Curriculum development and discursive practices: building a training culture around dual diagnosis

Steve Goldsmith

Dual Diagnosis Resource Centre, Victoria

Dual diagnosis (comorbid substance abuse and mental disorder) is an issue currently presenting great difficulties across health and community service sectors. Between 25% and 60% of people with mental health problems experience problematic substance use at some time in their lives (Fowler et al 1998; Regier et al 1990). Dual disorders are especially common among populations in which substance abuse is high, such as prisoners, unemployed and homeless (Timms and Balázs 1997). Dual disordered clients are particularly prone to suicide, noncompliance with treatment, social alienation, and risk-taking behaviour. Attempts at 'self-medication' with alcohol or drugs to alleviate depression and anxiety are common (Addington and Duchak 1997); alternatively, substance use can itself lead to depression, anxiety, and more rarely, psychosis (Baigent et al 1995).

Overall, clinical care of clients with dual disorders is inadequate (Drake and Noordsy 1995; Sitharthan et al 1999), and costs disproportionately more than other mental health treatments (Jenner et al 1998; Jerrell et al 1994). In fact, these clients have often been excluded from treatment altogether (Kivlahan et al 1991; Ridgely et al 1990). In comparison to either disorder alone, the current impact of dual diagnosis is marked by reduced functioning, difficulties accessing treatment services, and resultant poorer treatment outcomes for each disorder. Service criteria for treatment of mental illnesses often explicitly exclude those with serious substance use disorders; the converse is true in substance abuse treatment services. The burden on carers and family of people with dual disorders, and the cost of attempting to effectively access health and social services, commonly reaches totally unacceptable proportions. People with dual disorders have been described as the 'fringe dwellers' of the mental health and substance treatment service frameworks (Mence 1997); despite their prevalence, dual disorders have yet to be acknowledged as 'core' business by any mainstream health services.

The problems outlined above have become increasingly visible and prevalent in recent years, particularly with the shift of mental health and substance abuse treatment services from institutional to community-based service models (Drake and Wallach 2000). Of particular concern has been a rise in the general availability (and, arguably the potency) of an ever-increasing variety of licit and illicit drugs, which has had especially damaging consequences for those most at risk, including the mentally ill.

Ensuring that training needs are being effectively addressed

Historically there has been a low profile accorded to substance abuse issues in education for mental health professionals. This situation does not seem to be unique to any one profession; Aanavi et al (1999) found that although 91% of psychologists they surveyed do clinical work with substance abusers, most have had no formal

education (74%) or training (54%) in substance abuse issues. Similarly, deficiencies in substance abuse education have been identified in medical training curricula (Durfee et al 1994; Martin 1996). The knowledge and skills in dual diagnosis issues among staff of substance abuse treatment services is also often inadequate (Hall et al 2000; Vander Bilt et al 1997). 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. Of particular concern to mental health services are the enormous contributions these problems have made to current difficulties in the recruitment and retention of staff (Australian Health Ministers' Advisory Council 2000).

At present, clinical staff in mental health and drug treatment services need ongoing training and support on dual diagnosis issues. This need not be expensive, nor remote from daily work settings (Drake and Noordsy 1995; Jenner et al 1998; Siegfried et al 1999). A coordinated training program, sensitive to the diverse needs of treatment settings, and with an emphasis on clinical supervision to support practice, has great potential to resolve current difficulties.

Substantial research has been conducted at the Dandenong Psychiatry Research Centre (DPRC) into the relationship between serious mental disorder and substance abuse. This led in mid-1999 to the establishment of the Dual Diagnosis Resource Centre for the development of training materials, secondary and tertiary consultancies, and support for research activities in the area of dual diagnosis. The Centre aims to adopt a consultative, inclusive approach to addressing the concerns of all stakeholders in this area. Its key objectives are to:

- contribute to improvements in the quality of life of consumers who have dual disorders;
- improve the level of satisfaction with the service received by these consumers and their carers / relatives through Dandenong Area Mental Health Service; and
- improve the job satisfaction of clinical staff through enhanced knowledge and skills in offering treatment to dual diagnosed consumers.

The Dual Diagnosis Resource Centre's primary activities revolve around training and staff consultation about dual diagnosis issues. In general, the Centre's staff do not have a direct clinical function (ie client referrals are not taken, as would be expected if the Centre was a specialist clinical service). The central goals are to help improve the responses by existing services to dual diagnosed clients, and to advocate for enhanced access and communication between clinical and non-clinical agencies. As the Centre's coordinator, the author is active in the development of educational / support groups for consumers and carers, and of collaborative research with other services to augment the projects already in progress.

Resistance to dominant paradigms being challenged

As Van Maanen and Bailey (1984) observe, people actively produce their own meanings, at work as in other settings. Accordingly, individuals can potentially function as change agents to instigate and realise improvements in work practices (Rhodes 1997). However, the influence of management, and of the broader organisational culture, is a powerful mediating factor on change.

Riordan and Chesterton (1999) identified six 'barriers to curriculum change'. In an initiative with parallels to the current project, these barriers included:

1. Poor understanding of the innovation (p 5). Riordan and Chesterton refer to the need for a 'shared sense of the problem and the means by which it might best be addressed' (p 5). Recognition of the problem of dual diagnosis did not always translate into engagement with the *process* of change being undertaken; informal comments to the author indicated a persistent preference for being a passive recipient of a finished product.

2. Lack of commitment and readiness of staff (p 7). There was some questioning of the feasibility of clinical strategies advocated in the training curriculum, within the current systemic arrangements. Echoing Beavis (1997), a questioning of 'the readiness of staff to adjust to the different expectations and structures' (Riordan and Chesterton 1999, p 7) was also apparent in comments made during training development group sessions.

3. Tensions between intended outcomes and other expectations (p 7). A central principle of the Dual Diagnosis Resource Centre is building the capacity of existing mainstream services rather than creating a new, specialist service. In this light, it is significant that it took some time for certain individual work settings to begin to appreciate the value of the Centre's consultations, training and work on initiatives, such as development of more appropriate policies and procedures. A balance needed to be achieved between innovation and the pressures of everyday clinical work.

4. Lack of support from stakeholders (p 8). Riordan and Chesterton (1999) refer to 'perceived variance in levels of support among parents for the initiative' (p 8). As the current project was dealing with the highly controversial issue of illicit drug use, reluctance to move from familiar practices was understandable, despite broad-based support for the project from mental health consumer and carer groups, and the wider community.

5. Logistical issues (p 9). The changes to work practices advocated in the training curriculum had perceived implications for workloads, staff retention, and even service funding. Concerns from participants about performing roles they were not qualified or authorised to do subsided somewhat as the project progressed, but remain issues in need of sustained attention.

6. Absence of ongoing evaluation (p 9). As a core program of Dandenong Area Mental Health Service, the training curriculum developed by the Dual Diagnosis Resource Centre is part of an ongoing process of organisational change. Riordan and Chesterton (1999) recognise the importance of engaging with peoples' differing worldviews, and of collaborating with senior management to achieve sustainable change.

Rhodes (1997) also argues that the legitimation of organisational learning is a function of management. That is, in the context of the competing value systems within any organisation, 'events are labelled as being learning by people in whose interests it is to have events interpreted this way' (Rhodes 1997, p 11). Engagement

with management is a necessary component of organisational change, through the authority vested in management to create mechanisms to allow learning to be 'embedded in the organisational culture' (Rhodes 1997, p 11).

A key principle underpinning the Australian National Training Authority's strategic direction is 'to improve industry attitudes and commitment to training, with leadership by industry being essential' (Australian National Training Authority 1998, p 17). In health care, as in other industries, the promotion of a training culture is the key to achieving improved investment in training, particularly in relation to areas as problematic as dual disorders.

The balance that needs to be maintained between an organisation's charter, and its need to adapt to changing circumstances, can seem something of a paradox. The problem of dual disorders presents mental health and drug treatment agencies with some difficult choices about the scope of their activities, and the optimum methods of identifying and responding to their target client group. Reluctance of some agencies to invest in training seems to be due to:

- lack of, or inappropriate incentives;
- a preference to recruit appropriately skilled staff from outside the organisation;
- pressures of day-to-day workloads leading to training being accorded lower priority;
- inhibiting administrative structures; and
- lack of information (Falk et al 1999, p 109).

These barriers to investment in training need to be overcome if agencies working with dual disordered clients are to move beyond current ineffective and unsustainable work practices. Further, as Seddon (1998) observes, an integral factor in building the longer-term capacity of organisations to respond to change is research that builds on notions of 'learning organisations' (Welton 1991) as reflected in recent Australian policy debate (Crowley 1997; West 1998). This debate has recognised the need to move beyond competencies towards a focus on 'lifelong learning' (Robinson and Arthy 1999). Such a focus is essential if health care organisations are to effectively address the heterogenous and changing needs of clients with dual disorders.

Engaging clinical staff of mental health and drug treatment services

Hayton et al (1996) examined factors that affect the level of an industry's investment in training. These include:

- well-defined strategic links between training and an organisation's business strategy;
- a focus on and receptiveness to workplace innovation;
- a participatory and stable industrial relations climate, founded on concern for the development of individual employees that generates trust between management and staff;
- management commitment to the importance of training to the long-term success of the organisation; and

- integration of training activities with the organisation's overall history and culture.

The Dual Diagnosis Resource Centre recognises the international trend toward integration of services to more effectively meet the complex needs of people with dual disorders. The Centre has adopted a strategy of building the capabilities of existing mainstream services through consultations, training, and support for research to induce long-term, adaptive organisational change.

Over a period of three months in late 1999 and early 2000, a comprehensive process of consultation about dual diagnosis was undertaken by the Dual Diagnosis Resource Centre with clinical and community service agencies, primarily in the Greater Dandenong region, but extending across Melbourne. During this consultation, a short (four question) survey was sent out, asking clinicians from Dandenong Area Mental Health Service (DAMHS) and Westernport Drug and Alcohol Service (WDAS) to anonymously self-report their knowledge, skills, optimism and confidence about dual diagnosis issues, and to express their interest in discussing the topic further.

The research project

A research project was devised as part of the author's studies toward a Masters degree in Professional Education and Training, to evaluate the curriculum development process undertaken with staff at a mental health service and at a neighbouring drug treatment service. A training curriculum was developed that challenged the dominant discourses in respective work settings and encouraged change to familiar work practices.

The primary expectation for this research project was that knowledge about dual diagnosis could be improved by training. A secondary expectation was that the knowledge of training participants would improve to a greater degree over the period of the study than those of colleagues who did not participate in training. The research project was an experimental intervention study, which sought to generate an objective, quantifiable measurement of knowledge about dual diagnosis before and after the development of a training program on the topic. The magnitude of score difference between aggregated pre- and post-evaluation scores was expected to be greater within the experimental group than the comparison group.

Those who expressed interest were invited to participate in a training development group. These volunteers constituted the experimental group for an evaluation of the training curriculum development process. A comparison group was comprised of the remainder of staff from the mental health and substance treatment services, selected with reference to the human resource database of each service. The training development group met monthly, and were given presentations of the evolving training curriculum in an interactive format that allowed and encouraged feedback.

There are differing, and at times conflicting, language and agendas among both clinical and non-clinical services concerned with dual diagnosis issues. Accordingly, development and delivery of the dual diagnosis training curriculum involved collaboration between mental health, substance treatment and psychiatric disability

support services, underpinned by broad consultation with community service sectors.

Questionnaire development

Before commencement of the training development, both the experimental group and the comparison group were administered an anonymous questionnaire designed to give an objective measurement of knowledge about dual diagnosis. After completion of the training development program, a second questionnaire, identical in content to the first, was used to evaluate changes in knowledge among both the experimental and the active comparison group.

The questionnaire comprised sections dealing with mental illness, substance abuse and dual diagnosis issues. Many of the questions were open to debate; in human service fields such as mental health and drug treatment, it is often difficult to reach universal agreement. Questionnaire items were chosen because of the strength of the evidence supporting what was identified as the 'correct' response, rather than aiming for a unified view. It was considered just as important for the questions to be put 'on the agenda' for debate within the services.

A total of 186 questionnaires were sent out for the first sample. There were 87 respondents; a response rate of 47%. 67.8% of respondents were female, reflecting the high proportion of females employed in both mental health and substance abuse treatment services. A majority of respondents (68.9%) were aged between 25 and 45, and primarily belonged to the nursing profession (65.5%). 49% of respondents reported having between 2 and 10 years experience in their chosen field, with a further 34.5% having more than 15 years experience.

The relative sizes of the mental health and substance abuse treatment services from which the sample was drawn was reflected in 79% of respondents identifying mental health as their work setting; this was consistent with the proportion of staff from each service in the original mailout.

Most respondents (64.4%) reported daily contact with dual disordered clients. Given this, their lack of relevant professional development was striking. Between 36% (mental health inservice) to 91% (alcohol and drug post-graduate tertiary qualification) reported no exposure at all to professional development activities, whether by formal education or workplace training to inform their work with this client population. The need for the current project was confirmed.

Results: pre-intervention

Mean scores for the total questionnaire seemed to be unaffected to a significant extent by any one respondent variable. Scores for medical and psychology staff were noticeably higher than those of other professions, but there were insufficient respondents from these two professions (3 and 6 respectively) to draw reliable conclusions.

Examination of mean scores from each section of the questionnaire also revealed little conclusive effects from particular respondent variables. Despite the appearance of marked differences between categories of particular respondent variables

(Profession and Age), the small sample sizes in these categories made further analysis irrelevant. The only significant effects found were in relation to the variable Work Setting, as presented in Table 1. These were in the expected direction; staff from mental health services scored better on questions about mental illnesses than staff from substance abuse treatment services. However, whenever substance abuse was a factor, as in the sections on substance abuse and dual diagnosis, staff from substance abuse treatment services recorded the better scores. These differences negated each other to some extent when the scores from each section were combined.

Results: post-intervention

Comparison of mean scores before and after the training development group (see Table 2) revealed a significant improvement after the intervention in scores recorded for the mental illness section of the questionnaire ($p = 0.003$) and for the overall score ($p = 0.022$). Small but insignificant improvements were found in the substance abuse and dual diagnosis sections.

Table 1: Mean scores by work setting

Section	Work setting	N	Mean	Significance (p)
Mental illness	Mental health	69	12.2609	
	Substance treatment	18	9.9444	**
Substance abuse	Mental health	69	11.3043	
	Substance treatment	18	14.2778	***
Dual diagnosis	Mental health	69	6.2319	
	Substance treatment	18	7.8889	**
Total	Mental health	69	29.7971	
	Substance treatment	18	32.1111	

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

The comparison group, which was not exposed to the intervention of the training development, showed no significant improvements in any section, and a slight, although insignificant deterioration in score for the dual diagnosis section (see Table 3).

Table 2: Comparison of pre- and post-intervention scores – experimental group

Group Statistics

	PREPOST	N	Mean	Std. Deviation	Std. Error Mean
Mental Illness	1.00	7	11.4286	1.3973	.5281
	2.00	7	14.1429	1.3452	.5084
Substance abuse	1.00	7	11.1429	2.5448	.9619
	2.00	7	12.8571	1.4639	.5533
Dual Diagnosis	1.00	7	6.7143	1.7995	.6801
	2.00	7	6.8571	2.6095	.9863
Total	1.00	7	29.2857	2.9841	1.1279
	2.00	7	33.8571	3.4847	1.3171

Table 3: Comparison of pre- and post-intervention scores – comparison group

Group Statistics

	PREPOST	N	Mean	Std. Deviation	Std. Error Mean
Mental Illness	1.00	23	12.0435	2.7383	.5710
	2.00	23	12.7391	2.4720	.5154
Substance abuse	1.00	23	12.3478	2.8060	.5851
	2.00	23	12.4348	2.2121	.4612
Dual Diagnosis	1.00	23	6.6957	2.2040	.4596
	2.00	23	6.6522	2.9941	.6243
Total	1.00	23	31.0870	5.2822	1.1014
	2.00	23	31.8261	5.7497	1.1989

Reframing familiar knowledge – discursive practices as barriers to the development of a training culture

The influence of discursive practices on staff expectations, understandings and assumptions about their field of practice has profound implications for the way that they respond to change. The new curriculum developed around dual diagnosis involves, for many staff, a challenging of long-held values about the nature of mental illness and drug use, and requires - as Beavis (1997) observes - a reconstruction of work practice. This process can represent a threat to the established pleasures and satisfactions of familiar work practices, despite widespread acknowledgment of a need for change.

The biomedical model of mental disorder, adhered to by psychiatry, has been entrenched as the dominant order of discourse in mental health since the 1980s. Ongoing debates and struggles for ascendancy have occurred for most of the twentieth century between the 'neo-Kraeplinian' branch of psychiatry (named after an early psychiatrist), other psychiatrists and medical professionals, and other mental health professionals, notably psychologists. Neo-Kraeplinian dominance of contemporary psychiatry rests on the assertions that:

1. psychiatry is a branch of medicine and should base its practice on scientific knowledge;

2. psychiatry treats people who are sick, and there is a boundary between the normal and the sick;

3. mental illnesses are like physical illnesses, discrete entities with a biologic component; and

4. diagnosis and classification are legitimate areas of research and diagnostic criteria should be valued and taught. (McCarthy and Gerring 1994, p 158)

An interesting aspect of McCarthy and Gerring's (1994) discussion is their review of neo-Kraeplinian reshaping of the 'intertextual web in the mental health field … [reconstructing] … the consensual knowledge and research agenda of the field' (p 159). They refer to Blashfield's (1984) study into the social and political forces behind the DSM, which included a

> citation analysis of an article – Feighner *et al*, 1972 – published in the prestigious *Archives of General Psychiatry*. This article defined criteria for 16 mental disorders and was coauthored by six neo-Kraeplinians at Washington University in St. Louis. Whereas a typical publication in the *Archives* is cited, on average, two or three times a year, Blashfield (1984, p. 39) finds that the Feighner paper was cited approximately 1,650 times in the 10 years following its publication. (McCarthy and Gerring 1994, p 159)

Blashfield concluded that the citations proliferated 'exponentially', largely through extensive cross-citation by co-authors, and associates of the co-authors of the Feighner et al (1972) paper in subsequent publications. By the early 1980s

> (t)he sheer number of pieces sharing the neo-Kraeplinian orientation forced mental health researchers to acknowledge the importance of the biomedical model. (McCarthy and Gerring 1994, p 160)

There is by no means universal agreement on the veracity of the biomedical paradigm of mental health. Snook (1980), in summarising the discourses of the mental health movement as embodied in World Health Organisation documents, takes a sociological stance, identifying, for example, 'a move from the judicial to the therapeutic model' (p 39) of deviance. Snook highlights the 'cultural relativism in ascribing illness … to particular persons' (p 40), asserting that

> some psychiatric diagnoses constitute a re-description of moral categories: [for example] the drunkard becomes an alcoholic to be treated not punished. (Snook 1980, p 45)

A shift away from judicial models of discourse is also evident in drug treatment services. However, the dominance of the biomedical paradigm seen in mental health is nowhere near as strong; discourses of drug treatment are primarily centred on harm minimisation.

The example given by Snook (1980) of the recategorisation of the 'drunkard' provides a historical summary of the two moral discourses of drug use that were dominant for most of the twentieth century (O'Malley 1999). Discourses of addiction held that users were compelled by forces beyond their own will, and gave rise to concepts such as an 'addictive personality' and the 'demon drink'. Discourses of abuse, on the other hand, conceptualised drug users as wilfully deviant and requiring punitive sanction. Both addicts and abusers needed assistance to recover from their condition, which was seen as arising from either moral or medical pathology. Indeed Kohn (1997) summarises the 'core drug morality formula' as one of 'instant addiction, leading through inevitable decline and degradation to death' (p 140).

In contrast to the above, harm minimisation, which is the current ascendant paradigm of drug policy, takes as its starting point an acknowledgement of drug consumption as a 'normal' activity in modern society (O'Malley 1999). Harm minimisation identifies a spectrum of conditions and forms of use, from informed, controlled and responsible, to excessive, harmful, inappropriate and dependent. The legal status of particular drugs (for example, nicotine, alcohol, cannabis and heroin) is of secondary importance to the risks of health, social or economic harm arising from the drug use. These risks are determined by the interactions between the physical, social and economic characteristics of the drug user and her/his environment, and the properties of the drug (Directorate of School Education, Victoria 1995).

However, harm minimisation means different things to different people. The tension underlying much of the drugs debate is, at least in part, due to the diverse range of views being expressed about drug use; illegal drugs in particular are 'powerful symbols … of fears about threats to a society unsure of its future direction' (Kohn 1997, p 142). Models of drug governance focus on proscribing appropriate degrees of free will. These range from:

- the use of specific sanctions in response to excessive use (as in drink driving while on a probationary licence); and
- the reintroduction of prohibitive measures for inappropriate use in specific contexts that directly exposes others to risk (seen in the blanket application of the 0.05 blood alcohol level for drivers); to
- the retention of punitive responses to unauthorised distribution or 'trafficking' of illegal drugs (O'Malley 1999, p 201).

An indication of the persistence of deviance models of drug abuse calling for punitive sanctions is the statement by the Australasian Centre for Policing Research (2000), that

> the prevention of alcohol and other drug use … [seems] … to have far more in common with the prevention of crime than with the provision of drug treatment. (Australasian Centre for Policing Research 2000, p 10)

This is of course not a surprising position for law enforcement agencies to take. Debate over the scope of harm minimisation, and the persistence of competing paradigms of drug use, are indicative of the controversial nature of the drugs problem. As Jagger (1997) posits in her examination of the development of government policy on 'glue sniffing'

> only those expert discourses (or aspects of these) which are compatible with government's existing political programme … will be taken up and used in the formulation of policy. (Jagger 1997, p 446)

The willingness of group participants to engage even partially in the curriculum development process indicated a preparedness to extend their knowledge beyond the expectations, understandings and assumptions inherited from their workplaces (Beavis 1997).

Wider influences

The intervention of the training development saw some improvement in group participants' questionnaire scores, as expected in the project design. The dominant discourses in each work setting seemed to have a significant impact on scores of staff from each service. However, as the intervention was centred on a process of training curriculum development, rather than the actual delivery of a training program, it is useful to consider possible reasons for the extent of this effect.

A large part of the impetus for establishment of the Dual Diagnosis Resource Centre was a growing recognition by staff of Dandenong Area Mental Health Service of the extent of the drug abuse problem among clients, and the attendant difficulties providing effective treatment to this population. From its inception, the Centre has had to be active in addressing these difficulties; as the Centre's work became more established and recognised, it became increasingly unrealistic to limit interventions to the training development group. Besides the activities of this group, other work by and emanating from the Centre influenced staff knowledge of dual diagnosis issues. These included:

- Inquiries made to the Centre by staff in relation to the treatment of specific clients. These secondary consultations were often in the context of team meetings at particular work settings, and sought to facilitate information sharing among clinical staff.

- Resources provided by the Centre as part of its function within the service. These include books, videos and government reports that are freely available as references to service staff; pamphlets are also available from the Australian Drug Foundation and other sources. Information from these resources

became widely disseminated throughout the service.

- Informal discussions and debates among service staff about dual disorders. These often included contributions by the author, and increasingly incorporated reference to the consultations made and resources provided by the Centre.

Curriculum development and discursive practices

There is an explicit focus in the training curriculum on the fundamental principles, knowledge and skills underpinning each of the three sectors involved in the curriculum development. However, there seemed in the training development group to be an at times marked reluctance to give feedback on draft curriculum content about familiar topics. Feedback was most forthcoming when the group was presented with a virtual finished product, or when the content was previously unfamiliar to individual participants. Participants from both work settings seemed equally difficult to engage in curriculum development about topics they were already familiar with; it is possible that participants may have viewed already familiar content as less valuable inclusions in the curriculum. When considering reasons for this difficulty of engagement, it is useful to recall the discursive practices operating within the group, as outlined earlier. A clarification of the term 'curriculum' is needed; the definition offered by Cherryholmes (1987) seems appropriate in this context:

> What students have an opportunity to learn [along with] a study of what is valued and given priority and what is devalued and excluded. (p 297)

Whether group participants were operating within orders of discourse grounded in the harm minimisation approaches of drug treatment, or the more biomedically oriented paradigms of mental health services, group participants seemed more responsive to new ways of approaching issues around dual disorders than they were to familiar methods. This would explain the project's success in improving group participants' questionnaire scores, and may be an encouraging indication of participants' willingness to adapt to new ideas and work practices.

Conclusion

Professional education and training are necessary but not sufficient components of improving organisational effectiveness. Through building on an organisation's strategic direction, and making provision for individual contributions to curriculum and policy development, professional education and training can become embedded as core elements of organisational culture.

The dominant discourses in respective work settings were borne out in questionnaire results, affirming the need for training curricula that challenge and encourage change to familiar work practices. The project has also demonstrated the value of working collaboratively with staff and management when developing new training curricula. Cultural aspects of individual and organisational learning need to be acknowledged and incorporated into the design of curriculum development processes, to narrow the gap between the theoretical realm of training and the reality

of clinical practice, and to align training curriculum development with the broader context of organisational life.

There is a strong trend in the literature toward integration of services to more effectively meet the complex needs of people with dual disorders. The process of developing a training curriculum in collaboration with the major service sectors involved, and after consultation with a wide range of key stakeholders, has produced a training curriculum that affirms this trend. The Dual Diagnosis Resource Centre has adopted a consultative, inclusive approach to addressing the needs of all relevant stakeholders. The Centre's strategy of building the capabilities of existing mainstream services through consultations, training and support for research has the potential to induce long-term, adaptive organisational change.

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Contact details

Steve Goldsmith

Coordinator, Dual Diagnosis Resource Centre
Dandenong Area Mental Health Service
PO Box 956, Dandenong
Victoria 3175
Ph: +61 3 9554 1847
Fax:+61 3 9554 1860
Email: s.goldsmith@southernhealth.org.au