service (JGOS) and Partnerships Against Homelessness projects improve the health and welfare outcomes of people with high support needs such as those experiencing comorbidity.

Addressing the issues associated with comorbidity falls in line with a number of priorities outlined in the NSW State Plan. In particular, priority S3: Improved health through reduced obesity, smoking, illicit drug use and risk drinking and priority F3: Improved outcomes in mental health. Through managing comorbid substance use and mental illness, the sector can work towards reducing the rates of substance use and meeting the mental health targets of reduced readmissions within 28 days to the same facility; increased percentage of people with mental illness who are employed and increased participation in the community.

SECTION 2

Nature of the document

This document provides a coordinated framework for addressing priority areas of concern. It aims to:

- Promote better health for those with comorbidity
- Improve assessment and intervention in relation to comorbidity
- Reduce the long-term disability associated with comorbidity through better and assertive management of the condition.

The Framework's objectives are:

- To ensure that new approaches to providing equitable and effective health services to assist people with comorbid mental health and drug and alcohol problems are trialled and tested
- Set directions based on expert and clinical consensus, good practice standards and evidence, to respond to comorbid mental health and drug and alcohol abuse
- To address systemic barriers to communication and collaboration and trial new ways of working together
- Improve responses in key settings and with complex and/or disadvantaged populations
- Improve and maintain collaborative relationships and partnerships across drug and alcohol and mental health, and across the government and non-government sectors
- To increase the capacity and competency of both the mental health and drug and alcohol workforce to manage and respond to comorbidity.

Governance

NSW Health will monitor the rollout of the Framework for Action, including the activities it presents. Outcomes will be measured through a governance structure that will ensure projects are delivered appropriately and accountability measures are transparent.

The NSW Health Drug and Alcohol Council and the NSW Health Mental Health Program Council have oversight of the Framework, while the NSW Health Comorbidity Subcommittee will have responsibility for the Framework for Action. The eight Area Health Services and their agencies will lead in the delivery of specific actions.

Within these arrangements, the NSW Health Comorbidity Subcommittee provides advice and analysis on comorbidity generally, and on the implementation of the Framework for Action specifically.

Implementation

Implementation of the Framework will occur through consultation and collaboration with Area Health Services and non-government organisations, the establishment of new partnerships in research and improved information sharing. Key stakeholders from the non-government sector and clinical experts from the field have joined with members of the Drug and Alcohol Program and Mental Health Program Council, and formed the NSW Health Comorbidity Subcommittee.

The NSW Health Comorbidity Subcommittee will monitor, advise and assess the success or otherwise of the reported activities. The Subcommittee will also be responsible for identifying emerging and critical issues that relate to comorbidity in the time that the framework is implemented.

The Aboriginal Health and Medical Research Council (AH&MRC) is a member of the NSW Health Comorbidity Subcommittee. Its input and that of its members will be sought throughout the development, implementation and monitoring of activities and to consider future priorities and directions.

Evaluation

The progress of the *NSW Health Mental Health/ Drug and Alcohol Comorbidity Framework for Action* will be reported on at regular intervals to the NSW Health Drug and Alcohol Council and the NSW Health Mental Health Program Council.

Reporting to these Councils will include:

- Progress reports on the implementation, and where available, outcomes of the Framework's action areas
- A review of information from Area Health Services including qualitative and quantitative research projects
- Strategies for addressing any identified emerging and critical issues
- An examination of data collected for the period 2006–2009 that provides information about comorbidity presentations and outcomes.

SECTION 3

Action areas

Action area 1. Workforce planning and development

Investment in workforce is crucial for the maintenance of standards and for the currency and applicability of employee knowledge. Workforce development represents a multi-faceted and multi-level approach to supporting and sustaining effective work practice. It pertains to the individual worker, the organisations within which they work and the systems that surround them.

The key to successful workforce development strategies lies in the capacity of the field to adopt a coordinated and collaborative approach across multiple levels. In the drug and alcohol field, one that is confronted by constant change, workforce development aims to improve and maintain the capacity of the organisations, services and occupations that respond to drug and alcohol issues. In recent years, significant development in approaches to treatment has occurred, and patterns and prevalence of drug use have changed.

There have also been significant reforms in the delivery of mental health services. De-institutionalisation has resulted in psychiatric care and treatment shifting from stand-alone institutions to community-based care and treatment supported by acute short-stay psychiatry units situated in general hospitals (Benson, 1994).

A workforce that can respond cogently to emerging issues is needed to develop a professional, efficient and quality level of service in the drug and alcohol and mental health sectors.

Partnerships with non-government and training organisations will improve collaboration and the development of workforce strategies that support a coordinated and effective response to comorbidity by the spectrum of health service providers.

Responding to increasing shortages of key health workforce professions is one of the biggest challenges facing the overall health system. In particular, there are fewer specialist workers within the fields of mental health and drug and alcohol at a time when the need and demand for combined mental health/drug and alcohol care and treatment in the community is increasing.

In regional areas, our research indicates that resource constraints including the capacity to attract and retain staff have resulted in pragmatic approaches to structure and process. These responses have developed out of necessity and suggest that the capacity to work well together is reliant on particular individuals rather than sustainable approaches. Workforce strategies need to specifically address this issue.

Problems with local Aboriginal people's access to mental health care have been consistently reported for many years. Aboriginal Health Workers and Communities have identified major issues impacting Aboriginal people with mental health disorders including problems with alcohol and other drug use, availability and access to a range of specialist services, and suitability of services to deal with complex cultural, social and emotional issues. Severe shortfalls in the Aboriginal workforce and adaptability of mainstream service providers to adequately address comorbidity issues for Aboriginal clients is recognised as an area of action within this framework.

The 2001 National Health Survey (NHS) did not include information on Indigenous mental health due to concerns about the cultural appropriateness of the mental health-related questions in that survey. A 1994 survey indicated that there was more widespread experimentation with drugs, particularly marijuana, among the urban aboriginal community than the general urban population. A report by the Australian Institute of Health and Welfare in 2004 found that 16 per cent of people who had recently used cannabis had been diagnosed with or treated for a mental health disorder in the last 12 months compared with 9 per cent of non-users.

It is key to engage stakeholders via a combined approach, to combine the best possible care and also community involvement in on-the-job training. This facilitates role clarification and teamwork through reflective practice with both the Aboriginal community and health workers. A holistic approach to targeting comorbidity in this group is appropriate, to ensure it is a lifestyle change being

initiated not a short-term fix. It is of vital importance to develop the Aboriginal workforce to improve their health status, and also to create health services that are culturally relevant, strength-based and integrated.

Our response

NSW Health will engage in and develop a range of programs to improve the knowledge and understanding of comorbidity amongst those involved in the drug and alcohol and mental health sectors, and also amongst other professionals who can play an important role in identifying and responding to comorbidity. We will deliver workforce strategies that train a mix of health professionals in identified priority areas, to support the care of people with comorbid disorders.

New course materials to further education

We are working with peak training bodies and training organisations to develop new courses that will up-skill the mental health and drug and alcohol workforce.

These include the *AH&MRC Aboriginal Health College* which has been funded to customise a *Diploma of Dual Diagnosis*, which focuses on Aboriginal comorbidity. The new national Aboriginal Health Worker competencies and qualifications have recognised comorbidity as elective units of competence within the community care stream at certificate IV level. As such, Aboriginal Health Workers employed in NSW Area Health Services and Aboriginal Community Controlled Health Sector in the D&A and mental health fields will be able to undertake these once the national competencies are fully implemented.

In addition the Aboriginal Health College will offer comorbidity elective units in Certificate IV and above drug and alcohol and mental health courses.

We have been collaborating with TAFE NSW on the development of a graduate certificate for drug and alcohol and mental health. We will promote this new opportunity to undertake post-graduate training to both mental health and drug and alcohol workers in 2007.

Engaging with a broader workforce on comorbidity issues

A series of projects will be delivered to engage key professionals and partner organisations that can play a role in responding to comorbidity. Our immediate action will be to target General Practitioners (GPs) and Psychologists.

In collaboration with the Alliance of NSW Divisions the '*Teams of Two*' project was expanded to provide education and training for GPs in relation to mental health and drug and alcohol issues. The program established local networks, and included community GPs working with mental health and drug and alcohol services. Over 2,500 health workers have attended the workshops, of whom more than half were GPs.

In 2006, NSW Health licensed the Australian General Practice Network to use Teams of Two in an Australian-wide campaign called the "Can Do' Initiative: Managing Mental Health and Substance Use in General Practice, which is funded until 2008 by the Australian Government.

We are introducing a *graduate program for psychologist-in-training* which will increase the number of psychologists with skills and an interest in drug and alcohol, with a particular focus on patients with concurrent mental health conditions. A total of 37 new graduates will be placed in Area Health Services, the Aboriginal Health and Medical Research Council and Network of Alcohol and other Drug Agencies. Specific new comorbidity training will be developed and provided to support these placements.

We will also deliver a new comorbidity training package to provisionally registered psychologists during 2007.

In order to improve the management of clients with comorbidity, a training package that focuses on assessment, screening and brief interventions will be developed and implemented. This package will provide specific mental health training to staff in drug and alcohol NGOs, and specific drug and alcohol training to staff in mental health NGOs.

Aboriginal workforce

NSW Health in partnership with the Office for Aboriginal and Torres Strait Islander Health (OATSIH) has supported the NSW Aboriginal Drug and Alcohol Network (ADAN), which is a network of Aboriginal Drug and Alcohol Workers employed within Area Health Services and Aboriginal Community Controlled Health Services in NSW. The ADAN has been formally established for four years and over this period has ensured that comorbidity is a priority area of professional development and action at each of the annual symposiums.

NSW Health is investigating linking the two workforces of ADAN and the Mental Health Workers Forum to discuss issues of commonality. This forum would

provide the opportunity to discuss issues such as comorbidity prevention, early intervention, treatment and referral pathways.

New publications to guide the work of Drug and Alcohol, and Mental Health workers

A number of new resources will guide the work of Drug and Alcohol and Mental Health workers.

In conjunction with the Network of Alcohol and other Drug Agencies, a *resource booklet* is currently being developed for drug and alcohol workers that addresses mental health issues. A similar resource for mental health workers is also being developed to inform them of drug and alcohol issues.

Currently, there are no standards or guidelines for managing patients presented in acute care settings with mental health and drug and alcohol comorbidity. Further, the *2000 Mental Health and Substance Use Disorder Service Delivery Guidelines* require refinement and revision. The Mental Health and Drug and Alcohol Office (MHDAO) has identified the need to develop *NSW Health Clinical Guidelines for the Assessment and Management of People with a Coexisting Mental Health and Substance Use Disorder in Public Health settings* and the need to review and refine the 2000 *Mental Health and Substance Use Disorder Service Delivery Guidelines*.

The new Guidelines will be supported by the development of an implementation plan, including a communication strategy and an evaluation mechanism, which will provide advice on the delivery of training workshops on the practical application of the revised guidelines.

Other guidelines will be revised to address comorbidity. These include:

- Developing treatment protocols for drug induced psychosis, with a particular focus on cannabis and amphetamines
- The inclusion of a section devoted to comorbidity and families and carers in drug and alcohol clinical practice guidelines for psycho-social issues. The document will outline clearly how stepped care might look and the variety of ways that drug and alcohol services communicate clinically with mental health. The guidelines will provide practical concepts that will assist the education and training process in relation to comorbidity.

Up-skilling the workforce

Clinician-Conducted Research Grants (CCRG) are available as part of a research program to build the knowledge and understanding of drug and alcohol and mental health issues. These specific grants provide an opportunity for clinicians without a research track record to engage in research. It encourages links between clinicians and experienced researchers.

In order to ensure that rural hospitals and mental health services have access to staff with drug and alcohol knowledge and experience, Greater West Area Health Service and Greater Southern Area Health Service will establish *Drug and Alcohol Consultation Liaison* services to the Area mental health services, emergency departments and hospital wards. These services will provide important assistance to the rural workforce, particularly in the screening and assessment for drug and alcohol problems in patients presenting at acute care settings and mental health services. Education and training of hospital and mental health service staff will assist in building the capacity of these services to address comorbidity issues.

A cross-sector staff exchange program will be trialled in Sydney West Area Health Service. This will enable cross-fertilisation and coordinated service delivery. The outcomes of the program will be considered and it may provide a model for application in other Area Health Services.

The Mental Health and Drug and Alcohol Office conducts a Research Grant Program that provides funding each year to selected research focussing on identified priority areas.

Funds have been allocated to conduct research in the area of comorbidity. The research package focussed on three areas of comorbidity:

- psychostimulant use and mental health
- cannabis use and mental health
- comorbidity in young people.

Seven projects were selected.

Funding has also been allocated to the Mental Health Coordinating Council (MHCC) and the Network of Alcohol and other Drugs Agencies (NADA) to administer mental health and *comorbidity research grants* under the Research Grants Program. This grant program will support mental health Non Government Organisations (NGO) and drug and alcohol NGOs to conduct mental health and comorbidity research with other research partners.

Action area 2. Infrastructure and systems development

Our research found that service models for dealing with people who have coexisting disorders vary across health services. Where the systems are integrated, there is a strong collaborative approach to service delivery across all presentations. Where there is a specific Comorbidity service, the focus is on co-managing clients at the more complex end of the spectrum.

Parallel services co-manage clients through assessment, referral and treatment processes. These tend to have formalised arrangements around joint clinical and systems management meetings. These arrangements are designed to enhance collaborative approaches to comorbidity, and include joint education and training opportunities.

A slight variation on this approach is a joint co-treatment approach, including joint assessment, case management, and structural arrangements for combined case conferencing, secondments, and specific overseeing committees.

Stakeholders confirmed the importance of continuously improving the quality of our services and of safeguarding high standards of care. In addition to workforce development and building staff capacity to respond to comorbidity, addressing organisational culture and practice was seen as important to improving health system models and performance in relation to comorbidity.

The development of systems that maintain relationships, formal partnerships, advisory and consultation structures and planning processes is needed. While many services work collaboratively with local informal arrangements in place, formal agreed processes could ensure a collaborative response to priority and complex issues. Levels of resourcing and the recognition of comorbidity as a priority were similarly identified as needing attention.

The absence of comprehensive evidence and data on comorbidity is an impediment to making accurate decisions about treatment needs and relevant responses. When the same patient accesses drug and alcohol and mental health service streams, separate client level databases are used. These databases cannot currently be linked.

Improving data and information sharing, and monitoring of health service responses, are critical to improving the capacity and performance of the health service system on these issues.

The collection of meaningful data and data sharing from both drug and alcohol, and mental health services were raised during consultations as priorities to ensure an accurate understanding of the nature of comorbidity, the responses to presentations and the outcomes for this client group.

Our response

NSW Health will test new approaches to alleviate service challenges and barriers in key settings, and improve service and data integration to enable improved care across services. Our trials will build on the current service models while considering their benefits and limitations.

Corporate structures will be put in place to support strategic planning, and develop and maintain strategic relationships with key players in the mental health and drug and alcohol fields.

New corporate structures that focus on comorbidity as a priority

We will support the new Comorbidity Subcommittee of both the Mental Health Program Council and Drug and Alcohol Council, to provide the corporate governance structure that drives strategic planning in relation to comorbidity. It will also feed into the mental health and drug and alcohol clinical governance structures that ensure liaison with, and priority setting for, key clinicians.

A *Research and Health System Development team* within the Department of Health has been established, with responsibility for identifying and developing policy, programs and projects in response to new and emerging issues and priorities. Comorbidity will be one of the major program areas of this new team, with a focus on improving co-ordination between the mental health and drug and alcohol fields.

Improvements to information collection and management

We will work towards a *shared information system* for drug and alcohol and mental health, to build the knowledge base and improve information management about clients with comorbidity. We will focus on building the infrastructure and capacity of the system to respond to these presentations. These improvements to the collection of health data and information will support the development of responses to state wide issues related to comorbidity, service delivery, quality

management, and planning and monitoring. As a result, we will be able to provide reports on this client group and greatly enhance the ability to make evidence based decisions at both policy and service level.

At Area Health Service level, the capacity exists across mental health databases to link treatment across settings. We intend to extend this to a State level and include the drug and alcohol database in this linkage process so that reporting at State and Area levels occurs across both service streams. We will extend this across both admitted and non-admitted settings.

Enhanced infrastructures to address comorbidity in New South Wales

The difficulty faced by drug and alcohol residential rehabilitation services to cater for comorbid clients was an issue raised in the systems analysis. As a result, a residential rehabilitation service that caters to comorbid clients will be enhanced. The service will be able to upgrade its staffing profile in regard to relevant skills and qualifications. This will provide a model for effective, safe residential rehabilitation for comorbid clients.

To further develop their facilities and operations, we will *enhance the four existing Cannabis Clinics*, to enable better responses to the service demands for this priority client group and allow for the development of an integrated service delivery model. This will bring together drug and alcohol and mental health specialists to improve collaborative care across specialities and services during treatment and aftercare, specifically targeting individuals with significant mental health problems.

We are building strategic partnerships and working with the non-government sector via the Mental Health Coordinating Council and the Network of Alcohol and other Drugs Agencies to run a comorbidity service delivery pilot. This will enhance the capacity of local non-government drug and alcohol and mental health services to respond to their client populations with comorbidity issues.

Services will be reorientated within a capacity building framework to incorporate either an additional drug and alcohol or mental health focus.

The pilot will sit within a wider context of workforce development and aims to ensure that service delivery is characterised by quality, innovation and evidence based practice. It recognises that investment in staff training is unlikely to be effective unless there are structures and systems in place in the workplace that support and reinforce the content of training.

Building the evidence base to support systems development

Research into comorbidity treatments, new and improved interventions and approaches to reducing risks and harms are important for ensuring our work is based on evidence. We need to be aware of changing challenges and emerging issues.

Key mental health and drug and alcohol research will be commissioned and reviewed. This will add to the public health knowledge base, and benchmark and evaluate the effectiveness of programs and strategies.

Seven new research programs have been funded in Area Health Services and Universities to conduct research in the area of psycho-stimulant and cannabis use, and links to mental health; early interventions for comorbidity in young people; and the treatment of comorbidity. We will disseminate the findings of these research projects to inform the development of service models and interventions to address comorbidity.

In the coming years, we aim to continue supporting additional research and build the capacity of both the drug and alcohol, and mental health fields to undertake and disseminate the findings of their research.

In addition to new research, there is an ongoing need to test and increase the knowledge and understanding of comorbidity and its presentation and responses. We have been told that there is no agreed evidence-based treatment for either marijuana dependence or harmful/dependent amphetamine use.

We will undertake focused evaluations of the cannabis clinics and new stimulant treatment programs (see our response to action area 4) to gain a greater understanding of the needs of the population, above and beyond managing the crises in which they present. These evaluations will describe the new models developed for the clinics and provide an overview of their impact and outcomes.

Action area 3. Promotion, prevention and early intervention

Implementation of prevention programs can be universal (whole populations), targeted (vulnerable or at risk groups within the population) or indicated (people with early signs and symptoms). Early intervention and indicated prevention have blurred boundaries, although early intervention tends to imply some kind of action (which might include individual therapy or medication).

The *Public Health Systems Model for Prevention* (Holder, 1989, Lenton, 1996) illustrates that individual health outcomes are subject to a complex web of influences and processes. These range from macro-social impacts to the risk protection profiles that are specific to individuals, families and communities.

Health promotion involves action taken to maximise health and wellbeing among populations and individuals. This includes broader social support for young people such as employment, income, education, vocational training, housing and social supports. It must, therefore involve a range of partners.

Population and clinical studies suggest that people with comorbid disorders are harder to treat, have a worse prognosis and cost the health system more than people with either a psychiatric or a substance use disorder alone. People at risk of depression, anxiety and other mental disorders are more likely to abuse substances and similarly substance abuse increases the risk of depression, anxiety and other mental disorders (Kessler, 1994).

Strategies that focus on health promotion, prevention and early intervention are, therefore, well supported and seen as a priority. Consultation with clinicians highlighted that promotion, prevention and early intervention were warranted based upon the return for better health from this investment.

In particular, this type of support for vulnerable young people is seen as a priority. They are at important developmental stages, particularly in terms of social and emotional wellbeing. The peak incidence and prevalence of mental and substance use disorders occur in the 15–25 year age range. Young people with emerging comorbidity problems can fall in the gaps between child and adolescent services and adult services, and mental health and drug and alcohol services. Young people who do not receive care at the appropriate time may present in crisis situations, when they are a greater risk of harm to themselves and/or others.

In addition, during the development of this framework, stakeholders and the systems analysis identified that education, information and support for families and carers, and communities should be strengthened. They also identified that better promotion of the services and resources available to health care professionals in relation to managing comorbid clients would be useful in encouraging collaboration and informed responses to clients.

Our response

NSW Health will deliver strategies in the community to raise awareness of the development and signs of comorbidity and encourage help seeking behaviours of individuals and their families. In addressing comorbidity, we will target population settings, including schools, youth services, disadvantaged groups in the community and general practices.

Promoting services, activities and resources to health workers

We will work with health services and our partners to record the many activities that are currently underway to address comorbidity. This will be promoted to our stakeholders as part of the Statewide Table of Activities, accompanying this Framework. Services will be encouraged to liaise with their colleagues and learn from the lessons and successes of others. Evaluation results will be promoted and we will support services to write up models of practice.

The feasibility of extending the use of existing resources and models of activities will be considered.

Strategies that have benefits for young people

We have redeveloped '*School Link*', an existing mental health program for adolescents, to include a drug and alcohol module. Three two-day pilot courses were conducted in March and April 2006.

To reduce the progression of comorbidity and relapse, we will trial an *early intervention model* for working with young people whose lives are directly affected by comorbidity. This trial will aim to improve the capacity of drug and alcohol and mental health service providers to work with young people, build relationships between health services and youth services in the area, and improve the health outcomes for young people who might not normally engage with health services. A team of drug and alcohol and mental health specialists will

visit youth and related services in a trial area to provide expert advice and assistance to support young people with emerging or at risk of comorbidity issues.

Nepean Youth Drug and Alcohol Service (NYDAS) provides specialist treatment for young people aged 12–20 years presenting with drug and alcohol problems. The service is designed to provide a broad range of interventions along the care continuum from prevention and early intervention to inpatient and long-term care, according to need. NYDAS is designed to assist adolescents and young people in conjunction with the Nepean Hospital Department of Paediatrics, the Area Child and Adolescent Mental Health Service and the Nepean Division of General Practice.

The *Youth Mental Health Services Model* (YMHSM) is aimed at providing youth mental health services for young people 14–24 years in youth-friendly settings, co-located with primary health, drug and alcohol and other services. The focus of the model will be on early intervention and prevention, flexible approaches to service provision and access as early as possible to a range of health services for young people.

We will continue to work with the *Richmond Fellowship* of NSW to develop strategies and partnerships to address issues around comorbidity. The Young People's Program, managed by the Fellowship, is a residential psychosocial rehabilitation facility for young people who are experiencing serious mental health problems. It is a unique program, providing medium-term, multi-level support to young people within a collaborative care framework. The program is designed and best suited to 17–25 year olds who have a serious mental illness (generally schizophrenia or psychotic illness) and are willing to, and require assistance to, work on the myriad of complex issues that affect their everyday lives. The majority of young people entering the program also have a co-existing substance abuse issue. We will monitor the program and consider its feasibility for implementation with other services.

We will continue to work to enhance relationships between Justice Health, Adolescent Area Health Services and Adolescent Community Services.

Engaging with and supporting appropriate family and carer participation

We are reviewing new draft information materials developed by the Commonwealth to support the involvement of carers and consumers in the treatment planning for people with drug and alcohol and mental health comorbidity. If appropriate for use in New South Wales, we will promote these materials to health services and work with the Commonwealth to encourage their use Nationally.

We will consider the potential use of carer profiling tools to assess family capacity to provide practical support. The strengths, capabilities and needs of these families will be reviewed for potential use by health services.

In recognition of the potential therapeutic value of involving the family and carers in treatment and care, a new *Family and Carer Mental Health Program* was introduced in 2006. The Service model identifies a comprehensive suite of supports and services to be delivered across the mental health, and non-government organisation sectors, which complements other supports and services available for all carers. The program will target carers of people with a mental illness and will be delivered in both drug and alcohol and mental health settings.

There are additional resources available for carers including, Children of Parents with Mental Illness (COPMI)[9]. Links available on the site provide information relevant to the needs of children and young people where a parent has a mental illness.

Further support is being made available through the Personal Helpers and Mentors Program, an initiative of the COAG National Action Plan. This program has been developed to assist people who have a severe functional limitation resulting from a mental illness, and their families and carers, to better manage their daily activities and to access a range of appropriate services/supports when they need them. Mentors will be appointed to assist clients engage in a range of services.

The *Aboriginal Families and Carers Training* (AFACT) Project developed in response to the need for information and resources to support families and carers of Aboriginal people with drug and alcohol issues. The resulting resources developed by Streetwize Communications and titled *No Shame, No Blame* consist of a Workers Guide, a Family Comic and a Promotional Poster. The resources were distributed throughout NSW in February 2007 to key services that support Aboriginal families and carers coping with the drug or alcohol problem of a family member.

Action area 4. Priority clients and settings

Specific groups of people were identified, during our consultations, as having the greatest level of disadvantage in accessing care for their comorbidity disorders or for whom there are limited services that are likely to provide lasting change and health improvement. They were seen as priority clients requiring specific and immediate responses to ensure they have better care and health outcomes.

These groups include amphetamine and cannabis users who are experiencing mental health disorders. This is an emerging area of concern both in Australia and internationally and was reinforced by our research and consultations.

In the Australian context research has indicated that specific attention should be given to the "increased number of methamphetamine users experiencing anxiety, depression, aggression/hostility and psychotic symptoms such as paranoia, delusions and hallucinations" (Topp et al 2002, 74). This statement was supported by the expressions of our key stakeholders, who communicated the need for the increasingly hazardous and harmful use of methamphetamine to be addressed. Similarly, cannabis users with mental health problems were also seen as a key priority group for focused attention.

In addition, prisoner populations have also been identified as some of the most disadvantaged and stigmatised individuals. The over-representation of mental health disorders in the offender population was highlighted by our research and consultations. A potentially high proportion of this population is reported to have either a diagnosed or undiagnosed dual disorder. The continuum of mental illness appears to begin at an early age as is evidenced by the high proportion of young people in custody with mental health disorders. The need to address the continuity of care, drug dependence and mental health issues of offenders and ex offenders was seen as important because of its positive impact on individual health as well as recidivism.

Homeless people with co-existing mental health and substance use problems are another overly disadvantaged group that has been specifically identified as requiring immediate attention. Access to appropriate accommodation and personal space while engaging with relevant services was seen as critically important.

Aboriginal people generally have less access to health services, are a relatively socially disadvantaged group with poor health status and exposure to greater stressors. AIHW 2004 data suggests that the Aboriginal community has higher rates of mental health disorders among cannabis and amphetamine users.

Our stakeholders also discussed the significance of intersectoral relationships. One issue of concern was the role of drug and alcohol and mental health professionals in a role of mediator between the broader human services sector for example, between housing and community services. This was seen to pose a challenge and a great burden of responsibility on these services.

Opportunities for clients, and when appropriate their families, to participate in decision making about their own treatment and the development of policies and services may lead to more effective and relevant programs. Research and our consultations support this involvement when appropriate. Treatment programs, which are firmly grounded in the experiences of clients, are reported to be more likely to lead to long-term benefits for the client.

Priority settings were also identified as requiring specific attention in relation to building capacity to respond to comorbidity. In part, this need is likely to relate to the complexity of specific client groups presenting to these settings, some of which are outlined above. The settings that were identified as needing targeted support to manage comorbid clients appropriately were the emergency and residential rehabilitation settings, as well as rural areas.

Our response

NSW Health will trial initiatives to address priority presentations and located in priority settings. We will work to determine what services and approaches to the treatment and management of comorbidity are successful in managing these targeted groups and specific settings.

We will test new models for the intervention and treatment of people with complex and difficult comorbidity issues in New South Wales. These will deliver improved mental health and substance abuse outcomes for people with problematic amphetamine and cannabis use, offenders and ex-offenders and those without stable accommodation.

Collaborative responses in emergency departments and in rural areas

To enhance the ability of emergency services to address comorbidity problems, we are currently trialling the *Psychiatric Emergency Care Centres* (PECCs) program, which provide mental health triage and critical care service involving on call access to a psychiatrist, Transit Nurse and Health Security Assistant. The PECCs will be located at nine major metropolitan hospitals.

We will enhance these services with extended trials of drug and alcohol acute service response teams. This will improve the management of drug and alcohol issues presenting in patients at the PECCs. These trials will provide models, whose results will be disseminated and expansion considered.

In order to ensure that rural hospitals and mental health services have access to staff with drug and alcohol knowledge and experience working in the field, drug and alcohol *Consultation Liaison* (CL) services will be delivered to both the Greater Southern and Greater Western Area Health Services.

As is locally appropriate, these services may provide support with screening and assessment for drug and alcohol problems in patients presenting at acute care settings and mental health services; appropriate referral for outpatient support and treatment; effective discharge plans; and education and training of hospital and mental health service staff.

Focusing on residential rehabilitation

We will appoint *after-care workers* to work with residential rehabilitation services in each of the four metropolitan Area Health Services. These positions will establish and maintain effective linkages for clients who are exiting either drug and alcohol or mental health residential rehabilitation services and require follow up in relation to comorbidity.

In addition, where required, the aftercare workers might establish linkages to support networks within the local community, including access to medical facilities, vocational education facilities, general practitioners and accommodation and support services. This will ensure continuity of care for clients and improve health outcomes and quality of life for clients post residential rehabilitation.

Meeting the needs of clients with specific drug use

We will provide specific services for cannabis and stimulant users who have a coexisting mental illness. The enhancement of cannabis clinics also provides improvements to current infrastructure as outlined in action area 2.

Stimulant treatment program

We will trial and evaluate two Stimulant Treatment Program clinics in the Hunter region at the Royal Newcastle Hospital and at St Vincent's Hospital in South East Sydney. This will be available to anyone seeking assistance for stimulant use and will cater to all levels of drug use from the provision of information and education, to inpatient withdrawal management followed by ongoing treatment.

These new and innovative services will provide longer-term support to build on the current role of mental health and emergency departments in providing assessment and stabilisation services.

This will test the benefits of withdrawal management, pharmacotherapy interventions, psychosocial interventions, and education and peer support services for this priority group of clients.

New programs to better engage with those without accommodation

Working with the Department of Housing, we will drive the trial of local service strategies for engaging clients with comorbidity who do not have stable and secure accommodation. Our focus will be on embedding systems of collaboration and coordination and on ensuring appropriate referral between agencies. Client populations will include ex-offenders, young people and Aboriginal people who are experiencing, or face the prospect of experiencing, both comorbidity and homelessness.

Community based offenders with comorbidity are also a priority for a new approach to engagement between relevant agencies. Where possible, in addition to treatment, housing issues will be addressed for this group as well.

Enhancing diversion programs to address comorbidity

The drug and alcohol diversion initiatives have sought to engage mental health services in the assessment and treatment of comorbid presentations in Magistrates Early Referral Into Treatment (MERIT) and Drug Court Assessment and Case Planning. Additionally, we will support non-government organisations to provide comorbidity services to MERIT clients.

Improving post release care planning for clients with mental health and drug and alcohol health concerns

Justice Health will be initiating a post release care planning project called *Connections* from July 2007. This project aims to improve continuity of care for recidivist clients of the correctional centres and health settings with drug and alcohol problems, who are being released to the community. The Connections Project is a linkage model project that aims to link clients with relevant health and welfare service providers post release.

The Connections Project team will utilise a broad array of contacts, both in the correctional environment and the community, and link clients into services appropriate to their individual needs, including drug and alcohol and mental health, post release.

Justice Health Court and Community Team

The Justice Health Court and Community Team targets young people who have an emerging mental illness and/or drug and alcohol problems. The service comprises four main components:

- community based assessments and linking to appropriate community services
- court liaison and diversion
- discharge planning for young people in custody and for some young people occupying mental health inpatient beds
- case management of a small number of clients.

Youth drug and alcohol court

The NSW Youth Drug and Alcohol Court (YDAC) program is aimed at reducing offending and drug use amongst young people who have become entrenched in the criminal justice system. The YDAC attempts to address the wide range of young offenders' needs in a holistic way through intensive case management behaviour and increase their ability to function as law-abiding members of the community.

The program employs a part-time psychiatrist to review and assess young people who have been identified with mental illness or emerging mental illness. A treatment plan is developed for each participant.

Participants in the program receive treatment for any identified mental health and drug and alcohol needs. A discharge/ongoing care plan is developed in order to link young people with appropriate community based care upon exit of the program.

Integrated Perinatal and Infant Care (IPC)

IPC is a comprehensive and integrated health response to the needs of families during the perinatal period (pregnancy to infant aged two years). IPC links to the NSW Government's *Families First* initiative administered by the Department of Community Services (DoCS).

The Mental Health component of Families First is the Integrated Perinatal and infant Care (IPC) initiative. IPC is also known as *Safe Start*. IPC (Safe Start) involves antenatal psychosocial assessment (including screening for depression) for all pregnant and postnatal women in NSW. Integral to the assessment and screening process is development of local protocols for implementation of integrated care pathways for all families identified with psychosocial risk factors, mental health or drug and alcohol problems.

Work is underway to increase the capacity of the drug and alcohol workforce to recognise and understand the impact of drug use on parenting abilities. This is in line with the work that has been undertaken in the mental health sector through Crossing Bridges training. The Crossing Bridges training has been designed to enhance clinical practice for mental health staff when working with families in which adults with a mental illness have a responsibility for children.

NSW Health will also undertake a review of the statewide Drugs in Pregnancy Services including their location, services provided and links to other services including Department of Community Services, mental health and drug and alcohol. The review will make recommendations around how to improve integration between services and provide future options for service delivery.

Culturally appropriate services

A statewide clinical drug and alcohol service will be established to provide triage, clinical assessment, brief intervention, advocacy and skilled referral for people of culturally and linguistically diverse (CALD) backgrounds experiencing problems arising from substance use. The service will be based at the Transcultural Mental Health Centre in Sydney West Area Health Service. The aims of the service will be to build on its successful brokerage model and provide effective, culturally-informed primary responses to comorbidity clients with complex needs.

A one-off pilot will entail recruitment of bi-lingual specialist drug and alcohol clinicians to complement the existing pool of Clinical Consultation & Assessment Service (CCAS) bi-lingual mental health professionals.

The pilot program would provide benefits in terms of culturally informed improved health outcomes for CALD clients in SWAHS as well as across the state.

APPENDIX 1

Development of the framework for action

The Comorbidity Framework for Action is the result of a four-phase development process. The four phases of the development process were; research, discussion, action, and confirmation and commitment. The process encouraged a flourishing of ideas and a free-flow of information.

The outcomes of each phase were reflected on and used as the building blocks for what was to come. In each phase, new ways to think about comorbidity and related issues emerged.

It was these formative developmental stages that have lead to the Framework for Action. We created the platform to listen to what our experts and stakeholders wanted to say, and the mechanisms to effectively respond. In doing so, new relationships have been forged and knowledge has been shared.

Phase 1. Research

The Centre for Drug and Alcohol (CDA) at the NSW Department of Health commissioned a statewide consultation process to explore the adequacy of system responses to comorbidity issues within the NSW Health system.

Key stakeholder consultation was a significant aspect of this analysis and informed the key findings of the Systems Analysis report. Siggins Miller Consulting was commissioned to complete the consultations and to write the report. This has been submitted to NSW Department of Health.

The main aims of the Systems Analysis were:

- To investigate the prevalence, severity of affliction, and characteristic diagnostic combinations of comorbidity in the clinical populations served by drug and alcohol and mental health services.
- To map formal service agreements (where they exist) between drug and alcohol and mental health services and provide analysis on the effectiveness of these processes.
- To identify common views about potential strategies for addressing concerns or gaps at a systemic level.
- To provide a snapshot of common views about strengths, weaknesses, barriers and gaps in the current management of comorbid presentations to both drug and alcohol and mental health services across New South Wales.

The key findings of the Systems Analysis, as identified in the final report were:

- **Improving collaboration among services** – strategies for improvement include strengthening partnerships across the continuum of care; focusing on delivering a seamless comprehensive service to clients including joint assessments; a planned approach to care management and discharge planning as well as a designated primary care worker.
- **Enhancing communication** – strategies for enhancement include the practice of regular joint case reviews; formalising a process for networking and liaison particularly between community-based services and in-patient units.
- **Increasing workforce development** – strategies for increasing include enhanced opportunities for cross-sectorial training, education, supervision, mentoring and staff rotation.
- **Supporting families and carers** – education, information and support for families and carers should be strengthened.
- **Addressing Justice Health** – consultations revealed the need to formalise approaches to clients within the criminal justice system; to ensure prior planning includes discharge medication arrangements on release and that ongoing collaboration and communication is ensured.

Specific activity recommendations included:

- Revising the *Mental Health and Substance Use Disorder Service Delivery Guidelines* (2000)
- Interrogating actions at inter-departmental/ intersectoral level

- Working with key sectors of the health system
- Disseminating examples of good practice between Area Health Services
- Developing a research, monitoring and evaluation capacity
- Reviewing related policy and legislative procedures
- Achieving a shared understanding of the problem of comorbidity and what this means in giving patients the best possible care
- Increasing the confidence of Non Government Organisations (NGOs) in delivering comorbidity care
- Drug and Alcohol and Mental Health services being made inclusive rather than exclusive to foster a culture of trust and skill sharing.

Informants were asked for their ideas about the best 'way forward'. There was consistency in the views people had about this, despite the wide range of services and the total number of people consulted.

Respondents suggested the following

Service delivery:

- Develop specialist teams for those clients who had serious mental health and substance use problems
- Expand the role of consultation liaison and consultancy positions to work across both services
- Provide cross-sector secondment opportunities and shared positions to develop cross-fertilisation and facilitate the coordinated service delivery
- Expand the availability of specialised services such as Anxiety Clinics
- Jointly develop treatment paradigms to apply to patients in either service, as each service should be responsible for a client and have the skills to treat them.

Organisation and Infrastructure:

- Strategic planning in relation to comorbidity, including the development of a corporate governance structure to manage the change process at all levels within a service and a clinical governance structure to ensure liaison at clinician level
- Develop a shared information system
- Develop common language to promote a common culture
- Promote and support ongoing education and training
- Informants were emphatic of the need to ensure that people working in the sector were competent in handling mental health issues in combination with addiction issues
- Commission research to identify the effectiveness and impact of managing known problematic areas and to address emerging areas of concern
- Examine funding models to ensure sustainability of projects and/or pilot schemes.

Siggins Miller supported the need to develop a plan of action that identified the things that need to happen now and in the longer term. The need to hold a forum with key stakeholders for discussion to identify emerging issues and priority areas for action was also recommended.

Phase 2. Discussion

In May 2006, NSW Health held the Comorbidity Forum (Mental Health and Substance Abuse). Over 40 stakeholder representatives and experts from the mental health and drug and alcohol field attended and participated.

The forum aimed to provide an opportunity for a range of stakeholders to consider the findings of the Systems Analysis report and to discuss the apparent and emerging issues of comorbidity.

It was our aim to gather relevant and timely input from workers in the field and other stakeholders to create a direction for the immediate and long-term management of comorbidity.

Participants at the forum divided into three agreed groups and were involved in drafting recommendations for responses within the settings of the community, emergency departments and post-release from health settings and detention.

Much brainstorming occurred, and participants identified a range of possible responses to areas of concern. Importantly, suggestions for management were also tabled and this assisted in closing the gap between knowledge and practice.

Each group outlined a number of important and timely primary objectives for further discussion.

The primary objectives for Community Settings were:

- Establishing a stepped care/chain of care so that consumers can move seamlessly from one part of the system to another

- Developing memorandum of understandings (MOUs) between services regarding the roles and responsibilities that include the role of oversight groups to monitor performance against the MOU at Area or service level
- Developing client focussed information systems that facilitate and do not inhibit holistic care
- Establishing a range of accommodation options that enable the delivery of support and treatment options on site or via in reach to comorbid clients in the community
- Developing a comprehensive workforce development strategy to ensure that all workers in all settings where comorbid clients are present can provide high quality care and interventions
- Ensuring that families are appropriately engaged in treatment and care
- Developing and disseminating effective comorbidity early intervention and prevention interventions.

The primary objectives for Emergency Departments were:

- Developing clinical guidelines for the management of intoxication and behavioural disturbance in Emergency Departments (EDs)
- Developing system-wide operational guidelines regarding expectations about how Drug and Alcohol, and Mental Health services and EDs relate at the Area Health Service level.
- Building relationships and practical linkages between Psychiatric Emergency Care Centres (PECCs) and Drug and Alcohol services
- Ensuring that all staff in PECCs, mental health emergency, rural and remote and ED settings are trained in the assessment and management of comorbidity
- Up-skilling psychiatrists in the management of drug and alcohol problems
- Increasing the awareness of existing resources to ED staff
- Planning for drug and alcohol services that include the development of drug and alcohol into acute services and also community based settings.

The primary objectives for Post-Release Settings were:

- Establishing effective, realistic discharge planning for clients with comorbid issues in all settings, including justice, hospital, mental health units, Non Government Organisations (NGOs) and government-run residential services
- That discharge procedures link all relevant providers and stakeholders, including the patients and clients, their families and carers appropriately
- Developing consultation liaison services in hospitals or use of that model/establishment of that capacity/function where dedicated consultation liaison staff are not available
- Increasing investment in rehabilitation including better transition services in the jails
- Improvements to shared training for Drug and Alcohol and Mental Health staff
- Improved focus on good communication and better planning through the development of formalised relationships rather than trading on individual good will
- Developing MOUs between Drug & Alcohol and Mental Health services

Participants at the forum also engaged in the following issues:

- Identifying any risks or implications associated with the recommended actions
- Exploring the implications and issues raised on specific population groups
- Examining the communities' perspective on managing comorbidity
- Identifying potential strategies for addressing concerns or gaps at a systemic level
- Identifying opportunities for value adding by working in collaboration.

By identifying the primary objectives of managing comorbidity in community settings, emergency departments and post-release settings, a range of ideas about impacts, implications and potential strategies were discussed. Attendees acknowledged the need for immediate responses and improvements. They discussed priorities and the findings of the Systems Analysis, and recommended that focus should be directed to specific and focused objectives.

It was from this focus that nine key activity types emerged. These capture the essence of the forum; they are its intended and key outcome.

The nine outcome areas to be considered in managing comorbidity within NSW as identified at the forum are to:

1. develop service level agreements that formalise agreed processes to ensure mental health and drug and alcohol services work collaboratively,

and that improved data and information sharing and monitoring of health service responses occurs

2. improve training and ongoing supervision
3. develop early intervention and prevention strategies in the community, including raising community awareness of the development and signs of dual disorders and encouraging help seeking behaviours of individuals and their families
4. enhance the ability of Psychiatric Emergency Care Centres (PECCs) to respond to comorbidity issues
5. support appropriate family and carer participation
6. develop clinical guidelines for emergency and acute care settings, covering issues including the management of intoxication and withdrawal and discharge procedures
7. improve discharge procedures and planning for those with coexisting mental health and drug use problems on discharge from gaols and health settings
8. build health worker awareness of existing resources to assist in the management of comorbidity, such as the availability of the Drug and Alcohol Specialist Advisory Service
9. build intersectoral relationships that support clients, for example in providing appropriate accommodation options.

Phase 3. Action

To ensure the ideas and suggestions that resulted from phases one two were actualised, and that emerging issues were captured, NSW Health established the NSW Health Comorbidity Subcommittee (Mental Health and Substance Abuse) (Comorbidity Subcommittee).

The Comorbidity Subcommittee currently consists of senior representatives from within NSW Health and includes NGO representatives from Drug and Alcohol and Mental Health, clinical experts, and experts in the field of Justice Health. Importantly, the State's Clinical Advisor for Drug and Alcohol, and the State's Chief Psychiatrist are members of the Subcommittee.

The Comorbidity Subcommittee reports to both the NSW Health Drug and Alcohol Council and the NSW Health Mental Health Program Council. Within these governance structures, the Comorbidity Subcommittee provides advice and analysis to the NSW Health Drug and Alcohol and Mental Health programs in relation to comorbidity in the State's health settings. The Comorbidity Subcommittee is an integral component to the development of comorbidity initiatives in NSW.

The Comorbidity Subcommittee has utilised the information gathered from the consultation processes at the Forum and from the Systems Analysis, and from engagement with the Area Health Services. It provides the knowledge, skills and expertise to ensure that future and current actions are necessary and appropriate.

The Comorbidity Subcommittee aims to:

- Shape future directions for closer working relationships across drug and alcohol and mental health services in New South Wales
- Oversee the development and implementation of the NSW Health Co morbidity Framework for Action
- Link to, and inform initiatives of both the NSW Health Drug and Alcohol Council and the NSW Health Mental Health Program Council
- Identify and respond to emerging clinical and policy issues of relevance to effective practice with regard to comorbidity

In considering the potential and ability to respond to the recommendations of the Forum, a developmental process was undertaken to describe the four Priority Action Areas under which the activities objectives might sit. It was then possible to consider how they could be translated into activities for implementation.

In doing this, the Comorbidity Subcommittee has developed four Priority Action Areas:

1. ***Workforce development***

- New course materials to further education
- Engaging with a broader workforce on comorbidity issues
- New publications to guide the work of drug and alcohol, and mental health workers
- Up-skilling the workforce.

2. ***Infrastructure and systems development***

- Review and compare the current infrastructure
- Information systems infrastructure development
- Enhanced infrastructures to address comorbidity in New South Wales.

3. ***Promotion, prevention and early intervention***

- Prevention strategies
- Health promotion strategies
- Early intervention strategies.

4. ***Priority clients and settings***

- Enhance the ability of emergency services
- Support appropriate family and carer participation
- Increase our ability to service priority clients
- Improve discharge procedures and planning.

These four Priority Action Areas have been developed in response to the foremost issues of the key activities outlined above. They act as a guide for the strategic direction and structure of the Framework for Action and its accompanying Statewide Table of Activities.

These four Priority Action Areas and the Comorbidity Subcommittee represent the commitment that NSW Health has made to address comorbidity in health settings and working with its partners. They are a framework for the specific activities that will be taken to ensure that positive change occurs for workers and communities, now and in the longer term.

Phase 4. Confirmation and commitment

In the final development phase, NSW Health held a follow-up Comorbidity Forum (Mental Health and Substance Abuse) in December 2006.

At the Forum, participants reaffirmed the identified priority areas and reviewed the processes for developing the Framework for Action. Outcomes of the statewide systems analysis were presented and relevant programs matched to the identified priority areas.

References

1 For further explanation of this process, refer to Appendix 1

2 Note: from hereon comorbidity of drug and alcohol and mental health will be referred to as comorbidity. Nicotine is excluded in the term "drug"

3 Siggins Miller (2006). Management of comorbid substance use and mental health disorders by Mental Health and Drug and Alcohol Services: a systems analysis

4 Williams R, Cohen J (2000). Substance use and misuse in psychiatry wards: A model task for clinical governance? Psychiatric Bulletin, 24, 43–46

5 http://www.health.nsw.gov.au/pubs/2006/pdf/mental_health.pdf

6 http://www.nsw.gov.au/stateplan/pdf/State_Plan_complete.pdf

7 http://www.community.nsw.gov.au/documents/mental_healthplan.pdf

8 http://www.coag.gov.au/meetings/140706/docs/nap_mental_health.pdf

9 http://www.copmi.net.au/

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