

The Management of People
with a co-existing

Mental Health and Substance Use Disorder

Discussion Paper

Better Health Good Health Care

NSW HEALTH

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NSW HEALTH DEPARTMENT

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EXECUTIVE SUMMARY

This Discussion Paper was developed by the NSW Health Department's Dual Diagnosis Project, to explore the issues and health care needs of people with co-existing mental health and substance use disorders (Appendix 3). The terms dual disorder and dual diagnosis refer to people who have these comorbid conditions.

The nature and extent of dual disorders, evident in population and clinical studies, suggest that these disorders frequently co-exist and their prevalence may be increasing. Depending on the population sample, 30% to 80% of people with mental disorders have a co-existing substance use disorder and corresponding rates of mental disorders are reported for people with substance use disorders. The cost to the health system for someone with a dual disorder is significantly higher than it is for someone with a single disorder. They have higher rates of suicide, hospitalisation, criminal behaviour and because of the complexity of their problems they are often identified as 'difficult' and may not receive the care they require, falling between programs and services (Burdekin Report).

These comorbid disorders may vary in their severity and complexity. Many are mild or time-limited and therefore do not require specialist interventions. However for those people with more disabling disorders, a health care system with the capacity to meet their needs is required. Barriers to service provision for people with dual disorders are outlined in this paper and include separate services, funding and administration, as well as differing philosophies, skills and training. Access to services has become increasingly restricted as more and more health care organisations are operating within an exclusive, rather than inclusive model of care. Consequently expertise on how to identify and manage comorbid disorders has diminished and the ability of health services to provide effective interventions is less than optimal.

A review to determine what, if any, programs are provided for people with comorbid mental health and substance use disorders, found that service delivery across NSW varied significantly. While there was a need for a system of care that consistently endorsed a philosophy of inclusive and comprehensive health care, service provision seemed at times to rely largely on the interest and expertise of individual clinicians. The findings suggest that the quality and effectiveness of service delivery need to be further developed.

Models of treatment, including sequential, parallel and integrated services are reviewed and the notion of a "best practice" model is addressed. While integrated care is seen to be ideal, particularly for people with severe comorbid conditions, there remains no real evidence on what treatments or service models best meet the needs of people with various co-existing mental health and substance use disorders. The need for further research and clinical trials is recommended, to determine the most appropriate and cost effective clinical interventions.

The question of what can be done to improve the health care and health outcomes of people with comorbid disorders is raised and the need to implement health promotion, prevention and early intervention strategies is recommended. To further reduce the onset, duration and severity of dual disorders, collaborative partnerships and an increasingly skilled workforce are identified as important strategies. There is a need for agreed frameworks on how services can better meet the needs of people with such disorders. This has led to the development of service delivery guidelines.

1. INTRODUCTION

It is a well known, but poorly addressed fact, that drug and alcohol problems often co-exist with mental disorders (Regier, 1990; Hall, 1996). However the emerging literature suggests that despite the growing prevalence of dual disorders both here and overseas, service delivery systems need to better meet the needs of this group (Reiss, 1992).

Much of the psychiatric literature concerned with co-existing substance abuse and mental health problems focuses on people with a chronic psychotic disorder such as schizophrenia and substance use problem. However many other mental disorders are associated with increased rates of substance use disorders including mood disorders (alcohol, stimulants), personality disorders, particularly anti-social and borderline personality disorder (alcohol, polysubstance), anxiety disorders (alcohol, benzodiazepine), PTSD (alcohol, cannabis), eating disorders (alcohol, stimulants), and conduct disorders (alcohol, polysubstance) (Regier et al, 1990; Smith & Hucker, 1994; Ouimette et al, 1996).

In fact it is not clear if there are any psychiatric illnesses which are not associated with a higher incidence of substance use disorders, not that the substances used will be specific for any particular type of disorder.

2. AETIOLOGY FACTORS

Psychosocial and biogenetic factors have long been considered to be instrumental in the development of both psychiatric and substance use disorders.

Early psychoanalytical formulations focused on drug use as a symptom of some other underlying psychopathology (Wurmser, 1974) and systems theorists studied the role of familial dysfunction in the development of addictive disorders (Steinglass, 1987). Social scientists, on the other hand, emphasise the role of cultural mores (Becker H.S, 1980).

Andrews in his paper on Comorbidity and the General Neurotic Syndrome (1996) argues that a general vulnerability factor, associated with personality traits of high anxiety and poor coping, is a principal cause of comorbid anxiety and depressive disorders. Vulnerability to the development of disorders was thought to be substantially-influenced by a common genetic factor that influences temperament.

The co-occurrence of affective disorders and alcoholism in families is widely acknowledged but explanations for this clustering remain controversial. A study by Maier and Merikangas (1996) found that the sharing of familial aetiological components was not a major contributor to the excess comorbidity between depression and alcoholism. They did however find a positive correlation between familial components of bipolar mood disorders and alcoholism. This field is complex and there is a large body of evolving research which should further clarify aetiology and the roles of genetic, familial, shared environments, psychological, social and cultural determinants.

Consumers in a VICSERV survey (McDermott, 1995) suggested that people with a mental illness take drugs for the same reasons as everyone else: that is, primarily to feel good.

3. EPIDEMIOLOGY OF COMORBID MENTAL HEALTH AND SUBSTANCE USE DISORDERS

People with a psychiatric illness are more likely to have a substance use disorder than people without a psychiatric illness. Similarly, people with a substance use disorder are more likely to have a psychiatric disorder than people without a substance use disorder (Regier, 1990; Burkstein, 1989; Fisher & Bentley, 1996). The association between mental disorders and substance use is complex. People with such co-existing disorders are not a homogenous group, they suffer a range of disorders which vary in their severity and which fluctuate over time. Disorders may be primary, secondary or independent of each other but they are nevertheless intrinsically connected and increasingly they are being identified as intertwined problems.

It is agreed that there is a need for improved data on the prevalence of disorders, health service utilisation and treatment requirements for people affected by mental health and substance use disorders.

A recent counter to this dearth of knowledge is the 1997 National Survey of Mental Health and Wellbeing of Adults in Australia. Approximately 10,600 people aged 18 years or over from private households in all States and Territories participated in the survey. It was designed to provide information on the prevalence of a range of mental disorders that occurred in the preceding 12 months. These included anxiety disorders, affective disorders and substance use disorders (Appendix 2). People with schizophrenia and other low prevalence disorders were not included in this survey. However, data on this population has also been recently reported (Jablensky et al., 1999).

The former report confirmed that almost one in five adults (18%) have a mental disorder with young people (18 -24 years) showing the highest prevalence at 27% in any one year. Men and women had similar overall prevalence rates but differed by the type of disorder. Women have higher rates of anxiety (12% compared with 7.1%) and affective disorders (7.4% compared with 4.2%) but men are twice as likely to have substance use disorders (11% compared with 4.5%). Patterns of comorbidity also differed between men and women. Women are more likely to have anxiety and affective disorders in combination (22%), while men are more likely to have substance use disorders in combination with either anxiety (13%) or affective disorders (8.4%). Of those with mental disorders only 38% had visited a health service in the 12 months prior to the interview with 29% consulting a general practitioner. Hospital admissions were rare - less than 1%. This survey confirms what was suspected to be the extent of mental disorders and substance use disorders in Australia. The large percentage of people who are not accessing health services is of particular interest. This report also highlights the critical role of general practitioners. While some people have disorders that are mild or time-limited and as such may not require professional involvement, a significant proportion of people are clearly struggling with disorders, that if treated, could restore their quality of life and improve their day to day functioning.

A study to investigate the prevalence and needs of people with co-existing mental health and substance use disorders in Victoria was conducted in 1988 by VICSERV, a peak body of the community managed psychiatric disability services. This project was developed after an exploratory telephone survey revealed that between 40% and 70% of their clients had such comorbid disorders and most were having problems accessing services. The study identified that people with such dual disorders are a diverse group with various complex needs and as such require a range of treatments and services (McDermott F. & Pyett P., 1995). They recommended the following guidelines:

- that cross-sector collaboration is used in formal structures and networks to develop frameworks for service delivery;
- that outreach support and maintenance programs are developed to meet the range of needs required by people with co-existing mental health and substance use disorders;
- that the concept of harm minimisation is adopted in service delivery;
- that a specialist service is developed as an adjunct, rather than an alternative to existing services for some people with both a serious mental disorder and problematic substance use;
- that relevant peak bodies oversee training needs for service providers and that initiatives at the level of policy and administration are built into service agreements - to ensure training is implemented;
- that organisations work collaboratively to develop protocols for data collection to facilitate research, evaluation and service planning;
- that those most affected by dual disorders be involved in future research activities.

Prior to these surveys, Burdekin (1993) noted that despite the lack of large-scale data in Australia, the prevalence of substance abuse and mental illness in our population would be comparable to that found in the United States.

Other population-based data concerned with co-existing mental health and substance use disorders has come from large community wide surveys undertaken in America. The Epidemiological Catchment Area (ECA) Survey (Regier, 1990) was used to derive community estimates of major DSM-111R disorders, experienced in the lifetime and in the past year. The study was conducted in five catchment areas in the USA and involved face-to-face interviews with 20,291 Americans aged 18 years and over. The study was undertaken between 1980 and 1984.

In summary this study found that 22.5% of the general population had a lifetime prevalence rate for any mental disorder other than a substance use disorder. For alcohol dependence or abuse the lifetime prevalence was 13.5% and for drug dependence or abuse it was 6.1%. Of the 22.5% with a mental disorder, twenty-nine per cent also had a co-existing substance use disorder (i.e. a dual diagnosis) and 37% of those with an alcohol disorder had another mental disorder. Seventy per cent of those with drug disorders also had an alcohol or other mental disorder. For alcohol and drug use disorders, rates of comorbidity were higher for women than for men. Rates of co-morbidity showed wide variation by specific psychiatric diagnosis (Appendix 1).

The National Co-morbidity Survey (Kessler et al., 1994) is another population based survey that was undertaken between 1990 and 1992 to specifically examine the extent of comorbidity between substance use and non-substance use disorders in the United States. Major disorders were defined using the DSM-111R classification and the survey was a probability sample of 8,098 15-54 year olds. The rate of co-morbidity between substance use disorders and mental illness was generally found to be higher in this study than in the ECA. The study found that 48% of the sample had an overall lifetime prevalence of any psychiatric disorder and the prevalence of any disorder in the past year was 29%. Rates of such dual disorders were particularly high among those with alcohol dependence: 78% of men and 86% of women with alcohol dependence had another mental disorder.

These American studies and the Australian National Survey, reveal the significant prevalence of people with comorbid disorders within the general community.

3.1 CLINICAL SAMPLES

Of course rates of comorbidity are higher in clinical populations than amongst the general community. High rates of substance abuse have been confirmed among in-patient psychiatric populations (Toner, 1991), in emergency services (Barbee, 1989) and in young men with mental disorders living in poor urban areas (Drake & Wallace, 1989).

When Khalsa et al (1991) examined substance abuse rates in 584 people presenting to a psychiatric assessment unit, they found 78% reported lifetime substance abuse, and 39% met DSM-III-R diagnostic criteria for a current coexisting psychiatric disorder and substance use disorder.

A study in the Hunter Area Health Service recently investigated the prevalence of substance use in a community outpatient clinic for people with schizophrenia. One hundred and ninety four outpatients were assessed using a structured interview, standardised rating scales, urine drug screens and case manager assessments. They found lifetime prevalence rates for schizophrenia and problematic substance use to be 59.8% and 6-month prevalence was 26.8% (Fowler et al., 1998).

The National Drug and Alcohol Research Centre (Mattick, 1997) examined the prevalence of psychiatric disorders in a sample of 270 methadone maintenance clients from three separate non-government clinics in Sydney. They reported significantly higher lifetime rates of depression (30%), anxiety/panic disorders (8%), social phobia (40%) and antisocial personality (42%) compared to the general population. Apart from the elevated rates of social phobia these results are consistent with previous studies for opiate dependent people (Reiger et al., 1990).

4. INCREASING PREVALENCE

A worrying trend is the increasing numbers of people developing comorbid mental health and substance use disorders. A review by El-Guebaly (1990) reported rates of such dual diagnosis in clinical populations ranging between 20 and 75%, depending on the specific nature of the diagnosis. However even this very considerable incidence has been suggested to significantly under-report the extent of the problem. A number of factors that may lead to this under reporting have been suggested and include the following:

- *Definitions and reporting* - Investigations limited to self-reports and patient interviews may lead to under reporting, as patients may not disclose through fear of criminal prosecution, embarrassment, or failure to recognise or acknowledge the extent and impact of their substance use.
- *Treatment setting locations and criteria* - The prevalence of substance abuse varies with the location, the treatment setting and the program criteria.
- *The nature of the population being measured* compared to populations within an urban university medical centre, a demographically matched psychiatric population exhibits a two to four times greater use of substance use (El-Guebaly, 1990).

A number of reasons for the increased prevalence of substance use disorders in people with a psychotic illness have been advanced by Smith and Hucker (1994) and include:

- attempts to self medicate symptoms of psychiatric illness and side effects of prescribed medications;
- social drift into environments where substance use is common;
- attempts to facilitate social interaction;
- attempts to participate in certain subcultures;
- attempts to develop an identity more acceptable than that of a patient with mental illness;
- attempts to cope with the disabilities of mental illness (isolation, poverty);
- a possibility that substance abuse may precipitate, perpetuate or cause such psychiatric illness.

Smith and Hucker's study confirms what many clinicians are reporting: an increase in the number of people with such disorders. Several reasons are proposed to account for this. Firstly de-institutionalisation has resulted in more patients living in the community, and this exposes them to substance using cultures. Secondly an increase in the social acceptability and prevalence of substance use, may contribute to higher levels of disorders. It is also possible that increased interest and awareness of the problem has resulted in an increased index of suspicion, with more clinicians actively seeking evidence of dual disorders in their patients.

A further issue may be that rates of one or both types of disorder are increasing. Rutter and Smith (1995) have suggested that there is evidence of mental disorders increasing in young people.

There is also evidence of a rise of drug use in the general community. Australian statistics indicate that the proportion of young people using cannabis, inhalants, hallucinogens and narcotics has increased in the past 10 years, with cannabis being the most widely used illicit drug. In 1992, 30% of boys and 21% of girls in the 12-17 year age bracket had experimented with cannabis. By 1996 this had increased to 38% of boys and 30% of girls. (Australian School Students Survey, 1998).

Both these trends may contribute to higher levels of comorbidity, particularly in young adults.

5. SIGNIFICANCE PREVALENCE OF COMORBID MENTAL HEALTH AND SUBSTANCE USE DISORDERS

5.1 CLINICAL SIGNIFICANCE

So what is the significance of these emerging trends for service providers? Lehman (1989) considers there are four clinical hypotheses to address when discussing the relationship between substance use disorders and psychiatric conditions. These are:

- Primary mental disorder with substance abuse sequelae.
- Primary substance abuse with psychiatric sequelae.
- Dual primary diagnosis.
- Common aetiology.

Clarification of the relationship is sometimes possible if a thorough, longitudinal history is taken. However this is not always feasible, particularly with first presentations when acute disturbances of one disorder can accentuate or mask the other. The relative contribution of co-existing disorders will vary at different times so premature decisions regarding which disorder is primary are not advised.

Hall (1996) reports that mental disorders complicated by substance use disorders and conversely substance use disorders complicated by mental disorders are recognised as having a poorer prognosis and being more difficult to treat. Such disorders are;

“more likely to be chronic and disabling, and to result in greater service utilisation. They are therefore more likely to cause considerable misery and suffering among those afflicted by them, and considerable social costs in terms of marriage breakdown, social isolation, poor educational attainment, unemployment and chronic financial difficulties.” (Hall, 1996, p. 168)

There is in fact considerable evidence to suggest that people with comorbid disorders do less well than people with either a psychiatric or substance use disorder alone (Tohen, 1990; Connexions, 1992; Drake, 1993). Low rates of treatment, increased frequency of relapse, re-hospitalisation, suicide attempts and violence have been consistently reported in people with comorbid mental health and substance use disorders (Ridgely, 1990). Increased rates of non-compliance, tardive dyskinesia and neuroleptic refractoriness have also been reported (Bowers, 1990).

Compounding all these problems are the related social and occupational costs. People with comorbid disorders have an increased chance of developing a range of associated problems including legal, family and financial difficulties, with increased rates of incarceration, homelessness and housing instability (Reis, 1992; Drake & Wallach, 1989; Osher & Kofoed, 1989).

Of course the prevalence and consequences of these disorders will vary with particular populations. Groups such as Aboriginal and Torres Strait Islander peoples, prisoners and young people will have specific needs which need further clarification.

In summary, research indicates that people with these diagnoses have more problems, are harder to treat, have poorer outcomes and have higher service utilisations when compared to people without such comorbidity.

5.2 SERVICE USE SIGNIFICANCE

Given the apparent increase in the numbers of people with comorbid disorders, what are the implications for health care services, which are specifically designed to treat single disorders? Evidence of potentially inefficient patterns of service use have been noted, with heavy and episodic use of emergency psychiatric services and overall increased service costs (Richardson et al 1985). To gain a more recent statewide measure, a census of clients with drug and alcohol problems presenting to community health centres was done by the NSW Health Department in 1991 and 1992. This census demonstrated that people with these comorbid disorders were more likely to be receiving social security benefits, and less likely to be employed full time than those with a single disorder. Clients with these comorbid disorders have a higher level of resource use in terms of personnel type, frequency and duration of intervention. Their referral sources are more likely to be doctors, psychiatric hospitals or health centres. These clients are less likely to self refer, are more likely to receive medication, to be seen more than once a week, and to have received more than two types of intervention (Muir et al., 1991).

These surveys found that almost a quarter (23%) of the clients seen in drug and alcohol services in the 1991 and 35% of clients in the 1992 surveys had a concurrent psychiatric diagnosis. However, it should be noted that coding differed over the two surveys; ICD-9 diagnostic categories were used in the 1991 census while ICD-10 categories were used in the 1992 census. On the particular day chosen for the 1991 census 1252 clients were seen and 682 or 54% of them were dealt with by staff who were not specialist drug and alcohol workers. In part this reflected the number of clients with comorbid disorders such as schizophrenia, but after removing dual disorder cases over a third (36%) of clients were seen by non specialist staff.

This is not so surprising when the numbers of mental health staff are compared with the number of drug and alcohol staff. The 1996/97 National Survey of Mental Health Services reported that over 5,000 staff are employed in mental health services across NSW. Precise numbers on how many staff are employed within drug and alcohol services are not available, but according to the Network of Alcohol and Other Drugs Agencies (NADA) there are approximately 100 non-government drug and alcohol organisations in NSW. Together with staff employed by NSW Health this indicates that around 1,100 staff work in drug and alcohol services. Given these figures, there are clear implications for service provision. For instance, access to drug and alcohol services is limited on weekends and outside regular working hours, consequently the care and treatment of people with comorbid disorders is largely provided by mental health and mainstream health services. This clearly indicates the need for mainstream and mental health staff to have up to date skills on the assessment and management of substance use disorders. Furthermore, attempts to develop collaborative partnerships with drug and alcohol professionals, in government and non-government sectors, are required for people with disorders which are complicated by substance use.

6. SERVICE PROVISION FOR PEOPLE WITH COMORBID MENTAL HEALTH AND SUBSTANCE USE DISORDERS IN NSW

Despite the fact that people with such comorbid disorders utilise health services more than people with a single disorder, there are very few specialist services which focus on the ongoing care and management of individuals affected by both disorders. To address these issues a project officer was appointed in 1998 by the Centre for Mental Health and the Drug Programs Bureau of the NSW Health Department. This joint initiative was developed to identify and address the gaps in service delivery, to promote a model of collaborative partnerships and specifically, to develop service delivery guidelines to improve the health care and health outcomes for people affected by dual disorders.

The project initiated a review to determine what, if any, programs are provided for people with dual disorders and found that service delivery across NSW varied significantly. Service provision seemed to rely more on the interest and expertise of individual clinicians, than a system of care that consistently endorsed a philosophy of inclusive and comprehensive health care. These findings suggest that the quality and effectiveness of service delivery could be further developed to address these issues. A cultural shift in attitudes, from exclusion to one of holistic and inclusive care is required.

More recently, a number of projects have been developed by Area Health Services to address the issues of such comorbid disorders and an education and training program is currently being developed by the Institute of Psychiatry. Services within and surrounding metropolitan Sydney are significantly better resourced than country areas. However, despite this shortage or perhaps because of it, clinicians in remote areas tend to be more accustomed to and accepting of the need to provide comprehensive and inclusive health care.

7. BARRIERS TO SERVICE PROVISION IN NSW

Evidence given to the Burdekin Inquiry indicated that despite the high prevalence of such dual disorders, a severe lack of communication existed between mental health and drug and alcohol services. As a result of this, the Inquiry was told that people with a dual diagnosis tend to "fall through" the gaps in the health care system. It was suggested that mental health services are unwilling to admit them because of their addiction and conversely detoxification centres and other organisations treating substance abuse are unable or unwilling to provide treatment for people with a mental illness.

"If somebody with a psychiatric disability has a drug problem and is on medication, to try and get them into a detoxification centre is impossible because detox centres will not take anyone on medication.. [and] to try to get anyone with a drug problem into an accommodation service designed for psychiatrically disabled people, is almost impossible." (Burdekin Report 1993, p.665).

These management issues noted by Burdekin, should be seen in the context of the differing philosophies and approaches that underpin treatment in the mental health and drug and alcohol services. For example, mental health workers generally aim for an assertive follow-up model, pursuing clients if they miss an appointment. In drug and alcohol services there is a greater reliance on self-motivation and helping a client abstain from substance use is a primary goal. This creates major difficulties for people with both a mental disorder and substance use problem, who may depend on psychiatric medication for their mental health and stability and who all too often are refused access to treatment and support because they do not meet the strict entry criteria of many services. It should be noted however that these services were once part of an integrated service framework dealing with both types of disorders in one organisational system. The question of the appropriateness of such a model is not the focus of this paper however.

During an early phase of the NSW Health Department's project, clinicians, academics, consumers, carers and managers from mental health and drug and alcohol services were consulted, to discuss the needs of people with dual disorders. Of particular concern and interest were the barriers to service provision documented in the Burdekin Report. A recurring theme was that as organisations have become more specialised and exclusive, primary care providers were called upon to provide the majority of care – a role for which they frequently felt a need for a greater level of skills, knowledge, expertise and back up for necessary referrals. Two further major issues that impede effective health care for people with such comorbid disorders, were reported to be the complex nature and development of disease processes and the organisational issues related to service delivery.

7.1 DISEASE PROCESS ISSUES

Disease process issues noted in this consultation process and supported in the literature, can be summarised as the following:

- failure to detect substance use disorders in people with mental disorders: a high index of suspicion is required.
- mis-identification of substance intoxication or withdrawal as symptoms of psychiatric illness.
- exacerbation of acute psychiatric symptoms and overall severity of mental health disorders by substance use (some authors suggest that almost any substance use by patients with schizophrenia should be considered problematic) (Drake, 1990).

- substance use to reduce the symptoms of psychiatric illness and the effects of medication, resulting in the perpetuation of substance use disorders.
- the presence of both disorders is indicative of increased disease severity and chronicity (of psychiatric and / or substance use disorder).
- the onset of many mental disorders at a time when exposure to and experimentation with substances is most prevalent - ie adolescence.

7.2 ORGANISATIONAL ISSUES

Organisational issues identified as barriers to comprehensive service delivery include:

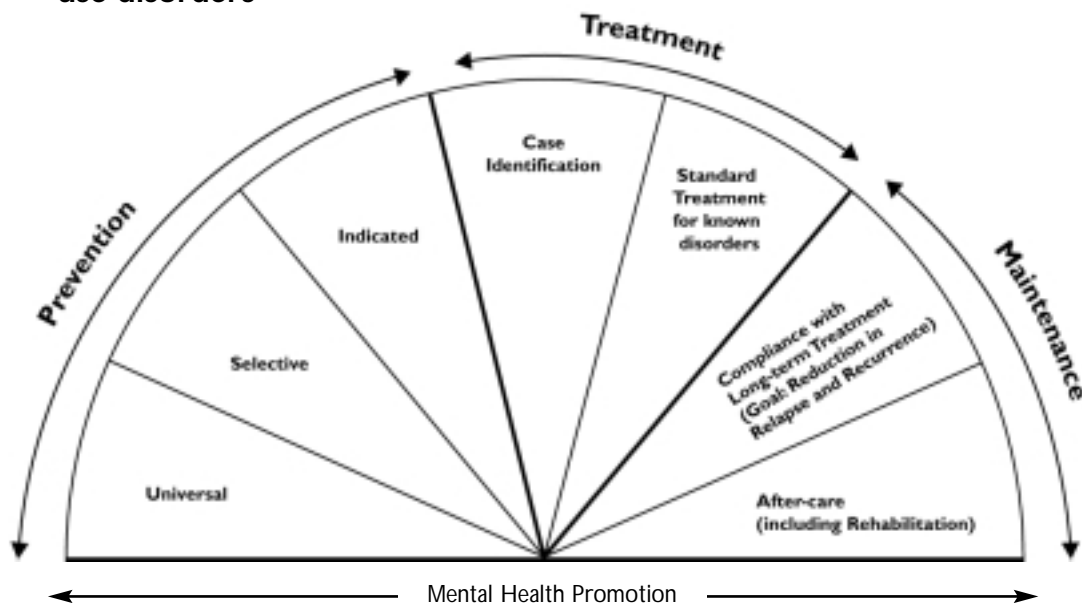
- separate cultures of service provision eg. public health harm minimisation focus compared to specialist health service delivery.
- separate drug and alcohol and psychiatric rehabilitation programs: separate funding, administration, clinicians, training, aims, physical locations.
- strict entry criteria to some programs which exclude people with more than one disorder.
- lack of specific programs addressing the special needs of these patients.
- differing philosophies between drug and alcohol and psychiatric services. For example at the extremes, mental health services may see substance use disorders as 'character disorders' while drug and alcohol services may perceive psychiatric illnesses as a manifestation of substance abuse and consequently be opposed to the use of psychotropic medication.
- symptoms of a substance use disorder can interfere in psychiatric rehabilitation program participation; and symptoms of psychiatric disorder can interfere in drug and alcohol rehabilitation program participation.
- a psychiatric disorder may make it more difficult for the patient to comprehend and participate in the drug and alcohol program.
- drug and alcohol programs may refuse access to some people with psychiatric disorders because they may require psychotropic medications, and may exhibit disruptive behaviours.
- psychiatric rehabilitation programs may refuse access to clients abusing substances.
- for similar reasons clients may be discharged before completion of the drug and alcohol or psychiatric rehabilitation program.
- there is a lack of cross sector training and support between services.

These concerns could be summarised as reflecting difficulties in the clinical recognition and assessment of potentially dual disordered clients; difficulties in accessing appropriate services; and difficulties in identifying best practice approaches for clients with more than one disorder.

8. PREVENTION AND TREATMENT MODELS

Despite the high prevalence of comorbidity there is scant evidence about the nature of 'best practice' services for this client group on how to impact on current or increasing prevalence, a need for better outcome data for both prevention and treatment trials. There is a need also to bring together the two service frameworks, both from the point of view of public health and personal health care delivery. The following model is increasingly seen as relevant to this aim.

Figure 1: The mental health intervention spectrum for mental health and substance use disorders



From Mrazek PJ and Haggerty RJ. (Eds.) 1994. *Reducing Risks for Mental Disorders. Frontiers for Preventive Intervention Research.* Washington, D.C., National Academy Press, p.23

Mrazek and Haggerty (1994) have highlighted the importance of a spectrum of interventions in impacting on the prevalence and disability, including the personal and population impacts of mental and substance use disorders.

This requires the provision of appropriate evidence based interventions from prevention to treatment to maintenance across this spectrum to achieve the service package of "best-buys" to improve outcomes.

8.1 PREVENTION

While the field of substance use problems has a strong public health and prevention approach these programs have only very recently become a focus in mental health although there is a sound and growing evidence base here also.

Prevention programs directed at decreasing risk of onset of these disorders, and hence comorbidity should focus on many common variables, because of the many generic risk and protective factors. This joint focus for prevention, for instance in childhood and adolescence requires much further development.

Nevertheless the prevention of substance use and mental disorders can be contributed to by programs building self-efficacy and resilience; improved parenting for young children and decreased child abuse; school based programs to enhance school environments and provide educational programs about prevention, self-care, and building strengths.

Because of the heightened risk of the onset of both disorders in the mid to late adolescent years this is often a critical period for prevention and early intervention to decrease the risk of i) disorders developing ii) comorbidity and iii) adverse outcomes including suicide (Mrazek & Haggerty, 1994).

These opportunities provide an important component of the intervention spectrum and link well with treatment services which should be available in both primary care and specialist settings.

The need to develop these programs further is dealt with below (see section 9).

8.2 TREATMENT SERVICES

Most studies have had very small sample sizes, lack of controls, and short follow up periods (Jerrel et al., 1995; Greenfield et al., 1996). Nevertheless, effective treatment interventions, both brief and longer term are available for both types of disorders and should be made available in clinically appropriate and integrated ways.

Information from the United States has led to heightened recognition of people with a dual diagnosis and a concomitant increase in the amount of services they consume and their problem of homelessness (Reis, 1992). In fact the term, dual diagnosis, originated in the United States during the 1980 when Minkoff (1989) and Osher and Kofed (1989) described an integrated model of treatment and stressed the importance of addressing both disorders concurrently.

In recent years as mental health and drug and alcohol professionals have become increasingly aware of co-existing mental health and substance use disorders, various attempts have been made to adapt treatment to the special needs of these people.

These attempts have reflected philosophical differences about the nature of those comorbid disorders, as well as differing opinions regarding the best way to treat them. They have also highlighted the limitations of available resources, as well as differences in treatment approaches for different types and severities of dual disorders. Three commonly used treatment models described includes; sequential, parallel and integrated care (Reis, 1992).

8.2.1 SEQUENTIAL TREATMENT

With sequential treatment the patient is treated by one system (drug and alcohol or mental health) and then by the other. For example, a person may receive treatment at a community mental health centre during occasional periods of depression and then attend a local drug and alcohol treatment program for binge drinking. This model allows the mental health and drug and alcohol services to operate in separate spheres. When clinicians from mental health and drug and alcohol services were consulted by the NSW Health Department in 1998, there were vastly different ideas and opinions on the optimum order of treatment for these dual disorders.

Some clinicians believe that drug and alcohol treatment must always be initiated first, that the individual should be abstinent from drugs before treatment for the psychiatric disorder can begin. Other clinicians believe that treatment for the psychiatric disorder should begin prior to the initiation of abstinence and drug and alcohol treatment. Still other clinicians believed that the disorder that emerged first should be treated first and then others believed that symptom severity at the time of entry to treatment should dictate whether the individual was treated in a mental health or a drug and alcohol setting. The need to treat both disorders concurrently, with priorities for treatment being determined by the current and specific needs of individual clients is increasingly identified as important and an approach requiring comprehensive and integrated care.

8.2.2 PARALLEL TREATMENT

Parallel treatment involves the simultaneous involvement of the client in both mental health and drug and alcohol treatment. For example, an individual may participate in groups with the drug and alcohol service and attend therapy or medication education classes at a mental health centre. Coordination between settings is quite variable in this model, but more importantly, faced with the difficult task of negotiating two separate organisations, the client is rarely engaged by either service. More often than not they are referred from one service to another and because they may not fit easily in a health care system set up to deal with single disorders, they are frequently excluded by both (Ridgely, 1990).

8.2.3 INTEGRATED TREATMENT

An integrated approach combines elements of both mental health and drug and alcohol treatment into a unified treatment program. Integrated treatment involves clinicians cross-trained in both mental health and substance use disorders, as well as a unified case management approach, making it possible to monitor and address both psychiatric and substance use disorders. Integrated programs (inpatient and outpatient) include features such as consumer education programs, peer group support, psychotherapy, psychotropic medications, psychoeducation, substance use disorder counselling, occupational therapy, family education and case management, when appropriate.

The main advantage of an integrated model, is the ability to directly address issues critical to clients with comorbid disorders, issues which are often not addressed in either psychiatric or drug and alcohol programs. These include education on the potential synergism of the two disorders; the potential for harm of even small amounts of substance use in vulnerable individuals; the pitfalls of attempting to self medicate; and the need to develop alternate coping strategies.

Two basic philosophical approaches have been reported in studies on integrated service models: the disease and recovery model (AA based) and the cognitive-behavioural approach. The most substantial study which compares outcomes of three treatment approaches within an integrated model, was conducted in the United States by Jerrell and Ridgley (1995a). The three interventions were 12-step recovery, behavioural skills training and intensive case management. The behavioural skills training approach performed best for substance use, psychiatric symptoms and psychosocial adjustment. The 12-step recovery approach may have helped with substance use, but, as expected, had little impact on psychiatric symptoms while the case management approach had some effect on psychiatric symptoms, but no effect on substance use.

Any such approaches should include recognition of the role of psychopharmacology in the treatment of both types of disorders when indicated clinically, for instance psychotropic drugs, anti-craving medication. The primary psychiatric diagnosis ie. psychotic or suffering from a non-psychotic depression or anxiety disorder will create specific treatment requirements, as well as decisions about the use of anti-craving drugs such as naltrexone and acamprosate. There is thus a need for careful monitoring of this component of treatment.

8.2.4 A BEST PRACTICE MODEL?

There are advantages and disadvantages in each model. Differences in dual disorder combinations, symptom severity, and degree of impairment, impact on the ability of one treatment model to suit all individuals. For example, sequential and parallel treatment may be appropriate for people who have predominantly one or other disorder, while an integrated approach would suit clients with severe disorders.

Currently no single method of treatment for any of the various comorbid disorder combinations has been proven and health care providers rely more on clinical judgement than research evidence (Room 1997). However the studies that have reported health outcomes for people with such comorbid disorders, treated within an integrated service model, have found reductions in hospitalisations and slight changes in psychosocial functioning and symptoms (Jerrell and Ridgely, 1995b).

The study by Jerrell and Ridgely (1995b) to examine the effectiveness of an integrated treatment model for 147 patients with severe mental illness and secondary substance abuse found that at an 18-month follow up, participants had achieved significant improvements in the area of work productivity, independent living and social contacts. There was a significant decrease in observable psychiatric symptoms, a reduction in the use of emergency services but there was little change in substance use and overall satisfaction with life did not significantly improve.

To understand which treatments are most effective for people with dual disorders Drake (1993) reviewed the clinical research in this area and identified several elements of treatment that are common to successful programs. These included:

"An assertive style of engagement, techniques of close monitoring, integration of mental health and substance abuse treatments, comprehensive services, stage-wise treatment, a long term perspective and optimism" (Drake 1993, p.610).

Particular concerns relate to the treatment of people with severe comorbid disorders who tend to be disorganised with erratic and self-destructive behaviour. These people are usually poor, may be homeless and frequently have few social supports. However despite being clearly identified as people with the greatest need, they may be the ones least likely to get help from health care services (Burdekin, 1993). With this particular population in mind, evidence given to the Burdekin Inquiry by the Western Australian Council of Social Service called for a more integrated approach to people with dual disorders:

"There is a need for the integration of services, including the designation of a 'primary care' worker (regardless of discipline or agency) to be responsible for the complete care of a person. Emphasis was placed on the importance of adopting a holistic approach to treating people and that all agencies should consider themselves part of a team and accordingly coordinate all treatment." (Burdekin Report, P.668).

Minkoff (1989) states that the development of an integrated model represents 'best practice' in the care of individuals with dual diagnosis. In New Hampshire a mental health service has developed an integrated service model, whereby the whole service incorporates mental health and drug and alcohol expertise. Treatment teams have staff cross-trained in both specialities and people with dual disorders are assertively followed up, closely monitored and linked into stage-wise treatment programs. Recent studies on the effectiveness of such integrated care (Drake 1997, Mueser et al 1997) report fewer hospitalisations, more stable housing and reduced substance use. It needs to be stressed however, that the concept of dual diagnosis in the United States is primarily used to describe people with severe comorbid disorders. And while an integrated model does not necessarily entail the development of a specialist super-service, Hall and Farrell (1996) suggest that if this type of combined service were created, it should be evaluated for its cost effectiveness before being generally endorsed.

Todd (1997) suggests that the creation of specialist dual diagnosis services could perpetuate the 'buck passing' tendency, where clinical responsibility for such clients is perceived to be someone else's job, resulting in the delivery of minimal and 'defensive' treatment for the majority of clients seen by generic clinicians. Todd's work signals the potential danger inherent in the establishment of specialist services whose work is just focussed on the needs of this very diverse population. Such specialist dual disorder teams could provide a useful linkage between services with the ability to act as consultants, to develop research projects and to further the understanding of comorbid disorders through education and training. However the ability of such teams to provide the clinical care and case management for all people with dual disorders does not seem feasible. Furthermore, such a team may implement strict entry criteria and perpetuate the philosophy of exclusive care by limiting access to those people who do not quite meet the criteria, but who nevertheless require specialist attention.

Some researchers suggest that it may be more effective to improve linkages between existing services (Hall, 1996; Reis, 1992). Joint assessments, co-case management and cross sector consultations are strategies in this type of collaborative model. Systematic screening of mental health clients for substance use disorders and comprehensive assessment, including a mental state exam for people with drug and alcohol problems enables better identification of comorbid disorders. When an individual has a disorder of sufficient severity to warrant specialist drug and alcohol or mental health treatment, referral and follow-up is consequently organised. As Hall (1996) notes, disorders of mild severity may remit without professional involvement. In this case, services would be better directed to increasing public education and promoting self-help strategies, and support of primary care providers such as general practitioners rather than focusing on developing specialised services.

The Cochrane Collaboration, an international organisation established to review new trials and treatment relevant to evidence-based medicine is currently assessing 'The effectiveness of substance misuse treatments in people with severe mental illness'. Their review is not yet completed, but the fact that they are addressing this issue is evidence of the significance and importance the treatment of people with dual disorders now attracts.

Regardless of what model is preferred, specific difficulties such as trying to include clients with paranoid disorders in groups, difficulty in engaging people with psychotic disorders and having abstinence as a precondition to enter a program, will need to be addressed. Given the range of severity and variability associated with such dual disorders, perhaps the most important issue, is the need for greater cooperation between services. With a better understanding of comorbid disorders and a focus on the person rather than their diagnostic label or rigid compliance to program boundaries, treatment services would be more accessible.

While there remains no real evidence on what treatments or service models should be adopted for people with dual disorders, there is an urgent need for clinical trials across the spectrum of co-occurring disorders. New initiatives and programs should be evaluated for their clinical and cost effectiveness and attention to negative as well as positive findings needs to be frankly acknowledged.

9. WHERE TO FROM HERE?

Population and clinical studies suggest that people with such 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. The question is how can mental health and drug and alcohol services to this group of people be realistically improved? And given that the majority of services are provided by a wide array of human services (Kessler, 1996) what impact can the NSW health system have on the management systems that lie outside its boundaries?

9.1 HEALTH PROMOTION AND PREVENTION

To prevent the onset of mental illness and substance misuse, health promotion and early intervention strategies are well-recognised activities, that if implemented, could help reduce the morbidity and mortality associated with dual disorders (Kosky, 1992).

Research on suicide indicates that risk factors such as depression and anxiety are further compounded by substance use and circumstances associated with loss, deprivation and disadvantage. 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).

The development of these disorders is usually first identified in late adolescence but opportunities for intervention can present themselves in early childhood and in at risk population groups.

Drug and alcohol use by young people has long been a community concern. The increase of binge drinking, cannabis, hallucinogen, and narcotic use (Statistics on Drug Abuse in Australia), coupled with the fact that up to 24% of adolescents will have had a major depression by the age of 18 (NHMRC 1997), points to a continually increasing risk of young people developing mental health and substance use disorders. School based interventions remain the mainstay of prevention activities, however these programs may not reach those at greatest risk, those who are likely to be absent because of truancy, dropout and family disruption.

Family intervention programs have demonstrated effectiveness in enhancing parental skills such as limit setting, problem solving and positive reinforcement with at-risk children and as such, are identified as effective preventative interventions (Dishion & Andrews, 1995). Strategies to promote greater community awareness of mental health and substance use related problems would be further advanced through utilization of the mass media. Clearly a multi-pronged approach to prevention incorporating parent, school and media components is essential if the ever increasing prevalence of disorders is to be reduced. And, as the burden of care is largely carried by non-specialist health systems as well as the justice and welfare systems, to focus solely on mental health and drug and alcohol services would miss important opportunities for intervention (Room 1997).

9.2 EARLY IDENTIFICATION AND INTERVENTION

Early identification and intervention programs have been demonstrated to be both clinically and cost effective (Kosky, 1992). The new public health approach emphasises the need for multiple strategies which target the broader population groups and those identified as most at risk. Screening by primary care givers to identify at risk individuals is an obvious front line strategy, and would need to focus on general practitioners, youth services, and general community health centres as well as mental health and drug and alcohol staff in government and non-government agencies. There are established effective brief interventions for primary care settings. The use of comprehensive assessments and screening tools, is recommended to increase the identification of co-morbid states and should be a priority in both systems (Melinyshyn, 1996; Room, 1997). There are a number of screening instruments in use for the detection of either psychiatric or substance use disorders, but there are few that adequately cover the range of mental health and substance use disorders.

One recent exception is the Composite International Diagnostic Interview (CIDI). This World Health Organization instrument (Wittchen, 1994) has been of limited use in its original pen and paper form, because of the time required to administer and score the data. It has since been computerised and is more user friendly, however it does take between 20 minutes and an hour and a half to complete - depending on the specific diagnoses selected. Other screening tools, used primarily by general practitioners include the Prime MD and the WHO Educational Package for Primary Care Clinicians. These simple mental health tools focus on detection and intervention for commonly occurring psychiatric problems and include alcohol abuse.

With or without the use of one comprehensive assessment form, it is clear that service providers need to improve their competence in the identification and treatment of both mental health and substance use disorders (Woody, 1991). For clinicians in mental health services that would include the ability to take a drug and alcohol history and having access to specific tools, such as the AUDIT (Saunders, 1993) to determine the severity of abuse or dependence. For drug and alcohol workers, incorporating a mental state exam into their usual assessment and greater use of instruments, designed to detect depression, anxiety, and post traumatic stress disorders would increase the identification of a range of mental disorders.

Therapeutic interventions for people with dual disorders have largely relied on the traditional programs for substance abuse (Alcoholics Anonymous) and the usual treatments, such as family therapy, group therapy and psychotropic medication that are common to mental health services. More recently however, the use of motivational interviewing, which was developed by Prochaska and Di Clemente (1992) to describe the stages of change people move through when contemplating a decision in their lives, is proving to be a successful intervention (Brady 1996). The model helps to identify a person's readiness to change and with a focus on self-efficacy rather than direct confrontation. Specific counselling strategies are used to encourage people to make positive changes in their lives.

9.3 EDUCATION AND TRAINING

A core component of health promotion and early intervention strategies is education, for clinicians, consumers, carers, and the general community. For primary care providers, given the task of treating people with these comorbid disorders, the need for education and training is essential. While it may not always change clinical practice, education that is local, ongoing and relevant to the specific population being served, can lessen the need to refer clients to outside agencies (Penick et al, 1990).

Education sessions on substance use in secondary schools are part of the NSW Drug Strategy and while drug and alcohol workers commonly provide this intervention - as community drug education is an accepted part of their clinical practice, mental illnesses and the synergism of both disorders have traditionally been neglected. Mental health services are focusing more on health promotion and prevention strategies and partnerships with educators are being established. Psycho education groups for clients and their families are also being developed and early evaluations of their efficacy are promising (Sciacca, 1989).

School based programs that are more broadly helpful include programs such as "Mind Matters" which is a curriculum and "Whole of School" approach and which can address these combined issues.

9.4 COLLABORATIVE PARTNERSHIPS

While services remain separate in their funding, administration, training, aims and physical locations, cross sector collaboration is hindered. Despite these difficulties, some Area Health Services in NSW have implemented a number of strategies to develop better partnerships and improve the knowledge and skills of their staff in an attempt to provide better treatment outcomes for dual disordered clients. These strategies include the practice of joint assessments and case management, cross sector in-service training, cross-sector secondments and employment opportunities. Additionally in some areas, project officers have been employed and, as a consequence, research projects, education and training sessions and psycho education groups for consumers and their families are being developed. For services with limited access to this expertise, the sharing of knowledge and skills between service sectors is essential (Hall, 1996).

9.5 SPECIFIC POPULATION GROUPS

Identification of high-risk groups and individuals requires special attention. The development of comorbid disorders in vulnerable individuals include people with a history of mental disorders, substance use problems and in people with family histories of either disorder. Additionally people with a history of abuse and trauma, those affected by chronic pain, homelessness and poverty, or others in various ways alienated from mainstream society are at risk of developing disorders. Their specific needs might vary according to their particular circumstances, nonetheless their human rights to accessible and culturally sensitive services needs to be assured. There is also a need for programs to be developed in partnerships with Aboriginal peoples and Torres Strait Islanders where the co-occurrence of mental health and drug and alcohol problems has been identified as a high priority. This type of program must both deal with the very adverse health situation affecting this group, and ensure a collaborative provision for care.

9.6 A NEED FOR GUIDELINES

It is this diversity that demands attention. It is the multiplicity of problems which range in their severity, which affect some groups more than others and which varies within the individual across their lifetime, that contributes to the complexity of dual disorders. Clearly it calls for a number of strategies to firstly identify those most at risk and secondly to better manage their care when disorders emerge. Much further research and data are needed, both at a basic science level (eg. aetiology) and in terms of treatment trials (efficacy) and effectiveness of service delivery. An educated consciousness of dual disorders and their synergism should be extended to social, legal, and general health care systems. However a logical priority would be to focus on the health services, with a view to developing policy guidelines that address the needs of people with dual disorders, their families and the communities in which they live.

Given the enormous difficulties faced by people with such comorbid disorders, it is important that all service providers improve their knowledge and skills in this area of major need. Guidelines that provide a framework for the development of collaborative partnerships as well as innovative programs are clearly required. Reform within the health services, with a shift away from exclusivity to one of inclusion is essential, if people with these comorbid conditions are to get the care and treatment they need.

A commitment to better data and information systems, to outcome monitoring and evaluation remains central. There are no miracle cures, but access to evidence based prevention, early intervention, treatment, rehabilitation and maintenance services can and should be provided. To quote Brian Burdekin 'These people are clearly among the most vulnerable and abused in our society. The cost of protecting their rights is not, therefore, an optional extra; it must be accorded an urgent and effective response' (Burdekin Report 1993, p. 577).

APPENDIX 1

Comorbidity for specific disorders - ECA study (Reiger, 1990).

Anti-social personality	Substance abuse	84%
	Alcohol disorder	74%
	Another drug disorder	42%
Schizophrenia	Substance abuse	47%
	Alcohol disorder	34%
	Another drug disorder	28%
Affective disorders	Substance abuse	32%
	Alcohol disorder	22%
	Another drug disorder	19%
Anxiety disorders	Substance abuse	24%
	Alcohol disorder	18%
	Another drug disorder	12%
Alcohol disorders	Another mental disorder	37%
	An anxiety disorder	19%
	Antisocial personality	14%
	Affective disorder	13%
	Schizophrenia	4%
Drug disorders	Another mental disorder	53%
	An anxiety disorder	28%
	Affective disorder	26%
	Antisocial personality	18%
	Schizophrenia	7%

Appendix 2

Mental Health and Wellbeing Profile of Adults Australia 1997

Table 12. Persons: Comorbidity of Disorders(a)

	Males		Females		Persons	
	'000	%	'000	%	'000	%
Physical conditions only	1,943.7	29.3	2,254.7	33.0	4,198.3	31.2
Mental disorders only						
Anxiety only	127.8	1.9	258.5	3.8	386.3	2.9
Affective only	58.0	0.9	133.7	2.0	191.7	1.4
Substance use only	368.6	5.6	111.1	1.6	479.7	3.6
Anxiety and effective only	48.4	0.7	95.0	1.4	143.4	1.1
Anxiety and substance use only	57.3	0.9	28.7	0.4	86.1	0.6
Affective and substance use only	*10.3	*0.2	*12.9	*0.2	*23.2	*0.2
Anxiety, affective and substances use only	28.8	0.4	22.6	0.3	51.5	0.4
Total mental disorder only	699.3	10.6	662.5	9.7	1,361.8	10.1
Mental disorders and physical conditions						
Anxiety and physical only	110.5	1.7	238.2	3.5	348.7	2.6
Affective and physical only	34.0	0.5	80.3	1.2	114.2	0.8
Substance use and physical only	181.2	2.7	57.4	0.8	238.6	1.8
Anxiety, effective and physical only	38.5	0.6	118.4	1.7	156.9	1.2
Anxiety, substance and physical only	30.8	0.5	34.4	0.5	65.2	0.5
Affective, substance use and physical only	29.2	0.4	*6.7	*0.1	35.8	0.3
Anxiety, affective, substance use and physical only	28.2	0.4	33.7	0.5	61.9	0.5
Total mental disorders and physical conditions	452.3	6.8	569.0	8.3	1,021.3	7.6
Total mental disorders	1,151.6	17.4	1,231.5	18.0	2,383.1	17.7
Total mental disorders or physical conditions	3,095.3	46.7	3,486.2	51.0	6,581.4	48.9
No mental disorders or physical conditions	3,531.8	53.3	3,351.6	49.0	6,883.4	51.1
Total	6,627.1	100.0	6,837.7	100.00	13,464.8	100.0

(a) During the twelve months prior to interview

Appendix 3

The Dual Disorder Project

This Discussion Paper was developed by the NSW Health Department's Dual Disorder Project, a joint initiative between the Centre for Mental Health and the Drug Programs Bureau of the NSW Health Department. The project goal was to review the issues and health care needs of people with co-existing mental health and substance use disorders and specifically to develop guidelines for mental health and drug and alcohol services.

A project officer was appointed and a steering committee was established to oversee the project. The service delivery guidelines were developed following statewide consultations with key stakeholders. This discussion paper provides a review of the current literature and describes, to some degree, the issues related to service delivery for people with dual disorders in NSW. It has provided the building blocks for the development of the service delivery guidelines, which accompanies this Discussion Paper. The NSW Health Department would like to thank the members of the project team for their significant contributions to this Discussion Paper and the subsequent development of the Service Delivery Guidelines.

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