

The Management of People
with a co-existing

Mental Health and Substance Use Disorder

Service Delivery Guidelines

Better Health Good Health Care

NSW HEALTH

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NSW HEALTH DEPARTMENT

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FOREWORD

The care and treatment of people with co-existing mental health and substance use disorders, is an important area of need in NSW. People with complex problems and disorders frequently challenge the capacity of health care systems to meet their needs. Nevertheless, their rights to accessible and culturally sensitive health care should be assured.

These Service Delivery Guidelines have been developed to provide a clear direction for health services to better meet the needs of people with co-existing disorders. The guidelines can be used as a blueprint for services to design, develop and deliver comprehensive health care for people with co-existing disorders. Strategies include the need to build partnerships, improve workforce training and provide a range of interventions aimed towards positive health outcomes.

The Guidelines are accompanied by the Discussion Paper 'The management of people with a co-existing mental health and substance use disorder'. This paper provides a review of the current literature and a background to the issues related to the care and treatment of people with co-existing mental health and substance use disorders. The Discussion Paper documents the need to improve the health and health outcomes of people with comorbid disorders and provides a rationale for the development of the Service Delivery Guidelines. Both documents complement each other and have been informed by the scientific literature.

Consultation with stakeholders from government and non-government mental health and drug and alcohol services, as well as general practitioners, consumers and carers in rural and metropolitan centres has ensured that the Guidelines reflect the diverse needs of differing areas, population groups and mainstream services in NSW.

I am pleased to release these documents on the management of people with co-existing mental health and substance use disorders. I am sure they will assist service providers working in this complex field and reduce the impact of these disabling disorders on clients, their families and carers and the community.



Craig Knowles MP
Minister for Health

EXECUTIVE SUMMARY

In this document the terms dual disorder and dual diagnosis refer to people who have a co-existing mental health and substance use disorder. These guidelines aim to meet the gaps in service provision for people with co-existing mental health and substance use disorders and are the result of a joint initiative between the Centre for Mental Health and the Drug Programs Bureau of the NSW Health Department.

Following broad consultation with key stakeholders and a review of the current literature, the guidelines were developed to enable services to design, develop and deliver more appropriate health care for people with dual disorders. Early intervention and prevention, harm minimisation, comprehensive health care and evidence based good practice, underpin the guidelines.

Service delivery models have been designed to provide direction and help clarify some of the issues related to service provision. People with dual disorders are not a homogenous group, they often present with a number of problems which vary in their severity and complexity. It is this diversity that challenges health care systems. To address these issues, the recommended service models describe how health care systems can meet the needs of people by identifying the nature and severity of their disorders and their current treatment needs. A focus on the person rather than their diagnostic label, or compliance to rigid program boundaries has been suggested. The need for comprehensive assessments and cooperation between services is essential to this process. Equitable access to health care and collaborative partnerships are core strategies in the provision of quality health care and improved individual health outcomes.

Key components to effective service delivery are outlined in the sections on Access, Screening, Engagement and Assessment. Specific strategies are further described in relation to specific settings, treatments and integrated care. The scope of education and training requirements covers primary care providers, specialist mental health and drug and alcohol workers, consumers, carers and the broader community. Ongoing education and access to supervision is recommended, particularly in country areas where specialist services are scarce. While there is a clear need for clinical staff to increase their knowledge base, it is not the intention that all clinicians will become specialist workers in this field. Nevertheless, all clinicians should have basic clinical knowledge and skills in this area. Referral and access to specialist services is recommended if and when required. However, when knowledge and skills are improved, the identification of comorbid disorders and inclusive health care should become the norm.

Responsibility for service provision remains with the Area Health Services, primarily with the Chief Executive Officers and service directors. With the development of improved clinical and management information systems, health care providers should be able to demonstrate that they are providing the necessary interventions that meet the needs of people with dual disorders. Service delivery, which adapts to suit the various areas across NSW, requires a range of resource options. To build on the capacity of services to deliver quality and effective health care, the implementation of one or more of the options suggested in the section on resource management is recommended.

SERVICE DELIVERY GUIDELINES

1. INTRODUCTION

These guidelines are the result of a joint initiative between the Centre for Mental Health and the Drug Programs Bureau of the NSW Health Department. They aim to address the needs of people with co-existing mental health and substance use disorders - dual disorders.

Currently, health care systems providing services to people with dual disorders may be hindered by various barriers. These include separate services, funding and administration, as well as differing philosophies, skills and clinical practice (Ridgely 1990). Access to services may be restricted through strict entry criteria by health care organisations operating within an exclusive, rather than inclusive model of care. Consequently expertise on how to identify and manage comorbidity has diminished and people with co-existing mental health and substance use disorders are repeatedly referred from one service to another, or left with nowhere to go (Burdekin 1993).

The cost to the health system for someone with co-existing mental health and substance use disorders is significantly higher than it is for someone with a single disorder (Drake 1989). They have an increased frequency of relapse, re-hospitalisation, emergency department attendance (Sitharthan et al, 1999), suicide, criminal behaviour and non-compliance (Ridgely 1990). Depending on the population sample, 30% to 80% of people with a mental illness have a co-existing substance use disorder and similar rates are reported for people with substance use problems. People with co-existing mental health and substance use disorders tend to be challenging clients and while they contribute to a significant proportion of the work undertaken by health care agencies, their comorbidity is often undetected and frequently mismanaged (Reiss 1992).

A review conducted in 1998 to assess service provision for people with co-existing mental health and substance use disorders, found that service delivery across NSW varied significantly. The quality and effectiveness of service provision may depend on the interest and expertise of individual clinicians, rather than a system of care organised around a philosophy of inclusive and comprehensive health care. This variability in service provision, coupled with the disability, multiplicity and high costs of problems associated with dual disorders, led to the development of these guidelines. They represent a starting point. To promote greater community awareness, an educated consciousness of comorbid disorders should be promoted through mass media campaigns and within the social, legal and education systems.

1.1 BACKGROUND

In February 1997 the Centre for Mental Health and the Drug Programs Bureau of the NSW Health Department, held a meeting with key stakeholders to discuss the issues related to the care of people with dual disorders. The need to provide a framework for both mental health and drug and alcohol services was recommended and a project officer was appointed in 1998.

A steering committee was established to oversee the project and advise the project officer. Membership included rural and consumer representatives as well as key stakeholders from mental health, drug and alcohol, general practice and non-government organisations. To ensure the guidelines incorporated the relevant and current needs of particular areas and population groups within NSW, consumers, clinicians and managers were consulted, from a broad range of rural and metropolitan areas. (See Appendix 2). At the same time, an extensive review of the literature was conducted by the project team.

A holistic and life span approach was adopted using a population health model. This involves both public health and personal health services as settings for intervention. Early intervention and prevention strategies were identified as important activities to target children and young people and promote resilience. To reflect the diversity seen in clinical practice these service guidelines were written to ensure that people with a range of mental health and substance use disorders were included. Therefore people with psychotic, mood, anxiety and personality disorders with problematic substance use, were all identified as meeting the criteria for having a dual disorder.

To help clarify some of the issues related to service provision, a service delivery model was developed. This model of care identifies how health care organisations can respond to people with varying degrees of risk, disorder and disability as well as positive functioning. Strategies to improve service provision, include the need to build partnerships, develop workforce training and provide a range of high quality interventions which produce positive health outcomes.

The guidelines incorporate the general principles outlined in the National Standards for Mental Health Services and are complemented by the requirements advocated by the major accreditation providers, Quality Management Services (QMS), formerly NSWCHASP, and the Australian Council on Health Care Standards (ACHS), The EQUIP Guide. They also fit within the National and State Mental Health Policies and the Drug and Alcohol Strategic Plan.

1.2 PURPOSE

These Service Delivery Guidelines are intended for service planners and service providers who are involved in delivering care to people with co-existing mental health and substance use disorders. They are very relevant for primary care eg. general practitioners, but are also specifically targeted to specialist mental health and drug and alcohol services, as well as relevant tertiary care.

The guidelines provide a framework for service providers to design, develop and deliver health care services for people with comorbid mental health and substance use disorders. They aim to achieve better health outcomes for people with dual disorders and provide a clearer direction for the improvement of services. The development of collaborative partnerships and local resources will also enhance the capacity of services to manage people with dual disorders.

1.3 AIMS AND EXPECTED OUTCOMES

- To improve the health care and health outcomes for people with coexisting mental health and drug and alcohol problems (dual disorders).
- To develop and implement a whole of life span approach to people with coexisting mental health and substance use disorders encompassing the full spectrum and interventions from prevention through to early intervention treatment and maintenance.
- To provide health care systems with a clearer direction, better understanding and greater capacity, to deliver holistic health care for people at risk of or experiencing comorbid mental health and substance use disorders.

- To increase the knowledge, skills and ability of all primary care providers to enable better identification, assessment, prevention and management for people with coexisting mental health and substance use disorders.
- To improve the links and partnerships between primary care, specialised services, non-government organisations and mainstream health care agencies to ensure the continuum of care for people with coexisting mental health and substance use disorders.
- To promote equitable access to a range of specialist and mainstream services for all people with coexisting mental health and substance use disorders.
- To improve the clinical and management information systems that assist in the identification and management of people with coexisting mental health and substance use disorders.
- To improve education and training for specialist and primary care providers.
- To implement and evaluate programs designed to meet the needs of individual consumers, their families and the communities in which they live.
- To increase community awareness of the risk factors associated with co-existing mental health and substance use disorders.

1.4 GENERAL PRINCIPLES

Harm minimisation Service delivery should have the capacity to prevent, reduce and manage the negative effects associated with comorbid substance use and mental illness for the individual, their family and the community.

Health promotion, prevention and early intervention Service delivery should have the capacity to develop multiple strategies to promote health, reduce the risk of illness and respond to the health care needs of all people across their lifespan.

Comprehensive and inclusive health care Service delivery should have the capacity to incorporate the physical, mental, social and cultural aspects of health care for all people and provide equitable access to health services.

Interagency links and partnerships Service delivery should have the capacity to develop collaborative partnerships with the diverse range of allied services to ensure specialised, coordinated treatment, and continuity of care for all consumers.

Evidence based good practice Service delivery should have the capacity to offer a range of high quality interventions which reflect the best available evidence for good practice and which emphasise positive health outcomes.

Health outcomes Service delivery should have the capacity to improve the health outcomes of individual consumers and of the population as a whole. Evidence of health outcomes should be documented and evaluated to determine best practice interventions from prevention to treatment to maintenance.

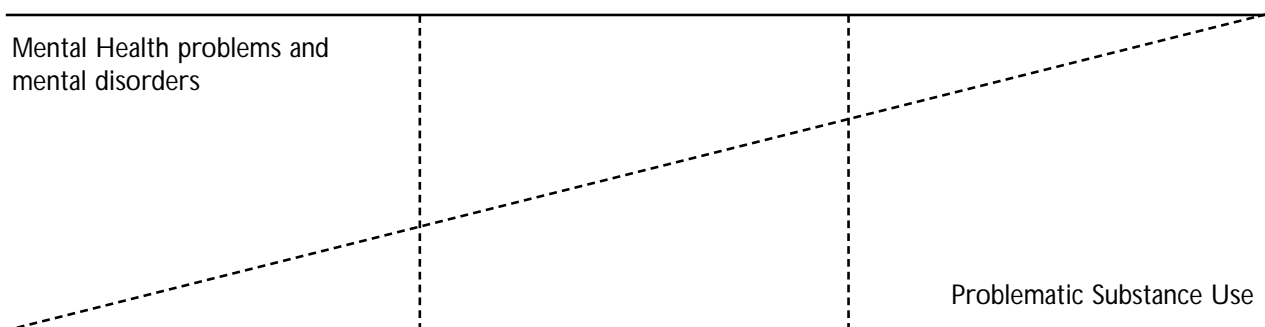
Building self-efficacy Service delivery should aim to improve the self-efficacy, confidence and self-esteem and wellbeing of consumers by involving them in their treatment and encouraging hopefulness.

2. SERVICE DELIVERY MODELS

Effective service delivery is largely dependent on the capacity of primary care providers to assess and respond to the various health problems which people present with at different times across their lifespan. It also depends on the ability of primary care providers to link with other agencies for specialist expertise and co-operative input.

A continuum scale of presenting problems could be used to identify where a person may be located at a given time, to determine treatment needs. People at either end of the scale can access the appropriate services, however those in the middle may have disorders that vary from mild to severe and their treatment needs will be different. Some may require an intensive coordinated approach through an integrated multidisciplinary model and others may only need a single contact person, for example a general practitioner - depending on the severity of the disorders.

A scale of Dual Disorders



(Adapted from: McDermott and Pyett 'Not welcome anywhere' 1995)

2.1 GENERAL MODELS

The following service delivery models are designed to fit within the primary role and function of separate services. They depict how services can meet the needs of people by identifying the severity of their disorders and current treatment needs.

- People **severely disabled by mental health problems and disorders and adversely affected by problematic substance use disorders** would generally be the primary responsibility of mental health services with extra support and assistance provided by drug and alcohol services.
- People **severely disabled by substance use disorders and adversely affected by mental health problems and disorders** would generally be the responsibility of drug and alcohol services with input from specialist mental health services as required.
- People **severely disabled by comorbid mental health and substance use disorders** will require a coordinated, integrated approach by both mental health and drug and alcohol services. Joint case management or an identified clinician with responsibility as care coordinator from the service most able to meet the current needs of the client will ensure continuum of care.

- People **mildly to moderately disabled by comorbid mental health and substance use disorders** may access both mental health and drug and alcohol services from time to time, but the primary care provider would in most cases be the general practitioner. At the milder end of the spectrum, this group represents the majority of people affected by dual disorders.

2.2 DUAL DISORDER PRESENTATIONS

<p>Mental Health Services</p> <p>Primarily responsible for people severely disabled by current mental health problems and disorders and adversely affected by substance use disorders.</p>	<p>Drug and alcohol Services</p> <p>Primarily responsible for people severely disabled by current substance use disorders and adversely affected by mental health problems and disorders.</p>
<p>Mental Health and Drug and Alcohol Services</p> <p>Shared responsibility for people severely disabled by comorbid disorders where both disorders are treated concurrently in the service best placed to meet the clients needs.</p>	<p>General Practitioners</p> <p>Primarily responsible for people with mild to moderate comorbid disorders but with access to expertise from specialist mental health and drug and alcohol services as required.</p>

While this model of care may clarify some of the issues related to service provision, there needs to be flexibility and collaboration between service providers. For instance a person with well-controlled schizophrenia and benzodiazepine abuse may be best managed by a general practitioner in collaboration with drug and alcohol services. People with dual disorders will have varying needs at different times across their life span. Some people may have mild or time limited disorders and therefore will not require specialist interventions. However others with more complicated or prolonged disorders will require access to a range of government and non-government services and this is better managed when the responsibility for continuing care is accepted by a particular service and clinician.

3. ACCESS

It is crucial that people with dual disorders have access to available health care services. Culturally appropriate and sensitive services need to be assured, particularly for people from culturally and linguistically diverse backgrounds (CALD) and people who may have particular needs relating to their language, cultural beliefs and practices. Aboriginal peoples and Torres Strait Islanders have identified a high level of comorbidity for mental health and drug and alcohol problems and the need for access to culturally appropriate and comprehensive services to address these problems. General Practitioners, community health centres and other health care agencies in the local area, as well as the police and schools, are often the first point of contact for people suffering dual disorders. The principles of equity and access to services must be maintained.

Access may also be difficult in rural and remote communities, both because of distance and difficulties in developing adequate staffing levels and expertise to deal with such complex problems. Access may be facilitated by outreach and may include visiting clinics and telemedicine.

Access to specific settings for different components of care should also be available – for instance community programs in mental health and drug and alcohol; detoxification units or programs; inpatient programs; rehabilitation programs; a range of residential and supported accommodation programs; neuropsychiatric and brain damage programs and so forth.

In some circumstances access, assessment, treatment and rehabilitation may be determined by the provisions of the Mental Health Act or the Disability Services and Guardianship Act.

4. SCREENING / COMPREHENSIVE ASSESSMENTS

4.1 Identification of high risk groups and individuals

The capacity to identify and respond to 'at risk' individuals and population groups is improved with the knowledge that disorders may develop in the following people:

- People with a mental disorder.
- People with problematic substance use.
- People with family histories of mental health and substance use disorders.
- Children of parents who have a mental disorder, substance use problem or both disorders.

Particular attention should be directed to populations and groups in the community who may be at higher risk, as well as individuals. These would include people with a history of abuse and trauma, those affected by chronic pain, homelessness and severe poverty, or others in various ways alienated from mainstream society, where access to social, economic, and cultural resources are limited. Vulnerability may also be associated with a family history of substance abuse or mental illness but many people with such family histories do not develop these problems.

4.2 Engagement

Engagement is the first step in developing a trusting alliance between the client and a service provider. Successful engagement is critical to effective intervention or treatment and is dependent on a number of factors including a clear delineation of the interventions that can be offered and their potential value. Rapport building and the development of a strong therapeutic relationship is paramount and the following strategies can enhance this process:

- Empathic, non-judgemental and compassionate attitudes.
- Individualised care that includes identified strengths as well as problems.
- Ability to assist with the basic and practical needs of clients.
- Availability of appointments that follow shortly after the initial contact.
- Protection of confidentiality and privacy.
- Promotion of self-efficacy.
- Matching interventions to a person's readiness to change.

4.3 Assessment

The development of a bio-psychosocial formulation and diagnosis requires ongoing assessment and may frequently involve collaborative information and specialised investigation. Individualised care plans should direct the planning of ongoing management to promote optimal recovery and prevent further impairment. The use of standardised assessment tools is recommended to improve the ability of clinicians to detect co-morbid conditions and to assist the assessment process. For mental health clinicians, the use of tools to detect substance use disorders, such as the Alcohol Use Disorders Identification Test, known as the AUDIT (Saunders 1993), would provide a framework for taking a drug and alcohol history. And for drug and alcohol staff, the

incorporation of a mental state exam in their regular assessments and greater use of psychological screening instruments, such as the General Health Questionnaire, Beck Depression Inventory and Mini Mental State examination, or other screening measures would increase the identification of a range of mental health problems and disorders. With or without the use of specific screening instruments, clinical interventions need to be culturally appropriate and include routine assessment of the following:

- History of present illness
- Physical state/ Medical history
- Personal history
- Mental state
- Drug and alcohol history
- Past history/ Family history
- Social and cultural issues
- Readiness to change

5. PREVENTION AND TREATMENT

There should be access to a comprehensive range of prevention, treatment and support services, which address the physical, mental, social, cultural, gender and lifestyle aspects of relevance to each person. While evidence on best practice interventions for people with co-existing mental health and substance use disorders is emerging, rigorous research into specific interventions and treatments remains limited. However the available evidence from clinical outcome studies (Jerrel and Ridgely 1995b) suggests that services should:

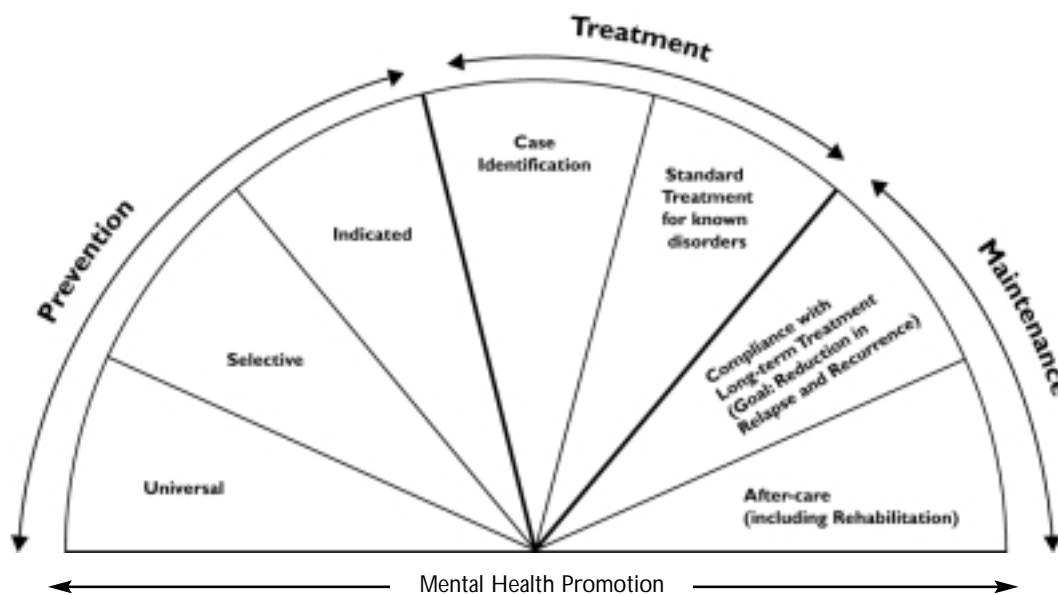
- engage people with or at risk of comorbid disorders and assess individual health needs in terms of all relevant disorders and as a base for prevention, promotion and treatment approaches.
- provide comprehensive health care and match individuals to the most appropriate interventions, choosing those most likely to be of benefit.
- promote integrated care to enable concurrent treatment of co-existing disorders including biological (medication) psychological (psychotherapies) and social treatment as appropriate.
- reflect current good practice and provide interventions based on the best available evidence of effectiveness.
- where appropriate offer ongoing case management for people with severe comorbid disorders.

The Spectrum of Interventions for people with Coexisting Mental Health and Substance Use Disorders

A population health approach is relevant for both a mental health and drug and alcohol approach. This recognises the need to identify the levels of disorders in the community, the factors that contribute to the onset and course, and the health impact or burden associated with them, as well as the ways in which they impact on individuals and families. To lessen this burden it is necessary to provide a range of interventions based on the best available evidence of effectiveness. These should include prevention, treatment and maintenance. It is now clear that health outcomes for the population can only be improved by using a range of such approaches, linked to a coordinated strategy for the population.

The spectrum of interventions is best reflected in the diagram below from the US Institute of Medicine Report on Prevention in Mental Health and Substance Use Disorder.

Figure 1: The intervention spectrum for people with co-existing 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

5.1 Prevention

Many common antecedents and risk factors exist for mental health and substance use disorders and provide a sound basis for prevention approaches in this field. Social determinants of health and ill health are also very relevant to both. Risk factors include a family history of either or both disorders, severe family and parental conflict or breakdown, experience of violence, loss and trauma, severe social adversity. Protective factors include nurturing family environments and attachments, rewarding experiences in schools, and elsewhere and positive social and personal environments. Prevention programs can be effective to broad population group through decreasing risk or increasing protective factors, or to populations at higher risk – for instance with family problems of conflict, parenting, or parental mental illness or substance abuse. Programs in schools, through health promoting schools, and in workplaces may also be effective. These interventions should form part of the spectrum of service provision for people with, or at risk of co-existing mental health and substance use disorders.

5.2 Acute management

The focus of acute management needs to ensure safety through rapid response and informed, systematic and careful assessment. Acute problems may mask or mimic other disorders and an initial assessment frequently identifies more than one primary diagnosis or problem. Some conditions may not be apparent initially. Further assessments should help to clarify the relationship between co-existing disorders and may lead to the identification of other disorders. Prioritisation for treatment and referral should focus on the following four main concerns.

- **Acute medical problems** - People with coexisting disorders, primarily because of their substance use, are at risk of developing a number of medical problems. Injury, gastro-intestinal, neurological, cardiac and respiratory problems as well as infections such as hepatitis C, B and HIV are all medical conditions which require prompt medical intervention.
- **Acute psychiatric conditions** - Acute psychiatric conditions such as psychosis or severe depression occur more frequently in people with a history of mental illness and who abuse substances, than in people with a history of health problems and disorders who do not abuse substances. Early identification and intervention is important in reducing the severity of psychiatric conditions and will require specialist mental health attention.
- **Suicidality, Violence and other problem behaviours** - The risk of suicide, violence and other problem behaviours is greater for people who have both a mental health and substance use disorder than it is for people with a single disorder. Attempts to minimise the mortality and morbidity associated with the risk of suicide, self-harm and danger to others should be a priority.
- **Intoxication, Overdose and Withdrawal** - Problems related to substance use need to be recognised as medical conditions and may become medical emergencies with the potential to become life threatening. Careful assessment and monitoring is necessary to determine treatment needs and medical intervention is frequently required.

5.3 Ongoing management

The delivery of treatment and ongoing care should be both focussed on the particular needs identified in the assessment and provided in ways sensitive to the individual. Where specialist services and programs are scarce, as is currently the case for many rural areas, the care and support of people is largely delivered by general practitioners, other generalist and mainstream services. Therefore priority for education and training, with access to clinical support and supervision, should be extended to general practitioners and other primary care providers in rural and remote areas. The recent development of distance education and tele-conferences should be used to help this process. The following sections deal with specific settings, treatments, integrated care and continuity of care. A focus on these issues is designed to enhance the capacity of services to meet the needs of people with comorbid disorders by developing programs and strategies which can be adapted to suit differing services, geographical areas and client groups.

6. SPECIFIC SETTINGS

6.1 Inpatient care

The need for inpatient care should be based on clinical indications relevant to the management of acute disorders as they present and what is considered to be both safe and appropriate. Detoxification and stabilisation of medical and psychiatric conditions may require inpatient care, but should not be restricted to designated, specialist inpatient units. A diverse range of inpatient facilities should have the ability to manage acute disorders, particularly in an emergency. Treatment should be provided by skilled clinicians ideally in the unit or setting best placed to meet a person's specific needs.

6.2 Community care

Service delivery in the community provides the mainstay of treatment for the majority of people with dual disorders. A comprehensive range of programs which are coordinated by skilled clinicians should be linked to the individual needs of people. Treatment should maximise choice, safety, and quality of life so people can develop optimal levels of functioning. Assertive follow-up and outreach programs are recommended to reduce the risk of relapse as well as the severity and duration of disorders. Programs should be evaluated for their effectiveness and aim to build on people's self-efficacy and independence.

6.3 Rehabilitation programs

Short and medium term rehabilitation programs are an integral component to many drug and alcohol, mental health and non-government organisations. These more intensive programs are suggested for people with severe co-morbid conditions and for whom other treatment options are not effective or appropriate (National Drug Strategy 1996). Rehabilitation may be community based, residential or part of a more broadly based supported accommodation program. Programs should be flexible, individualised and based on the best evidence of effective interventions. With a focus on holistic and comprehensive health care, inclusion of people with comorbid disorders should be the norm, not the exception. This would require a cross-skilled workforce or an integrated approach that ensures expertise is provided from both mental health and drug and alcohol services.

7. SPECIFIC TREATMENTS

7.1 Early and Brief Intervention

To better target harm reduction strategies for 'at risk' groups and individuals, identification of potential problems and the provision of short-term interventions should be carried out by a variety of health professionals in a range of service settings. Early identification and treatment of mental health and substance use disorders, particularly in young people can reduce the long-term negative effects associated with these disorders. Therefore, awareness of the potential problems associated with emerging disorders is particularly important for general practitioners and youth services. Recognition of a person's readiness to change, should direct the use of specific counselling techniques and interventions. 'Motivational interviewing' is one of the recommended strategies to help people move through the process of change (Brady 1996).

7.2 Pharmacological Treatment

A wide array of psychotropic medications are frequently prescribed for people with co-existing mental health and substance use disorders and these treatments should not exclude people from other interventions or programs. These include also the use of the newer anti-craving drugs for people with substance use disorders (for instance naltrexone,acamprosate). Where possible a single medical practitioner from an identified service or practice should regularly review and adjust pharmacological treatments. This is likely to result in an improved understanding of the client, the substances they use and the potential problems surrounding specific drug interactions. The opportunity to engage clients and provide effective interventions which reduce long-term health problems are further enhanced when medical practitioners assume this care coordinating role.

7.3 Individual and Group Therapy

Therapeutic interventions can be conducted on an individual or group basis and should be evaluated for their effectiveness. Groups may be more cost effective and clinically efficient, however they are not suitable for everyone. The success or failure of programs depends largely on the skill of individual therapists and their capacity to engage particular client groups. The location and suitability of venues are also important to the success or failure of specific programs and require consideration. Programs with a specific focus, clear aims and objectives tend to be more sustainable, however the overriding principle is that treatment programs should match the particular characteristics of individuals within divergent client groups. A non-confrontational, tolerant approach is suggested and specific interventions should aim to improve the self-efficacy, confidence and self-esteem of clients by involving them in their treatment and encouraging hopefulness. Groups may be therapeutic, with specific treatment aims, and dealing with both mental health and drug and alcohol morbidity or they may be supportive and assist people generally for instance community, self-help groups. Referral to such self-help groups, for example Alcoholics Anonymous, may be appropriate for some people.

8. INTEGRATED CARE

8.1 Interagency links and partnerships

To achieve optimal health outcomes, links to specialist and mainstream services are required. The provision of comprehensive and holistic health care frequently requires formal and informal collaborative partnerships across health and related care systems. These may involve links between specialist services such as mental health and drug and alcohol with a Memoranda of Understanding or service agreement. They may also involve shared-care arrangements – for instance between these specialist services and general practitioners or between health services and non-government organisations and so forth. Understanding how and who to contact in other health and related organisations should be established as core, every day business. Resource manuals and the development of clinical and management information systems, would help improve access to and knowledge of other service providers.

8.2 Joint assessment and co-management

The sharing of expertise, in joint assessments and co-management are two strategies to ensure better identification, treatment and care coordination. Collaborating in joint approaches should be two-way, mutually beneficial and focused on delivering comprehensive health care. This process would improve consumer outcomes, help the development of ongoing partnerships and increase the knowledge and skills of the participating clinicians.

8.3 Formal process of networking and liaison

To better integrate service provision and reduce the number of people 'falling through the gaps', formal networks and regular liaison between primary care providers across service sectors should be established. Open invitation and access to special interest groups, in-service education sessions and journal clubs, could be extended to cross-sector and related health services. Regular attendance by relevant clinical staff in case conferences and related meetings would further establish links and partnerships.

9. CONTINUITY OF CARE

9.1 Further assessment and assertive follow-up

Ongoing biopsychosocial assessments can help clarify the relationship between fluctuating co-existing disorders. The impact both disorders have on each other and their relative contribution to other problems can help determine appropriate treatment strategies. Ongoing follow up arrangements and attempts to re-engage people who have dropped out of treatment should be incorporated in individual care plans and actively pursued.

9.2 Case reviews

Attendance by relevant mental health and drug and alcohol clinicians in case reviews and conferences should be a regular and continuous process. To further safeguard continuity of care and reduce the number of people caught between service delivery gaps, the involvement of general practitioners and relevant staff from other agencies is recommended. Including consumers and their carers in these sessions may be appropriate at times and should be considered. Clinical supervision from a more experienced colleague could help direct treatment strategies and provide the necessary ongoing support and guidance for primary care providers.

9.3 Identified clinical care coordinator/case manager

Continuity of care for ongoing problems is better managed when the responsibility for ongoing support and treatment is identified to a particular service and person. This should be negotiated on a needs basis and where possible provided in ways which meet the client's current needs. In the majority of instances to ensure continuity of care, it will be important that the general practitioner has the primary role.

10. CLINICAL AND MANAGEMENT INFORMATION SYSTEMS

Clinical and management information systems need to be in place to enable the performance of services to be monitored and evaluated. Information on the utilisation of services, common clinical presentations, treatment needs and health outcomes of people with co-existing mental health and substance use disorders is important to the assessment and planning of service delivery. Therefore measures are required to ensure that information is accurate, reliably collected, routinely collated and accessible. The recording of relevant information on standardised clinical assessment forms and mainstream information systems should help provide accurate data which can be used to demonstrate the effectiveness and efficiency of services and enable managers to review and modify their services in order to improve them. While mainstream clinical and management information systems are currently somewhat limited, they are being developed and with further advancements they will provide:

- Information on the nature and extent of dual disorders amongst clients.
- Outcome measurement and monitoring.
- Assessment of the cost and clinical effectiveness of services.
- Information on the extent to which standards of care and treatment are met.
- Assistance to plan future direction of services.
- Identification of the skills and mix of staff required to provide effective health care for people with dual disorders.

11. QUALITY AND EFFECTIVENESS

Service provision needs to be evaluated for its quality and effectiveness. Incorporating quality improvement programs and utilisation of the National Standards for Mental Health Services, Equip or QMS to evaluate service provision is recommended. Programs should reflect good practice identified in the current scientific literature and documented in clinical outcome studies. Difficulty in defining outcomes for people with co-existing mental health and substance use disorders is recognised, particularly in the short term, however services are encouraged to explore a range of possible health outcomes from a number of perspectives including symptomatic and functional dimensions, and harm minimisation. Quantitative and qualitative methods of evaluation should include the following:

- Evaluation of quality improvement activities.
- Evaluation of specific programs and projects.
- Evaluation of health outcomes for individuals and the health service.
- Participation in research activities.

12. EDUCATION AND TRAINING

The need to develop, promote and maintain a broad range of education and training packages is an essential component to the provision of comprehensive and inclusive health care. Education for consumers, carers, and the community should be strengthened and incorporated in health promotion and prevention programs. To promote a better understanding and an improved capacity for services to meet the needs of people with dual disorders, the development of education and training should be provided for the following people:

Specialist and Primary care providers

- Undergraduate health professional education.
- General Practitioners.
- Medical and psychiatric registrar training.
- Specialist mental health and drug and alcohol clinicians.

Consumers and Carers

- Education for clients - in both inpatient and community settings.
- Education of family and carer groups.

General Community

- Promotion of education to the broad range of community groups to reduce the onset, duration and severity of illnesses developing.

To build on the knowledge and skills of all primary care providers and specialist staff, courses on dual disorders should be built into existing training programs and linked to clinical practice. Attendance at external courses designed by professional educational organisations should be encouraged. However education that is local, ongoing and relevant to the population groups seen by services, can reduce the need to refer clients to outside agencies. Ongoing training should include:

- Local cross sector education and training between services.
- Area based government and non-government training.
- Education packages for Divisions of General Practice.
- Access to formal / informal supervision.

13. RESOURCE MANAGEMENT

The responsibility for service delivery and the development of specific programs or projects, remains in the domain of Area Health Services. This enables the design, development and delivery of services, to better reflect the needs of local areas and ensures the management responsibility is carried by service directors. The implementation of the following strategies should support the development and management of resources, and help ensure comprehensive service delivery.

- Area Chief Executive Officers have primary responsibility for ensuring effective implementation of these guidelines within their Area. Area health plans could initially reflect what is achievable in the short term, however more comprehensive reform would need to be targeted in the long term.
- Area Directors of mental health and drug and alcohol services are responsible for the implementation of these guidelines. The development and delivery of services for people with dual disorders, should be documented in annual progress reports.
- Service managers and providers should be required to demonstrate through clinical and management information systems that they are providing or developing services which will assist their clinical workforce to better identify and respond to people with dual disorders.

Development of service delivery that is suitable to the specific needs of various services and geographical areas across NSW, could be targeted through the implementation of one or more of the following options.

- Integrated service provision under one umbrella organisation.
- Employment of a resource team or person.
- Established links between identified key staff in local services.
- Formal processes of collaboration and networks in joint meetings, journal clubs and case reviews by service providers in mental health, drug and alcohol, general practice and non-government organisations.
- Joint financial initiatives between service sectors to fund specific programs.
- Integrated services in 'one-stop shop' community centres.
- Cross sector secondment or short term placements of clinical staff.
- Employment of staff with drug and alcohol expertise in Mental Health services.
- Employment of staff with mental health expertise in Drug and Alcohol services.
- Provision of education and training for primary care providers in mental health, drug and alcohol, general practice and non-government organisations.

14. IMPLEMENTATION OF THE GUIDELINES

The implementation of specific strategies recommended in the Guidelines is the responsibility of the Area Health Services, specifically the Chief Executive Officers and Directors of Mental Health and Drug and Alcohol Services. However to assist this process, the NSW Health Department will develop a number of strategies to support their implementation across New South Wales and include:

- Dissemination of Discussion Paper and Service Delivery Guidelines to Area Health Services, Mental Health and Drug and Alcohol and other services, and to other relevant departments and government and non-government agencies.
- Dissemination of the Guidelines to key stakeholders including general practitioners, educators, consumers, non-government organisations and policy advisors through the NSW Health Department Web site.
- Implementation of a tender process, calling for expressions of interest from educational organisations, to provide education and training for Area Health Services. This program will be overseen by NSW Health and funded through the NSW Health Department.
- Development of Area programs for the prevention and management of coexisting mental health and drug and alcohol problems in line with guidelines and shaped by local service conditions and needs.
- Reporting annually on progress for the implementation of the Service Delivery Guidelines by Areas.

15. EVALUATION AND REVIEW OF THE GUIDELINES

A process of evaluation and review will be developed to assess the effectiveness of the guidelines in improving service delivery. This will include:

- Data gathering and reporting on rates of coexisting mental health and substance use disorders reported in NSW Health reporting systems.
- Review of consumer and carer perceptions of programs in terms of access and effectiveness.
- Monitoring of mental health and drug and alcohol outcomes for people with coexisting mental health and substance use disorders.
- Evaluation of service quality and effectiveness across prevention and treatment in line with Mental Health Service Standards.

There are many qualitative and quantitative indications of access to and effectiveness of such programs. Every endeavour will be made to tailor evaluation to local programs as well as population need.

Appendix 1

ASSESSMENT AND MANAGEMENT CHECKLIST For people with co-existing mental health and substance use disorders

Engagement

Assessment

- history of present illness
- past history
- family history
- physical/medical conditions
- drug use (amount & frequency)
- abuse or dependency syndrome
- social and cultural issues
- mood state
- suicidal or violent ideation
- anxiety symptoms
- psychotic symptoms
- readiness to change

Identify Problems / Diagnosis

Biopsychosocial Formulation

Is acute management indicated? Yes
No



Acute Management

- significant medical problems
- stabilisation of mental state
- management of suicidality or violence
- intoxication, overdose and withdrawal

Continuing Management Plan

Develop a comprehensive plan which also includes:

- assertive follow-up and ongoing case management;
- psychosocial and cultural aspects;
- regular monitoring of mental state, substance use and medication;
- access to acute services and reassessment as required;
- integrated care through collaborative partnerships, individual / group support;
- regular case reviews;
- discharge planning;
- involvement of general practitioners.

Appendix 2

CONSULTATION PROCESS

The development of these guidelines involved consultation with key stakeholders from government and non-government mental health and drug and alcohol services. Contributions from general practitioners, consumers and carers in rural and metropolitan centres, ensured the guidelines reflected the diverse needs of differing areas, population groups, and mainstream services in New South Wales.

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Illawarra Area Health Service

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Mr Brian O'Neill - Coordinator Drug and Alcohol Services.

Northern Rivers Area Health Service

Mr Richard Buss - Director Mental Health Services.
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Macquarie Area Health Service

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Mid Western Area Health Service

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Far West Area Health Service

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Greater Murray Area Health Service

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Central Sydney Area Health Service

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APPENDIX 3

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GLOSSARY

Assessment	The collection and organisation of relevant information about a person, so that an effective plan of treatment can be implemented.
Biopsychosocial formulation	The brief descriptive summary of a comprehensive assessment which includes the biological, psychological and social aspects of a persons health status and which leads to the treatment plan.
Brief Intervention	A single or limited number of contacts, where basic information and minimal intervention is provided.
Clinical information systems	The collection and dissemination of information that is relevant to the clinical assessment and treatment process.
Collaborative partnerships	The formal and informal process of linking with other service providers to provide a continuum of holistic health care.
Comorbidity	The co-existence of two or more disorders in the one person.
Comprehensive health care	Incorporates the spectrum of problems and conditions that effect people across the lifespan and provides a range of treatment programs and options.
Disability	A condition that renders a person unable, or with a reduced capacity to function normally.
Dual diagnosis	The co-existence of a psychiatric and substance use disorder in the one person.
Dual disorder	As above.
Early intervention	The early identification of disorders that enables prompt treatment to prevent or slow the progression to more serious or chronic conditions.
Engagement	The process of developing a therapeutic relationship with a person to enhance their willing participation in health care services.
Evidence based practice	Clinical practice and interventions that are based on a systematic review of clinical outcome studies and scientific data.
Equitable access	The opportunity for all people to access a range of heath care systems and programs despite their particular disabilities, socio-economic or cultural background.

Harm minimisation	The prevention, reduction and management of the negative effects associated with dual disorders for the client, their family and the community.
Health outcome	The change in the health of a person or population group which is attributable to an intervention.
Health promotion	The promotion of strategies to enable people to improve and maintain their optimal health, wellbeing and social functioning.
Holistic care	Treatment of the whole person rather than just the symptoms of their disorders.
Impairment	Refers to the damaged or weakened condition of a person due to a disorder or disease process.
Inclusive health care	The provision of health care is based on the need of the individual and does not discriminate against people or operate within an exclusive criteria.
Integrated health care	The simultaneous provision of psychiatric and drug and alcohol treatment by the same individual, team or organisation.
Management information systems	The collection and dissemination of information that is relevant to management.
Mental disorder	The existence of a set of symptoms or behaviours which impair an individual's cognitive, affective and/or relational abilities.
Motivational interviewing	A counselling intervention that uses specific techniques to motivate people to change.
Readiness to change	Identification of where a person is located on the stage of change model, described by Prochaska and Di Clemente (1986) to determine appropriate counselling interventions - usually motivational interviewing.
Substance use disorder	A pattern of drug and alcohol use that includes both abuse and dependence syndromes described in the Diagnostic and Statistical Manual of Mental Disorders.
Whole of life	Incorporates an individual's life from birth to death.