Australian treatment system's recognition of and response to co-occurring mental health & substance use disorders

(dual diagnosis / comorbidity / co-occurring disorders)

A Submission to the 2005 Senate Select Committee on Mental Health

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Co-occurring mental health and substance use disorders will most often, in any individual experiencing them, influence each other in their development, their severity, their response to treatment and their relapse circumstances.

Improving Australian treatment systems response to co-occurring disorders must become an urgent priority for all levels of the service systems because of

- ***the prevalence of co-occurring disorders,***
- ***the substantial personal and societal costs, harms and undesirable outcomes strongly associated with co-occurring disorders***
- ***consumer and carer demand for improved treatment and outcomes for persons with co-occurring disorders &***
- ***the potential for treatment systems to respond more effectively to co-occurring disorders.***

Increasing a system's capacity to provide effective treatment of co-occurring disorders is possible.
It requires the strategically-planned, collaborative and robust implementation of top-down and bottom-up strategies towards well-defined, locally-grounded goals

Contents

Executive Summary **5**

Section 1. Introduction **16**

Section 2. Co-occurring disorders: the territory & the terminology **17**

Section 3. Why should improving the response to co-occurring disorders be an urgent priority? **18**

3.1 The prevalence of co-occurring disorders 18
3.2 The substantial personal and societal costs, harms and undesirable outcomes strongly associated with co-occurring disorders 23
3.3 Consumer, carer and societal demand for improved treatment and outcomes for persons with co-occurring disorders 24
3.4 The potential for treatment systems to respond more effectively to co-occurring disorders. 24

Section 4. Barriers to more effectively addressing co-occurring disorders. **25**

Section 5. International perspectives **27**

Section 6. Where is Australia now in relation to co-occurring disorders? **29**

Section 7. Where should we be? Proposed co-occurring disorders goals **31**

Section 8. How can we get there? Approaches to system change **35**

Section 9. Recommendations **39**

References **40**

Breakout Boxes Index

Co-occurring disorders prevalence - *Key Facts* **18**

Comprehensive Continuous Integrated System of Care (CCISC) – brief profile **28**

Integrated Dual Disorder Treatment (IDDT) model– brief profile **28**

Integrated Primary Mental Health Service of Northeast Victoria– brief profile **31**

The debate around integrated treatment **34**

Executive Summary

1. Introduction

This submission provides an overview of key issues around the response by Australian treatment sectors to co-occurring mental health and substance use disorders. It argues that, in Australia, the priority placed on better addressing co-occurring disorders does not yet reflect the substantial evidence around prevalence and associated harms nor consumer, carer and societal demand for improved outcomes of treatment for person with co-occurring disorders.. That there is significant potential to improve the effectiveness of our treatment of both mental health and substance use disorders by developing our recognition of and response to co-occurring disorders. To date Australia's response to co-occurring disorders has had a warranted focus on the primary care sector however there is a substantial case for also prioritising and robustly, strategically addressing the response to co-occurring disorders by the Mental Health and A&OD treatment sectors.

International experience has demonstrated that rapid development of a system's recognition of and response to co-occurring disorders can occur without the input of significant extra resources. Improving the system's recognition and response requires the strategically-planned, collaborative and robust implementation of top-down and bottom-up strategies towards well-defined, locally-grounded goals. Integrated strategic planning processes and policy deployment are central to effecting enduring improvements to systems' recognition of and responses to co-occurring disorders.

2. Co-occurring disorders: the territory & the terminology

Co-occurring disorders –co-occurring mental health and substance use disorders.
Co-occurring disorders cohorts: Persons with co-occurring disorders are not a homogenous group - substantial diversity exists in the combinations of disorders, in their severity and in individual treatment needs.
Integrated treatment: a single treatment agency or clinician providing interventions for both mental health and substance abuse problems as a 'seamless, coherent package'

3. Why should improving Australian treatment systems response to co-occurring disorders be an urgent priority?

Improving Australian treatment systems response to co-occurring disorders must become an urgent priority for all levels of the treatment systems because of …

1. **The prevalence of co-occurring disorders,**
2. **The substantial personal and societal costs, harms and undesirable outcomes strongly associated with co-occurring disorders**
3. **Consumer, carer and societal demand for improved treatment and outcomes for persons with co-occurring disorders &**
4. **The potential for treatment systems to respond more effectively to co-occurring disorders.**

3.1 Prevalence of co-occurring disorders

- Co-occurring disorders are common in the general population
- Co-occurring disorders are very common, the *expectation not the exception* in persons receiving treatment for either a mental health or a substance use disorder.
- Having either a mental health or a substance use disorder substantially increases a persons risk of also developing the other disorder
- The prevalence of particular combinations of co-occurring disorders will vary with different treatment settings

Prevalence in the general population
The 1997 National Survey of Mental Health and Wellbeing found that …

- in any 12-month period 9.7% of the population met criteria for an Anxiety Disorder,7.7% for a Substance Use Disorder and 5.8% for an Affective (Mood) Disorder
- 1 in 4 of the persons with one of the disorders *also had one of the other disorders.*

Prevalence in metal health treatment settings
1997 NSMHW low-prevalence mental health disorder (psychosis) survey found that

- 40% of persons with psychosis met lifetime criteria for substance abuse or dependence
- 17.4% met criteria for abuse or dependence on two or more substances.
- 70% of the sample had or had had a Substance Use Disorder involving nicotine,
- 27% involving alcohol,
- 22% involving cannabis

Prevalence in substance treatment settings
A UK prevalence study of comorbidity amongst persons receiving treatment for Alcohol Use disorders found that 55% of clients had 2 or more psychiatric disorders, 19% had a Psychotic Disorder, 53% had a Personality Disorder, and 80% had Depression &/or Anxiety Disorder

Prevalence in primary care settings
Comorbidity of common mental disorders and alcohol or other substance misuse in Australian general practice

- 56% of patients attending General Practice have mental health and/or substance use disorders
- 12% of patients attending General Practice have co-occurring mental disorders and substance misuse

3.2 Substantial personal and societal costs, harms and undesirable outcomes strongly associated with co-occurring disorders

Co-occurring mental health and substance use disorders will most often, in any individual experiencing them, influence each other in their development, their severity, their response to treatment and their relapse circumstances. Most of the research to date has examined harms and undesirable outcomes associated with low-prevalence mental health disorder type comorbidity. In this cohort strong evidence shows that, compared to persons with a mental health disorder alone, such persons experience …

- More frequent relapse and hospitalisation
- Greater housing difficulties and homelessness
- Violence and exploitation: both as victims and perpetrators.
- Forensic involvement: Recent substantial Australia research has shown that persons with schizophrenia committed nearly 8 times the number of offences as a non-schizophrenia matched control group and that *much higher rates of criminal conviction were found for persons with schizophrenia with substances abuse problems than for those without substance abuse problems (68.1% versus 11.7%).*
- Greater incidence of physical disorders
- Incur increased treatment costs

3.3 Consumer, carer and societal demand for improved treatment and outcomes for persons with co-occurring disorders

In April 2003 the Mental Health Council of Australia reported on community priorities for future mental health policy. The two top priorities were

- Implementation of earlier intervention strategies nationally and
- Attention to the overlap between mental health and drug and alcohol abuse.

MHCA (2005) called for:

- Development of innovative approaches to primary care management of patients with both mental health and alcohol or substance abuse
- Development of staff education and professional training
- Development of clear agreements between national mental health and A&OD strategies
- Development of innovative approaches to provision of common specialist services
- Support for greater research into the changing patterns of comorbidity

In August 2004 Dr Sev Ozdowski, Australian Human Rights Commissioner and Disability Discrimination Commissioner, drew attention to community concerns around the apparent substantial increases in the numbers of persons presenting with mental health disorders complicated or caused by substance use and the dearth of services able to provide integrated treatment of the two disorders

A substantial focus of SANE's Mental Health Report for 2004wash the Commonwealth and State's response to co-occurring disorders. The report judged that **'***There are no coherent national strategies covering key issues such as dual diagnosis ….'* , It recommended '*leadership by the Australian government of all States and Territories in reform of the National Mental Health Strategy to focus on…national strategies for … dual diagnosis..*

3.4 The potential for treatment systems to respond more effectively to co-occurring disorders.

See sections 5, 6, 7 & 8

4. Barriers to more effectively addressing co-occurring disorders.

Developing with the recognition of the prevalence of and harms associated with co-occurring disorders has been an appreciation that there are significant systemic and other barriers to more effectively addressing co-occurring disorders.
Barriers include...

- Infrastructures geared to respond to single disorders
- Complicated, rigid service funding mechanisms
- Clinicians from either system having different qualifications and treatment philosophies
- Lack of staff expertise around effective co-occurring disorders treatment
- Difficulties with client engagement and willingness to disclose the extent of their disorders
- Difficulties in evaluation and assessment because of the presence of another disorder
- Exclusion from some treatment programs because of the co-occurring disorder
- Stigma around specialised treatment facilities
- Lack of primary care expertise in recognising and addressing co-occurring disorders.
- Training institutions resistance to cross-training of mental health and A&OD streams
- Differing views between drug treatment and mental health providers on the relationship between psychopathology and substance abuse.
- Scarce resources for treatment leads to both mental health and A&OD services excluding individuals likely to fail in treatment, to be disruptive or to require more resources.
- Consumers and families' lack of knowledge about the interplay of co-occurring disorders - confusion over causality may make it less likely that a person will seek treatment for both disorders.
- Poor communication between separate agencies and lack of service integration;
- Attitudinal issues such as judgemental attitudes and a perception that substance treatment is not the business of a mental health service.
- Lack of specialised services,
- Poor coordination of mental health and drug treatment services
- Frustrations with attempting to provide clinical services to this client group.

In recent Australian research barriers to service provision for young people with presenting substance misuse and mental health problems were identified including homelessness, challenging, volatile or violent behaviour, appointment-based service provision, definitional difficulties, lack of specialist services and dedicated resources, lack of expertise and dual skills, conflicting interests in service provision.

Ambivalence or pre-contemplation around addressing co-occurring disorders may be found at all levels of either treatment system. A key question is what approaches and strategies are most effective in nudging systems/ agencies/clinicians towards action around their response to co-occurring disorders?

5. International perspectives

United Kingdom
Substantial work and funding in the UK is being directed to improving outcomes for persons with co-occurring disorders. One of the most powerful levers on the mental health system to date has been the policy mandate that clients with co-occurring disorders are '*a mainstream responsibility for mental health services'* supported and reinforced by the publication of a mental health policy implementation guide the *Dual Diagnosis Good Practice Guide.*

USA
The Australian research community has some wariness about the generalisability of USA substance treatment-related developments. Nonetheless the USA is notable for its recognition of the evidence around prevalence and harms and consequent prioritisation of and substantial investment in improving the treatment systems' response to co-occurring disorders. There have been numerous developments in the USA with substantial potential to inform and benefit Australian approaches including

- The federal Substance Abuse Mental Health Service's Administration (SAMHSA) actions in…
  - identifying as <u>one of its highest priorities</u> the improvement of treatment and services for individuals with co-occurring mental and substance abuse disorders.
  - its <u>robust promotion of integrated treatment</u> of low-prevalence mental health disorder type comorbidity as one of six evidence-based practices identified for mental health services
  - <u>creating the *Co-Occurring Center for Excellence*</u> to 'provide the technical, informational, and training resources needed for the dissemination of knowledge and the adoption of evidence-based practices in systems and programs serving persons with co-occurring disorders'
- Development, dissemination and adoption of system change technology specifically targeting mental health and drug treatment system's response to co-occurring disorders
- Comprehensive Continuous System of Care (CCISC) implementation in a number of US states and territories. See text box on page for a brief overview of the influential CCISC model
- Development of New Hampshire-Dartmouth's Integrated Dual Disorder Treatment (IDDT) model targeting Serious Mental Illness type co-occurring disorders. See text box on page for a brief overview of the IDDT model
- American Society of Addiction Medicine Patient Placement Criteria - addiction triage criteria incorporate co-occurring disorders into national management guidelines for addiction treatment. They introduced concepts of *Dual Diagnosis Capability* (DDC) and *Dual Diagnosis Enhanced* (DDE) as program standards
- The USA's substantial and growing body of research around co-occurring disorders
- The widespread, generally state-based development, promotion and dissemination of practical, clinician-focused treatment manuals around best practice responses
- Development of auditing tools whereby an agency or clinician can self-assess their competencies in relation to co-occurring disorders.

Comprehensive Continuous Integrated System of Care (CCISC) model – brief profile

- 'CCISC is a model to bring the mental health and substance abuse treatment systems (and potentially other systems) into an integrated planning process in order to develop a comprehensive, integrated system of care'.
- The CCISC model is designed to improve co-occurring disorders treatment capacity at all levels of a treatment system - from an entire state system, to individual agencies, to programs within agencies
- CCISC is based on an integrated treatment philosophy and is designed around the needs of all cohorts of persons with co-occurring disorders. CCISC is built on the recognition that co-occurring disorders are the expectation throughout the service system and leverages substantial development of a treatment system *largely within existing resources*
- CCISC has been identified by the USA's federal SAMHSA body as an exemplary practice. CCISC was designed for application to any system of care and is in various stages of implementation in a wide range of US and Canadian systems with a wide variety of funding models and organisational structures.

Integrated Dual Disorder Treatment (IDDT) model– brief profile
• IDDT targets the needs of persons with co-occurring substance use and serious mental illness. The model was developed by the New Hampshire Dartmouth Research Centre (responsible for the world's largest body of research around co-occurring disorders). • IDDT integrates pharmacological, psychological, educational, and social interventions to address the needs of consumers and caregivers. It promotes consumer and family involvement in service delivery, stable housing as a necessary condition for recovery, and employment as an expectation. IDDT emphasises continuous treatment teams, assertive community outreach and stage-wise treatment • The IDDT model is claimed to *reduce* relapse of substance use and mental health disorders, hospitalisation, forensic involvement, service costs and duplication and utilisation of high cost services. The IDDT model is claimed to *increase* continuity of care, quality of life measures, housing stability, employment and independent living.

6. Where is Australia now in relation to co-occurring disorders?

<u>National Strategy contexts</u>

Alcohol & Other Drug strategy documents

National Drug Strategy Australia's Integrated Framework 2004–2009 states that

- Action will be taken to '*build strong partnerships between drug treatment services and mental health services to enhance responses to co-existing drug and mental health problems'.*
- *There will also be integration between the National Drug Strategy and other relevant strategies, for example, the …….National Mental Health Strategy'*.

Mental Health system strategy documents

National Mental Health Plan 2003-2008 states at the outset its assessment that,

- '*In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system'.*
- Without discussion of the relative efficacy of integrated or non-integrated treatment the plan states that '*People with comorbid conditions, particularly comorbid substance use disorders... often have complex needs that require a coordinated response from multiple service sectors'*.
- Similarly to the National Drug Strategy framework document the Mental Health Plan states that it is linked to the A&OD service system national strategy– however it is difficult to discern at what points and in what manner the two strategies are linked.
- As noted in Section 3.3 there has been substantial criticism of the absence of a coherent, goal-focused, national strategy addressing co-occurring disorders.

<u>Federal Initiatives</u>

National Comorbidity Project

The National Comorbidity Project is a joint initiative under the National Mental Health Strategy and the National Drug Strategy. A Project held a workshop in Canberra in 2000 which identified key priority areas and recommendations for action including <u>whole-of-government approaches to addressing co-occurring disorders.</u> The Project has delivered a number of valuable projects and reports which have provided more clarity around the extent and nature of co-occurring disorders in Australia and possible responses.

National Comorbidity Taskforce

A National Comorbidity Taskforce was established by the Inter-Governmental Committee on Drugs and the Australian Health Ministers' Advisory Council's National Mental Health Working Group to 'develop national frameworks and guidelines to facilitate better access to treatment for people with a mental illness and comorbid substance abuse problem'. The Taskforce was considering its priority action areas but has apparently not sat for some time

National Comorbidity Initiative
The Australian Government allocated $9.7 million, for the five years from 2003-04 to 2007-08, to a National Comorbidity Initiative to improve service coordination and treatment outcomes for people with coexisting mental health and substance use disorders. While this Initiative has a focus on the co-occurrence of illicit drug addiction and mental illness its activities are likely to benefit wider cohorts of persons with co-occurring disorders.
Priority areas include:

- facilitating resources and information for consumers;
- providing support to general practitioners and other health workers to improve treatment outcomes for comorbid clients;
- improving data systems and collection methods within the mental health and alcohol and other drugs sectors to manage comorbidity more effectively; and
- Raising awareness of comorbidity among clinicians/health workers and promoting examples of good practice resources/models.

National Alcohol and Mental Health Comorbidity Project: *Mental Health and Alcohol - Managing the Mix.*
A substantial collaboration involving the Alcohol Education and Rehabilitation Foundation, the Mental Health Council of Australia, the Australian Government Departments of Health and Ageing and Veterans Affairs, and Australian Divisions of General Practice. The Project has arisen from 'recognition of the links between alcohol & common mental health problems, the prevalence of such comorbidity and the potential for general practice to identify and treat such comorbidity'.
The Project's objectives are to:

- improve knowledge, skills & capacity of the general practice sector in prevention and management of high prevalence alcohol & mental health comorbidities
- build a critical mass of GPs and practice staff competent in the prevention, management and referral of alcohol and mental health comorbidity

33 Divisions of General Practice across Australia have been funded to implement *Managing the Mix* locally

State-level initiatives
Ongoing initiatives addressing co-occurring disorders exist in the ACT, Victoria and Western Australia. Victoria appears to have the largest scale initiative, the Victorian Dual Diagnosis Initiative (VDDI), jointly funded by the Victorian Mental Health Branch and the Drugs Policy and Service Branch. Operational since 2002 the VDDI has placed around 35 specialist workers across Victorian Mental Health and A&OD treatment systems. The VDDI aims to *'support the development of better treatment practices and collaborative relationships between drug treatment and mental health services. The key activities of the initiative are the development of local networks; training, consultation and modelling of good practice through direct clinical intervention, and shared care arrangements'*. An evaluation was recently completed.

Victoria's commitment to improving outcomes for persons with co-occurring disorders has been underlined with the recent formation of a Ministerial Advisory Committee on Mental Health with a specific remit to '*address a need for better coordination between mental health and drug and alcohol services to improve access and develop innovative models of integrated service delivery'* addressing co-occurring disorders.

7. Where should we be? Proposed co-occurring disorders goals for Australian treatment systems

Each sector of the service system has differing capacities around its recognition of and response to co-occurring disorders. A central argument of this submission is that Australia health planners should much more robustly pursue the goal of greater service system capacity to provide integrated treatment of co-occurring disorders.

System wide

- Central planning processes occur with a strong awareness of the prevalence of and harms associated with co-occurring disorders and their implications for service delivery.
- Central planning and policy is developed from an integrated, collaborative, central planning process that assigns treatment responsibility for the various cohorts of persons with co-occurring disorders (Minkoff and Cline, 2004)

Primary Care
Note: Many of the following goals are being actively pursued by the *Managing the Mix* project profiled in Section 6.

- Given prevalence data GP's have a high index of suspicion for co-occurring disorders
- Where either substance use or mental health disorders are detected GP's routinely screen for the other disorder
- GP's are aware of the most likely demographic correlates of co-occurring disorders and routinely screen persons with that demographic profile.
- GP's have competence in providing integrated treatment of high-prevalence mental health disorder type co-occurring disorders
- GP's have 'in-house ' mental health referral options for treatment of high-prevalence mental health disorder type co-occurring disorders (such as provided by the innovative Integrated Primary Mental Health Service of Northeast Victoria – see breakout box below.)
- Effective shared care arrangements with specialist mental health services and defined treatment pathways for persons with serious mental illness type co-occurring disorders.
- GP's are aware of likely physical health vulnerabilities of persons with serious mental illness type co-occurring disorders

Integrated Primary Mental Health Service of Northeast Victoria– brief profile
• Operational since 2002 the IPMHS is an innovative mental health service that has achieved collocation of a visiting mental health professional in each General Practice in the Eastern Hume region of North East Victoria and Albury-Wodonga. Visiting mental health professionals are able to provide up to 6 sessions of counselling for high-prevalence mental health disorders and early psychosis • All staff have received training around the prevalence of co-occurring substance use disorders and in recognising and providing integrated treatment of co-occurring substance use disorders • Other IPMHS staff are delivering a range of training modules targeting mental health literacy and also providing consultancy to non-General Practice primary care providers • Service evaluations have revealed a very high level of service satisfaction from clients and GP's. Auspiced by Mental Health Services, Northeast Health Wangaratta, IPMHS has braided Commonwealth (BOiMH & MAHs) and State (Primary Mental Health Initiative) funding

Mental Health systems
- All mental health clinicians have some level of competence in the recognition, assessment and integrated treatment of co-occurring substance use disorders.
- All persons assessed by mental health agencies are screened for a co-occurring substance use disorder, preferably using a validated tool.
- Where there is an indication of problematic substance use a detailed substance use assessment is integrated into the mental health assessment. The assessment incorporates the client's stage of change in regard to both metal health and substance use disorders.
- Where a person's mental health symptoms qualify them for service from a mental health agency any co-occurring substance use disorder is routinely treated in-house, using recognised, evidence-based practices, by the same clinician or team who is providing treatment for their mental health symptoms, i.e. integrated treatment.
- Substance use or abuse is never used as a criterion for refusing or limiting service.
- Co-occurring substance use disorder diagnoses are routinely recorded with mental health diagnoses
- Individual Service Plans document the strategies to be used to address both mental health disorders and any co-occurring substance use disorders.
- Inpatient unit's operating policies recognise the potential for clients to experience withdrawal (from mild to severe) on admission. Inpatient staff are competent in the use of withdrawal scales.
- Psychoeducation sessions for clients and carers incorporates information around substance abuse and co-occurring disorders

- The mental health agency provides consultation and advice to other agencies who provide services to persons with co-occurring disorders
- Training around co-occurring disorders and substance disorder treatment is ongoing for all staff.
- The mental health agency advocates for clients with co-occurring disorders. For instance, attempts are made to address systemic difficulties around secure, appropriate housing
- Medication prescribers have had specific training around the issues of prescribing to clients with co-occurring substance use disorders.
- Each program within a mental health service has a 'co-occurring disorders champion' with particular expertise in substance abuse treatment.
- Competency in delivering substance abuse treatment is a core criteria in staff appraisal activities
- Levels of competence in substance abuse treatment are key criteria in various position descriptions
- No wrong door policy: In cases where a person is assessed and it is deemed that the person's mental health symptoms do not qualify them for a service from the mental health agency but that service from a drug treatment agency is indicated then that person will still be warmly welcomed and actively and meaningfully assisted in gaining a service from the drug treatment agency. Service recording tools value and 'reward' such clinician activity.
- All service descriptions and operating philosophies refect the service's recognition of the prevalence and impact of comorbidity.
- There is substantial evidence of close, collaborative working relationships with drug treatment agencies. This includes routine staff placements with drug treatment agencies, services routinely being offered from the opposite agencies premises, joint education and training plans, routine management service planning meetings
- Clinicians, medical staff and management have a well-developed understanding of the prevalence and impact of co-occurring disorders.

A&OD Treatment system

- All drug treatment clinicians have training and competence in the recognition and initial assessment of co-occurring mental health disorders.
- All drug treatment clinicians have some level of competence in the integrated treatment of high-prevalence mental health disorder type co-occurring mental health disorders.
- All clients receive some level of screening for mental health symptoms or disorders.
- Where there is an indication of mental health symptoms or a disorder a plan is formulated for facilitating or providing further assessment and/or treatment for that disorder
- All drug treatment clinicians are familiar with pathways to assessment and treatment of mental disorders by primary care and specialist mental health treatment agencies
- Clinicians have training in and competency in providing a suicide risk assessment
- Workforce development initiatives include a substantial component on co-occurring disorders
- Treatment Plans document the strategies to be used to facilitate or provide treatment of co-occurring mental health disorders as well as substance use disorders.
- Training around co-occurring disorders and mental health disorders is ongoing for all staff.
- Each drug treatment agency has a 'co-occurring disorders champion' with particular expertise around mental health treatment
- No wrong door policy: In cases where a person is assessed and it is deemed that the person's substance use does not qualify them for a service from the drug treatment agency but that service from a mental health agency is indicated then that person will still be welcomed and actively and meaningfully assisted in gaining a service from the mental health agency. Service recording tools are modified to reflect and 'reward' such activity.
- All service descriptions and operating philosophies refect the service's recognition of the prevalence and impact of co-occurring disorders and specify the service's approach to detecting, assessing and either providing or facilitating treatment for their client's co-occurring mental health symptoms/disorder
- There is substantial evidence of close, collaborative working relationships with local mental health agencies.
- All staff have an understanding of the prevalence and impact of co-occurring mental health disorders.

The debate around integrated treatment
Substantial research attention has been devoted to determining whether integrated treatment of co-occurring disorders is more effective than non-integrated. The majority of research to date has

examined this question around the cohort of persons with Serious Mental Illness type co-occurring disorders. Research endeavours attempting to discover which form of treatment is the more effective are faced with considerable methodological challenges

Significant landmarks in this research include

- Drake, et als (1998) review of 36 North American research studies into effectiveness of integrated treatment of low-prevalence mental health disorder type comorbidity. Their positive findings have been particularly influential in the US where the federal Substance Abuse Mental Health Service's Administration promotes integrated treatment of low-prevalence mental health disorder type comorbidity as one of six evidence-based practices identified for mental health services.
- Cochrane Review of psychosocial treatment programmes for people with severe mental illness and substance misuse examined randomised trials of any programme of substance misuse treatment for persons with low prevalence mental health disorder type co-occurring disorders. They concluded that *there is no clear evidence supporting the effectiveness of any particular type of substance misuse programme for those with severe mental illness over standard care*. Discussing the Cochrane Review finding two of the authors cautioned that '*current lack of evidence of effectiveness is not evidence of lack of effectiveness'* and acknowledged the *'tide of opinion amongst leaders in the field …..that drug/alcohol treatment should be offered in addition to standard mental health care'* & '*encouraging indications that the developments to date are valuable'*
- A 2003 Commonwealth literature review concluded that '*an integrated mental health and drug and alcohol treatment for people with a range of dual diagnoses is beneficial across both mental health and substance use outcomes, at least within a North American context.*
- In 2005 Australian researchers Donald, Dower and Kavanagh authored a review of randomised controlled trials comparing integrated with non-integrated treatment of co-occurring disorders. In a separate recent paper Kavanagh stated that whilst there are large gaps in the evidence base about the most effective forms of treatment, especially for specific comorbidities '*there are strong suggestions about both what is and is not likely to be effective. Basic issues such as lack of detection, lack of treatment, and inadequately integrated treatment repeatedly emerge as issues in clinical practice'*

8. How can we get there? Approaches to system change around co-occurring disorders

Much of the following material has been influenced by the author's observations of the strategies, effectiveness and impact of the CCISC model (breakout box p.8). CCISC is in various stages of implementation in a wide range of US and Canadian systems with a wide variety of funding models and organizational structures

Cautions

Isolated examples of a shift to integrated treatment, -such as a single worker in a larger agency or an agency that has embraced effective integrated treatment or a specialist worker providing integrated treatment in isolation - do not per se impact significantly on the overall systems capacity or willingness to provide integrated treatment.

Developing co-occurring disorders specific treatment agencies (or deploying a specialist *treatment* workforce) effectively creates a de-facto third treatment system.

Such approaches

- Fail to recognise the evidence around prevalence in treated populations and are likely to contribute to, rather than alleviate, system complexity and clients 'falling through the gaps'.
- sends implied messages that workers do not have to develop their response to co-occurring disorders (as that is the domain of specialists) - that the only clients with co-occurring disorders that the workers need concern themselves with is those in whom the co-occurring disorder is highly-evident (in fact, the greatest room for development in treatment effectiveness, and potential human and financial costs

savings, is likely to be with those cohorts where the co-occurring disorder takes some skill and effort to elicit.
- are potentially stigmatising for clients treated in that system
- May lead to definitional disputes and 'turf wars' between clinicians over where a particular client should receive service.
- Even were there funds and political will to develop an additional treatment stream how would existing drug treatment and mental health clinicians and agencies occupy their time once they had lost 30 to 70% of their existing clients?

There is utility in having a specialist co-occurring disorders workforce but, as in Victoria, their role should be capacity building and modelling of detection and effective treatment.

Let's go...

Increasing a system's capacity to provide effective treatment of co-occurring disorders is possible. It requires the strategically-planned, collaborative and robust implementation of top-down and bottom-up strategies towards well-defined, locally-grounded goals

Increasing a system's capacity…

A capacity building approach is the approach most likely to yield *sustained* system change.

….to provide effective treatment of co-occurring disorders ….

Effective treatment entails the development of improved screening, assessment and integrated treatment. Indicators of effective treatment are suggested in Section 6.

…strategically-planned, collaborative and robust implementation of ……strategies

- A collaborative, inclusive, cross-systems strategic planning process is necessary to engage all stakeholders and develop consensus at the outset of a systemic change process.
- The more that change goals are clearly-stated and explicitly defined at the outset of a change process (along with preferred strategies to achieve those goals) the more likely that the change process will be successful.
- Goals should be derived from a careful evaluation of the best available evidence around improved treatment responses. Strategies to achieve those goals should be developed using a careful assessment of the current treatment situation and an explicit vision of a more effective treatment system.
- Achieving enduring change requires the implementation of a comprehensive array of strategies. Change is more likely to occur when there is *robust*, implementation of the strategies chosen.
- Perhaps the most useful tool that can be employed to guide a change process is a Stage of Change analysis of systemic, agency and clinician willingness to address the response to co-occurring disorders. Strategy selection and implementation needs to be informed by recognition that many parts of the system will be ambivalent about change around co-occurring disorders.

… top-down …

- Vision statements: Mental Health and Drug Treatment Central planning bodies should articulate a vision for how their systems will function when they are providing more effective treatment of co-occurring disorders.
- Policy: Policy is one of the most potent levers that central planners have to move a system towards more effective treatment.
- Expected clinician/worker competencies: need clear statements cataloguing necessary clinician competencies required in order to deliver the treatment response defined in the vision and policy statements.
- Education and training strategies, providers and curricula: articulate a training strategy for existing workers. Incentives to participate in training need to be devised. Training must address clinician attitudes as well as knowledge and skills. Clinical Supervision is a necessary adjunct to reinforce and 'work-in' learnings from training initiatives. Needs a training strategy specifically targeting needs of psychiatrists. Need to influence the drug treatment/ co-occurring disorders content in a range of undergraduate courses.
- Practical clinician-focused manuals –high priority should be the development and dissemination of clinician-focused, practical, screening and treatment manuals attuned to the specific needs of each of the drug treatment and mental health workforces

- Other tools – development or adoption of tools that allow agencies or clinicians to self-evaluate and benchmark their competencies in relation to co-occurring disorders
- Outcome measures –introduction of incremental, success-oriented outcome measures

…and bottom-up strategies towards well-defined, locally-grounded goals.

- Time-limited, task-focused, Regional Implementation Groups charged with specific tasks around implementing more effective integrated treatment locally, are a potent device towards grounding central policy directions in local circumstances and generating local ownership of a move to more integrated treatment, building links and meaningful partnership between local agencies and workers. Regional Implementation Groups should be tasked with generating a - *Regional profile of issues around co-occurring disorders* and a subsequent *Regional integrated treatment implementation plan*
- Specialist, co-occurring disorders field workers, can be a potent force in building local capacity around co-occurring disorders. Tasks assigned to specialist workers include training development and delivery, providing Clinical Supervision, consultation, protocol development activities, working competencies into job and agency descriptions
- Agency co-occurring disorders champions: each agency within a system should nominate a co-occurring disorders portfolio holder or 'champion', able to evaluate and develop the agency's response to persons with co-occurring disorders.

9. Recommendations

Recommendations

1. That the CCISC model be implemented in an Australian state.

2. That future A&OD and Mental Health National plans reframe as one of their highest priorities the improvement of treatment and services for persons with co-occurring disorders.

3. That future A&OD and Mental Health National plans cover similar time frames and arise from a collaborative, strategic planning process that adequately recognises the prevalence of and harms associated with co-occurring disorders, societal demand for improved treatment outcome for persons with co-occurring disorders and the potential to improve the system's response to co-occurring disorders.

4. That future A&OD and Mental Health National plans make clear statements to the workers within each system about their responsibilities around and desired responses to co-occurring disorders.

5. That an Australian body, (similar to the USA's Co-occurring Disorders Centre of Excellence), is established charged with identifying and disseminating evidence-based practices, for all of the cohorts of persons with co-occurring disorders, to clinicians, agencies and systems that provide services to persons with co-occurring disorders

6. That practical, user-friendly, clinician-focused manuals (describing integrated screening, assessment and treatment approaches) are developed for each of the mental health and A&OD workforces.

7. That tools for Mental Health and A&OD agencies or clinicians to self-assess their competencies in relation to co-occurring disorders are either developed or purchased and widely disseminated.

8. That funding is made available to extend the reach of the National Alcohol and Mental Health Comorbidity Managing the Mix Project.

1. Introduction

This submission provides an overview of key issues around the response by Australian treatment sectors (Primary Care, Mental Health, and Alcohol & Other Drug Treatment) to co-occurring mental health and substance use disorders. It argues that, in Australia, the priority placed on better addressing co-occurring disorders does not yet reflect the substantial evidence around prevalence and associated harms nor consumer, carer and societal demand for improved outcomes of treatment for person with co-occurring disorders. That, while valuable work has occurred in Australia around co-occurring disorders we have yet to see substantial, uniform developments in the effectiveness of service delivery. That there is significant potential to improve the effectiveness of our treatment of both mental health and substance use disorders by developing our recognition of and response to co-occurring disorders.

To date Australia's response to co-occurring disorders has had a warranted focus on the primary care sector. There is, however, a substantial case for also prioritising and robustly, strategically addressing the response to co-occurring disorders by the Mental Health and A&OD treatment sectors.

Increasing the system's capacity to provide effective treatment of co-occurring disorders is necessary and possible. International experience has demonstrated that rapid development of a system's recognition of and response to co-occurring disorders can occur without the input of significant extra resources. Improving the system's recognition and response requires the strategically-planned, collaborative and robust implementation of top-down and bottom-up strategies towards well-defined, locally-grounded goals. Integrated strategic planning processes and policy deployment are central to effecting enduring improvements to systems' recognition of and responses to co-occurring disorders.

2. Co-occurring disorders: the territory & the terminology

Co-occurring disorders – describes co-occurring mental health and substance use disorders.
Includes …

- substance use disorders co-occurring with high-prevalence, low-impact mental health disorders (such as Anxiety and Depression)
- substance use disorders co-occurring with low-prevalence, high-impact mental health disorders (such as Psychosis and Major Mood disorder)
- any mental health disorder co-occurring with either Substance Abuse or Substance Dependence

Other terms in frequent use include: '***Dual Diagnosis', 'Co-existing Disorders'*** and ***'Comorbidity'***.
'*Dual diagnosis'* is the most long-standing and perhaps most widely-recognised phrase used to describe co-occurring disorders. *'Comorbidity'* currently has the most currency in Australia but has been criticised for its pathological connotations. '*Co-occurring disorders'* has evolved as the preferred term in the USA (CSAT, 2005 b)

Co-occurring disorders cohorts: Persons with co-occurring disorders are not a homogenous group. Substantial diversity exists in the combinations of disorders, in their severity and in individual treatment needs. Various typologies have been proposed to classify the various cohorts of persons with co-occurring disorders. Cohorts may be classified by

- whether the substance use disorder co-occurs with either a high or low-prevalence mental health disorder (see above)
- the type of treatment agency which the person affected is most likely to access for treatment (Primary Care, Substance Treatment or Mental Health)
- The four quadrant model, a service planning tool in common use in the USA, classifies cohorts by symptom severity rather than diagnosis (CSAT, 2005 b).

I **Less severe mental disorder /** **Less severe substance use disorder**	**III** **Less severe mental disorder /** **More severe substance use disorder**
II **More severe mental disorder /** **Less severe substance use disorder**	**IV** **More severe mental disorder /** **More severe substance use disorder**

Diagram 1 - four-quadrant severity matrix (NASMHPD & NASADAD, 1998).

Integrated treatment: a single treatment agency or clinician providing interventions for both mental health and substance abuse problems as a 'seamless, coherent package' (Drake, Essock, Shaner, Minkoff, Lola, Lynde, Osher, Clark and Rickards, 2001).
Often contrasted with

- Sequential treatment (client alternates between receiving treatment from a mental health and an substance treatment agency)
- Parallel treatment (client receives simultaneous, perhaps uncoordinated treatment from both mental health and substance treatment agencies)

Integrated treatment does not require the integration of mental health & drug treatment systems or agencies
See breakout box on p. 34 for a profile of the debate around the evidence for integrated over non-integrated treatment of co-occurring disorders.

Serious Mental Illness (SMI): 'having had at some time during the past year a diagnosable mental, behavioural, or emotional disorder that met DSM-IV criteria and resulted in functional impairment that substantially interfered with or limited one or more major life activities' (NSDUH, 2004)

3. Why should improving the response to co-occurring disorders be an urgent priority?

Improving Australian treatment systems response to co-occurring mental health and substance use disorders must become an urgent priority for all levels of the treatment systems because of

- **The prevalence of co-occurring disorders,**
- **The substantial personal and societal costs, harms and undesirable outcomes strongly associated with co-occurring disorders**
- **Consumer, carer and societal demand for improved treatment and outcomes for persons with co-occurring disorders &**
- **The potential for treatment systems to respond more effectively to co-occurring disorders.**

3.1 Prevalence of co-occurring disorders

Prevalence - *Key Facts*

- Co-occurring disorders are common in the general population
- Co-occurring disorders are very common, the *expectation not the exception* (Minkoff and Cline, 2004) in persons receiving treatment for either a mental health or a substance use disorder
- Having either a mental health or a substance use disorder substantially increases a person's risk of also developing the other disorder
- The prevalence of particular combinations of co-occurring disorders will vary with different treatment settings
  - General Practice/Primary Care: high prevalence of persons with co-occurring Anxiety or Depression with Alcohol Use Disorder
  - Alcohol and Other Drug treatment: high prevalence of persons with range of Substance Use Disorders co-occurring with Personality Disorder or Anxiety &/or Depression
  - Mental Health treatment: high prevalence of persons with Psychosis co-occurring with Cannabis or Alcohol or Stimulant Use disorders
- The overall prevalence rates of co-occurring high-prevalence mental health disorder type co-occurring disorders (Anxiety or Depression) is less dramatic than the prevalence rates found with low-prevalence mental health disorder type co-occurring disorders (Psychosis & Major Mood Disorder). However the *actual numbers* of persons with high-prevalence mental health disorder type co-occurring disorders is far greater because of the much higher prevalence of Anxiety and Depression in the Australian community

Prevalence of co-occurring disorders

i. Prevalence in the general population

general population

Australian numbers

The last 15-20 years has seen a number of nations fund large scale studies to ascertain the prevalence of mental health disorders in the general population. The Australian version, the 1997 National Survey of Mental Health and Wellbeing (NSMHW), was a household survey that assessed a representative sample of 10,641 respondents for symptoms of high-prevalence mental health disorders including substance use disorders.

The NSMHW found that, in any 12-month period

- 9.7% of the population met criteria for an Anxiety Disorder,
- 7.7% met the criteria for a Substance Use Disorder and
- 5.8% met the criteria for an Affective (Mood) Disorder

(Andrews et al 1999)

In regard to co-occurring disorders NSMHW data has revealed that …

- 1 in 4 of the persons with one of the above common (high-prevalence) disorders also had one of the other disorders.
- In females while only 15% of females *without* an Alcohol Use Disorder had any mental disorder 48% of those *with* an Alcohol Use disorder also met criteria for an Anxiety, Affective or Drug Use disorder.
- In males, while only 9% of males *without* an Alcohol Use disorder had a mental disorder, 34% of those *with* an Alcohol Use disorder had another mental disorder

(Teeson, Hall, Lynskey and Degenhardt, 2000).

- Alcohol dependent persons were 4.5 times more likely than other Australians to also have an Affective disorder
- Alcohol dependent persons were 4.4 times more likely than other Australians to also have an Anxiety disorder
- Cannabis dependent persons were 4.3 times more likely than other Australians to also have an Anxiety disorder
- Tobacco users were 2.2 times more likely to also have an Affective disorder
- Tobacco users were 2.4 times more likely to also have an Anxiety disorder

(Degenhardt, Hall, Lynskey, 2001)

- 180,000 men and 130,000 women (310,000 Australians) had a Substance Use Disorder co-occurring with either an Anxiety or a Affective disorder in the previous 12 months

(Kavanagh, 2003)

- Of persons with an Alcohol Use disorder in the previous 12 months 18% also had an Affective disorder & 15% also had an Anxiety disorder
- Of persons with an Affective disorder in the previous 12 months 17% also had an Alcohol Use Disorder
- Of persons with an Anxiety disorder in the previous 12 months 16% also had an Alcohol Use Disorder

(Burns, Teesson, Lynskey, 2001)

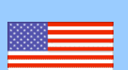
general population

overseas numbers

USA Epidemiological Catchment Area study : (*n* = 20,291)

- Persons with any mental disorder were 2.7 times more likely to also have a Substance Use Disorder
- 37% of persons with an Alcohol Use disorder also had a co-occurring mental disorder
- 53% of persons with a Drug Use disorder (excluding alcohol) also had a mental disorder
- Persons with Schizophrenia were 4.4 times more likely to also have a Substance Use disorder
- Persons with Bipolar disorder were 6.6 times more likely to also have a Substance Use disorder

(Regier et al 1990).



general population

overseas numbers

USA National Comorbidity Survey: (n=8000)

- Persons with anxiety disorders are 2-3 times more likely to have a lifetime SUD than the general population

(Kendler et al, 1996)

USA 2002 National Survey on Drug Use and Health: (n= 68,126)

In the past year

- 8 % of USA adult population (17.5milion) were estimated to have Serious Mental Illness (SMI)
- 23 % of adults with SMI (4 million) also were dependent on or abused alcohol or an illicit drug (among adults without SMI, the rate of dependence or abuse was only about 8%).
- Less than 1/2 of adults with co-occurring SMI and Substance Use disorders received mental health or specialty substance use treatment during the past year

(NSDUH, 2004)

UK 1995 National Household Survey (n=12,370)

In the general population only 12% of persons without substance dependence had a psychiatric disorder. However…

- 22% of nicotine dependent persons had a psychiatric disorder
- 30% of alcohol dependent persons had a psychiatric disorder
- 45% of drug dependent persons had a psychiatric disorder

(Farrell et al, 2001)

ii. Prevalence in mental health treatment settings

mental health settings

Australian numbers

The 1997 NSMHW also conducted a low-prevalence survey examining aspects of the lives of persons with psychosis (n=970).
(Jablensky, McGrath, Herrman, Castle, Gureje, Morgan and Korten, 1999).
This survey painted a grim picture of the quality of life of persons with psychosis in Australia and evidence of very high rates of co-occurring Substance Use disorders

- 40% of persons with psychosis met lifetime criteria for substance abuse or dependence
- 17.4% met criteria for abuse or dependence on two or more substances.
- 70% of the sample had or had had a Substance Use Disorder involving nicotine,
- 27% involving alcohol,
- 22% involving cannabis and
- 12% 'other substances'

(Kavanagh, Waghorn, Jenner, Chant, Carr, Evans, Herrman, Jablensky and McGrath, 2004)

Victorian Mental Health Branch 2002 telephone survey (n = 1858)

In 2002 the Victorian Mental Health Branch conducted a telephone survey of persons receiving treatment from Victorian mental health services. Despite methodology likely to lead to significant underreporting the survey still found that 45% of persons receiving acute mental health treatment reported a co-occurring alcohol or drug abuse/ dependence problem.

Prevalence in forensic mental health treatment settings

Ogloff, Lemphers and Dwyer (2004) assessment of patients at a forensic psychiatric hospital found that 74% of patients had a lifetime substance abuse or dependence disorder (and also that the patients with Substance Use disorders had more extensive criminal histories, had more complex needs and posed more risks than clients with mental illness alone)

mental health settings **overseas numbers**	**UK prevalence study of comorbidity amongst persons receiving treatment from a mental health agency** (*n* = 282) • 44% self-reported problem use of drugs or were assessed to have used alcohol at hazardous or harmful levels in the past year. • 25% reported hazardous or harmful alcohol use in the past year • 30% reported problem drug use in the past year. • Cannabis was the most frequently reported drug- 25%. • 16% of patients were assessed as dependent on one or more illicit or non-prescribed drug. (Weaver et al, 2002) **Graham and Maslin (2001) UK study** relied on mental health case manager ratings of client's substance use. (*n* = 1369) • 24% of persons with Severe Mental illness had problematic substance use

iii. Prevalence in substance treatment settings

substance treatment settings **Australian numbers**	**Prevalence of psychiatric disorders in persons recently entered a methadone maintenance programme.** (n = 62) In the 12 months prior to interview: • more than 50% met criteria for an Affective disorder • two-thirds fulfilled criteria for an anxiety disorder • just under half met criteria for both an affective disorder and an anxiety disorder At the time of interview: • 19% met criteria for a moderate or severe affective disorder. • 70% of males & 89% of females had a comorbid psychiatric illness. • 71% of the group with comorbidity reported that onset of psychiatric symptomatology predated the use of heroin. • The prevalence of psychiatric disorder is up to 10 times higher in the population on methadone maintenance than in the general population and is 2-3 times higher than that found in community surveys of those with a substance-use disorder. (Callaly, T., Trauer, T., Munro, L., Whelan, G. , 2001)
substance treatment settings **overseas numbers**	**UK prevalence study of comorbidity amongst persons receiving treatment from substance treatment services** **Alcohol services users:** (n = 62) • 55% of clients had 2 or more psychiatric disorders • 19% had a Psychotic Disorder • 53% had a Personality Disorder • 80% had Depression &/or Anxiety Disorder **Drug services users:** (n= 216) • 36% had depression or anxiety alone • 7.9% had a Psychotic Disorder • 37% had a Personality Disorder • 67.6% had Depression &/or Anxiety Disorder • 76% of person with Psychosis also had Personality Disorder and Depression or Anxiety (Weaver et al, 2002) **Psychiatric symptoms among clients receiving treatment for drug dependence** (*n* = 1075) (Variety of substance treatment settings / 90% of clients were opiate dependent) • 20% of subjects had had psychiatric treatment in the past 2 years • 10% had had in-patient psychiatric treatment in previous 2 years (Marsden, Gossop, Stewart, Rolfe, Farrell, 2000)

substance treatment settings **overseas numbers**	**Prevalence of clients with co-occurring disorders in outpatient substance abuse treatment** (n= 415) • Over 50% of substance treated outpatients screened positive for a co-occurring mental health disorder, most commonly Anxiety or Depression. • Over a 1/3 had 2 or more probable mental health disorders. (Watkins, Hunter, Wenzel, Tu, Paddock, Griffin and Ebener, 2004). **Psychiatric disorders among drug dependent subjects: primary or secondary?** (n = 425) Found lifetime prevalence rates of co-occurring mental health disorders of • 44% of sample had Antisocial Personality Disorder • 39% Phobic Disorders • 24% Major Depression • Generally onset of Personality Disorder and Phobic Disorders predated onset of drug dependence and Anxiety Disorders post-dated onset of drug dependence (Compton, Cottler, Phelps, Ben Abdallah and Spitznagel, 2000)

iv. Prevalence in primary care settings

primary care settings **Australian numbers**	The high prevalence of co-occurring disorders in the general population data reported in section (i) has relevance to the prevalence of co-occurring disorders in primary care settings – in 2000-1 the average Australian had between 4 and 6 consultations with a GP or specialist (AIHW, 2004) It is likely that persons with mental health disorders or substance use disorders either singly or co-occurring will attend General Practice more frequently than the average person in the community. **Comorbidity of common mental disorders and alcohol or other substance misuse in Australian general practice** (n=46,515) f • Overall prevalence of mental health and/or substance use amongst persons attending General Practice of 56% • Found co-occurring mental disorders and substance misuse in 12% of patients attending General Practice (Hickie et al, 2001)

3.2 Substantial personal and societal costs, harms and undesirable outcomes strongly associated with co-occurring disorders

Co-occurring mental health and substance use disorders will most often, in any individual experiencing them, influence each other in their development, their severity, their response to treatment and their relapse circumstances. This is likely to be so whether one examines high or low-prevalence mental health disorder type co-occurring disorders. Treatment that attempts to focus only on one disorder in isolation of the other, that fails to detect and respond to both disorders, is likely to be less effective.

Most of the research to date has examined harms and undesirable outcomes associated with low-prevalence mental health disorder type comorbidity. In this cohort strong evidence shows that, compared to persons with a mental health disorder alone, such persons experience…

- **More frequent relapse and hospitalisation**: (Drake and Wallach, 1989; Osher, Drake, Noordsy, Teague, Hurlbut, Biesanz and Beaudettt, 1994; Cuffel and Chase, 1994).

- **Greater housing difficulties and homelessness**: greater difficulties in retaining tenure of housing (Lipton, Siegel, Hannigan, Samuels and Baker, 2000) and more likely to become homeless (Olfson, Mechanic, Hansell, Boyer and Walkup, 1999).

- **Violence and exploitation:** Persons with co-occurring disorders are significantly more likely to experience violent victimisation (Sells, Rowe, Fisk and Davidson, 2003). Women with the combination of schizophrenia or schizoaffective disorder and substance use disorder have been shown to have particularly high rates of physical abuse and revictimisation (repeated experiences of victimisation) (Gearon, Kaltman, Brown and Bellack, 2003). Johns (1997) estimated that clients with co-occurring severe mental illness and substance use disorders were four times as likely to be violent as clients with severe mental illness alone.

- **Forensic involvement:** Australia researchers Wallace, Mullen and Burgess (2004) have recently provided striking evidence of the contribution made by co-occurring substance abuse to the likelihood that persons with schizophrenia will commit criminal offences. The researchers compared the criminal records of patients (*n* =2,861) with a first admission for schizophrenia in Victoria in 1975, 1980, 1985, 1990, and 1995 with those of an equal number of community comparison subjects matched for age, gender, and neighbourhood of residence. They found that persons with schizophrenia committed nearly 8 times the number of offences as the non-schizophrenia matched control group and also that much higher rates of criminal conviction were found for persons with schizophrenia with substances abuse problems than for those without substance abuse problems (68.1% versus 11.7%).
  Clark, Ricketts and McHugo (1999) in a three year study of persons enrolled in a dual diagnosis specific programme (*n* =203) found that 83% of participants had contact with the legal system and 44% were arrested at least once. In North American studies, having a severe mental illness confers a higher risk, than the general population, of being imprisoned (McFarland, Faulkner and Bloom, 1989) and having a co-occurring substance use disorder further increases this risk (Abram and Teplin, 1991).

- **Physical disorders**: Dickey, Normand, Weiss, Drake, and Azeni, (2002), noting that persons with a mental illness have been shown to have higher rates of medical disorders, set out to study whether this may be influenced by a co-occurring substance use disorder. They found that individuals with co-occurring psychotic and substance use disorders were at higher risk of experiencing five of the eight physical disorders assessed for than persons with mental illness alone. Disorders assessed for included diabetes, hypertension, heart-disease, asthma, gastrointestinal disorders, skin infections, malignant neoplasms and acute respiratory disorders.

- **Increased treatment costs:** Hoff and Rosenheck (1999) tracked health care costs over a six year period for two groups of veterans, with and without co-occurring disorders, who were receiving substance use treatment. The client group with co-occurring disorders (*n* =3,069) consistently had higher costs of treatment and service utilisation than did the client group without co-occurring disorders (*n* =9,538). Dickey and Azeni (1996) also examined treatment costs for persons with and without co-occurring substance use disorder (*n* =16,395). They found that overall treatment costs for persons with co-occurring substance use disorders were twice that of persons without co-occurring disorders, largely attributable to the costs of acute care.

3.3 Consumer, carer and societal demand for improved treatment and outcomes for persons with co-occurring disorders

In April 2003 the Mental Health Council of Australia (MHCA) launched its report on a national review of mental health services in Australia. '*Out of Hospital, Out of Mind'* (Groom, Hickie and Davenport, 2003) drew on data from three large national surveys, focus groups and public meetings across the country and found that …' *the situation of one of the most chronically disadvantaged groups in this country (persons with mental illness) continues to be ignored. After two 5-year National Mental Health Plans this does not represent a failure of policy, but rather a failure of implementation. This includes poor government administration and accountability, lack of ongoing government commitment to genuine reform and failure to support the degree of community development required to achieve high quality mental health care outside institutions'.*

'*Out of Hospital, Out of Mind*' reported community priorities for future mental health policy. The two top priorities were

- Implementation of earlier intervention strategies nationally and
- <u>Attention to the overlap between mental health and drug and alcohol abuse</u>.

In a related profile of community priorities (MHCA, 2005) MHCA called for:

- Development of innovative approaches to primary care management of patients with both mental health and alcohol or substance abuse
- Development of staff education and professional training
- Development of clear agreements between national mental health and alcohol or substance abuse strategies
- Development of innovative approaches to provision of common specialist services
- Support for greater research into the changing patterns of comorbidity
- Other (eg. combine drug and alcohol with mental health services)

Dr Sev Ozdowski, Australian Human Rights Commissioner and Disability Discrimination Commissioner in August 2004 described his recent Australia-wide consultations on mental health issues conducted jointly with the MHCA (AHREOC, 2004). Dr Ozdowski drew attention to community concerns around the apparent substantial increases in the numbers of persons presenting with mental health disorders complicated or caused by substance use and the dearth of services able to provide integrated treatment of the two disorders

A substantial focus of SANE's Mental Health Report for 2004wash the Commonwealth and State's response to co-occurring disorders. The report judged that **'***There are no coherent national strategies covering key issues such as dual diagnosis ….'* , It recommended '*leadership by the Australian government of all States and Territories in reform of the National Mental Health Strategy to focus on…national strategies for … dual diagnosis..*

The past two years have seen a number of calls from members of the Australian judiciary for a more effective response to co-occurring mental health and substance use disorders. Such calls have usually been in the context of the judge making the calls presiding over cases with extremely unfortunate outcomes in which the perpetrators had highly visible co-occurring disorders.

3.4 The potential for treatment systems to respond more effectively to co-occurring disorders.

Substantial potential exists for Australian treatment systems to provide more effective treatment of co-occurring disorders. Section 5 of this submission examines profiles international developments, Section 6 provides an overview of Australian developments in relation to co-occurring disorders; Section 7 proposes co-occurring disorders goals for each of the service sectors and Section 8 proposes strategies to move the systems towards more effective responses to co-occurring disorders.

4. Barriers to more effectively addressing co-occurring disorders.

Developing with the recognition of the prevalence of and harms associated with co-occurring disorders has been an appreciation that there are significant systemic and other barriers to more effectively addressing co-occurring disorders. The Addiction Technology Transfer Centre (ATTC, 2004) has catalogued many of these barriers...

- infrastructures geared to respond to single disorders,
- lack of a single point of responsibility for treatment and care coordination,
- mental health and drug treatment service systems competing for limited resources,
- complicated, rigid service funding mechanisms,
- clinicians from either system having different qualifications and treatment philosophies,
- lack of staff expertise around effective co-occurring disorders treatment,
- difficulties with client engagement and willingness to disclose the extent of their disorders,
- difficulties in evaluation and assessment because of the presence of another disorder,
- exclusion from some treatment programs because of the presence of the co-occurring disorder,
- stigma around specialised treatment facilities and
- a lack of primary care expertise in recognizing and addressing co-occurring disorders.

Zweben (2000) notes that training institutions may be resistant to change that incorporates cross-training of mental health and substance treatment streams and that addiction providers are wary of mental health managing their funding. Wallen and Weiner, (1989) cites as a barrier differing views between drug treatment and mental health providers on the relationship between psychopathology and substance abuse. Watkins, Burnam, Kung and Paddock (2001) identified that scarce resources for treatment leads to both mental health and drug treatment services excluding individuals who are likely to fail in treatment, to be disruptive or to require more resources. Drake, Essock, Shaner, Minkoff, Lola, Lynde, Osher, Clark and Rickards (2001) viewed consumers and families' lack of knowledge about the interplay of co-occurring disorders as a barrier to effective treatment, judging that confusion over causality may make it less likely for a person with co-occurring disorders to seek treatment for both disorders. Todd, Sellman and Robertson (2002) examined barriers to optimal care for persons with co-occurring disorders in New Zealand. Barriers identified included system issues such as poor communication between separate agencies and lack of service integration; clinical issues such as deficiencies in clinician knowledge and skills around effective treatment and attitudinal issues such as judgemental attitudes and a perception that substance treatment is not the business of a mental health service.

Australian researchers (Kavanagh et al, 2000) surveyed staff from both mental health and drug treatment services in order to determine their opinions and experiences in treating persons with co-occurring disorders. Issues raised as substantial problems included lack of specialised services, poor coordination of mental health and drug treatment services and frustrations with attempting to provide clinical services to this client group. In recent Australian research Szirom King and Desmond (2004) examined barriers to service provision for young people with presenting substance misuse and mental health problems. Identified barriers included

- homelessness
- challenging, volatile or violent behaviour
- appointment-based service provision
- definitional difficulties
- lack of specialist services and dedicated resources
- lack of expertise and dual skills
- conflicting interests in service provision.

Factors that may contribute to mental health and/or drug treatment worker's ambivalence or pre-contemplation around also addressing co-occurring disorders include

- Perception of *added work* rather than *more effective work*
- Lack of awareness of prevalence, harms, relationships between disorders and treatment implications
- 'Therapeutic nihilism' – lack of confidence in the effectiveness of 'the opposite' treatment approaches
- Lack of skills and knowledge in deploying drug treatment or mental health treatment approaches
- Implication of current 'wrong practice'

- Changes to practice, language, beliefs, values, exclusion criteria
- May be a change-weary and change-wary group
- Stigma of client group – two, relapsing highly-stigmatised disorders in the one individual
- Own cognitive dissonance (to address my client's substance use or mental health issue it is necessary, at some level, to examine my own substance use or mental health issues)
- History of own substance-related or mental health-related trauma
- Lack of knowledge of 'opposite' treatment system and the constraints on the extent of service possible from that system

(Croton, 2004b)

Ambivalence or pre-contemplation around addressing co-occurring disorders may be found at all levels of either treatment system. A key question is what approaches and strategies are most effective in nudging systems/ agencies/clinicians towards action around their response to co-occurring disorders?

5. International perspectives

United Kingdom
Substantial work and funding in the UK is being directed to improving outcomes for persons with co-occurring disorders whether they present to mental health, drug treatment or primary care treatment agencies. One of the most powerful levers on the mental health system to date has been the policy mandate that clients with co-occurring disorders are 'a mainstream responsibility for mental health services' (DoH 2002, Appleby 2000 cited in Abdulrahim, 2001). This policy has been supported and reinforced by the publication of a mental health policy implementation guide the *Dual Diagnosis Good Practice Guide* (DoH, 2002) which summarises current policy and good practice in the provision of mental health services to people with severe mental health problems and co-occurring substance misuse. Central guidance has recommended that a national strategy on comorbidity be developed and draft standards for mental health services around co-occurring disorders have also been published.

USA
The Australian research community has some wariness about the generalisability of USA substance treatment-related developments due to the USA's managed health care structure and its more concentrated focus on abstinence goals (I would add the influence of a different history with deinstitutionalisation to these concerns). Nonetheless the USA is notable for its recognition of the evidence around prevalence and harms and consequent prioritisation of and substantial investment in improving the treatment systems' response to co-occurring disorders. There have been numerous developments in the USA with substantial potential to inform and benefit Australian approaches.

These developments include

- The USA's, federal Substance Abuse Mental Health Service's Administration (SAMHSA) actions in…
  - identifying as one of its highest priorities the improvement of treatment and services for individuals with co-occurring mental and substance abuse disorders.

  - SAMHSA's robust promotion of integrated treatment of low-prevalence mental health disorder type comorbidity as one of six evidence-based practices identified for mental health services (SAMHSA, 2005).

  - SAMHSA's creation of the *Co-Occurring Center for Excellence* (COCE) linking SAMHSA and the states, communities, and providers. 'COCE provides the technical, informational, and training resources needed for the dissemination of knowledge and the adoption of evidence-based practices in systems and programs that serve persons with co-occurring disorders' (COCE, 2005)

- Development, dissemination and widespread adoption of system change technology specifically targeting mental health and drug treatment system's response to co-occurring disorders (ATTC, 2004)

- Comprehensive Continuous System of Care (CCISC) implementation in a number of US states and territories. See text box on following page for a brief overview of the influential CCISC model

- Development of New Hampshire-Dartmouth's Integrated Dual Disorder Treatment (IDDT) model targeting Serious Mental Illness type co-occurring disorders. IDDT is described as is an evidence-based practice aimed at improving the quality of life for persons with dual disorders by integrating substance abuse services with mental health services. See text box on following page for a brief overview of the IDDT model

- American Society of Addiction Medicine Patient Placement Criteria. These addiction triage criteria incorporate co-occurring disorders into national management guidelines for addiction treatment. They introduced the concepts of *Dual Diagnosis Capability* (DDC) and *Dual Diagnosis Enhanced* (DDE) as program standards (ASAM, 2001)

- The USA's substantial and growing body of research around co-occurring disorders

- The widespread, generally state-based development, promotion and dissemination of practical, clinician-focused treatment manuals around best practice responses to co-occurring disorders

- Development and use of auditing tools such as Mueser, Noordsy, Drake and Fox (2003) '*Dual Disorder Treatment Fidelity Scale*' (measures a service's fidelity to the IDDT integrated treatment model) or Minkoff and Cline's '*Compass*' tool (allows an individual agency to self-assess its competencies in relation to co-occurring disorders – other tools allow clinician self-evaluation of co-occurring disorders competencies – see www.Zialogic.org).

Comprehensive Continuous Integrated System of Care (CCISC) – brief profile

- 'CCISC is a model, first outlined by Minkoff, to bring the mental health and substance abuse treatment systems (and potentially other systems) into an integrated planning process in order to develop a comprehensive, integrated system of care' (CSAT, 2005).

- The CCISC model is designed to improve co-occurring disorders treatment capacity at all levels of a treatment system - from an entire state system, to individual agencies, to programs within agencies - mostly within existing resources

- CCISC is based on an integrated treatment philosophy and is designed around the needs of all cohorts of persons with co-occurring disorders. CCISC is built on the recognition that co-occurring disorders are the expectation throughout the service system and leverages substantial development of a treatment system *largely within existing resources*

- CCISC has been identified by the USA's federal Substance Abuse Mental Health Service's Administration body as an exemplary practice. The original 1991 design of CCISC was intended for application to any system of care. Although one of the first publications, in 1998, was in the context of SAMHSA's managed care initiative, the actual application has been undertaken in a wide range of US and Canadian systems with a wide variety of funding models and organisational structures. (CSAT, 2005; Minkoff and Cline, 2004, 2004b)

Integrated Dual Disorder Treatment (IDDT) model– brief profile

- IDDT targets the needs of persons with co-occurring substance use and serious mental illness.

- The model was developed by the New Hampshire Dartmouth Research Centre (responsible for the world's largest body of research around co-occurring disorders over the last 15-20 years).

- IDDT integrates pharmacological, psychological, educational, and social interventions to address the needs of consumers and caregivers. It promotes consumer and family involvement in service delivery, stable housing as a necessary condition for recovery, and employment as an expectation for many.

- IDDT emphasises continuous treatment teams, assertive community outreach and stage-wise treatment (Ronis, 2004)

- The IDDT model is claimed to *reduce* relapse of substance use and mental health disorders, hospitalisation, forensic involvement, service costs and duplication and utilisation of high cost services.

- The IDDT model is claimed to *increase* continuity of care, quality of life measures, housing stability, employment and independent living.

6. Where is Australia now in relation to co-occurring disorders?

National Strategy contexts

Alcohol & Other Drug strategy documents

The *National Drug Strategy Australia's Integrated Framework 2004–2009* (National Drug Strategy, 2004) states that

- Action will be taken to 'build strong partnerships between drug treatment services and mental health services to enhance responses to co-existing drug and mental health problems'.
- There will also be integration between the National Drug Strategy and other relevant strategies, for example, the …….National Mental Health Strategy'.

The discussion document, the **National Alcohol Strategy, 2005-2009**, in discussing treatment aspects around alcohol states that '*interventions need to address the specific issues of groups such as ...those with co-existing alcohol and mental health problems'*.

Mental Health system strategy documents

The *National Mental Health Plan 2003-2008* (Australian Government, 2003) states at the outset its assessment that,

- '*In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system'.*
- Without discussion of the relative efficacy of integrated or non-integrated treatment the plan states that '*People with comorbid conditions, particularly comorbid substance use disorders... often have complex needs that require a coordinated response from multiple service sectors'*.
- Similarly to the National Drug Strategy framework document the Mental Health Plan states that it is linked to the A&OD service system national strategy– however it is difficult to discern at what points and in what manner the two strategies are linked.
- As noted in Section 3.3 there has been substantial criticism of the absence of a coherent, goal-focused, national strategy addressing co-occurring disorders.

Federal Initiatives

National Comorbidity Project

The National Comorbidity Project is a joint initiative under the National Mental Health Strategy and the National Drug Strategy arising from the *Second National Mental Health Plan - 1998-2003* and the *National Drug Strategic Framework 1998-99 to 2002-03* recognition of the importance of addressing issues around co-occurring disorder. The Project held a workshop in Canberra in 2000 which identified key priority areas and recommendations for action. The priority areas included whole-of-government approaches to addressing co-occurring disorders. The Project has delivered a number of valuable projects and reports which have provided more clarity around the extent and nature of co-occurring disorders in Australia and possible responses.

National Comorbidity Taskforce

A National Comorbidity Taskforce was established by the Inter-Governmental Committee on Drugs and the Australian Health Ministers' Advisory Council's National Mental Health Working Group to 'develop national frameworks and guidelines to facilitate better access to treatment for people with a mental illness and comorbid substance abuse problem' (Dept. of Health & Aging, 2005 b). The Taskforce was considering its priority action areas but has apparently not sat for some time

National Comorbidity Initiative

Building on the foundations of the National Comorbidity Project the Australian Government allocated $9.7 million, for the five years from 2003-04 to 2007-08, to a National Comorbidity Initiative to improve service coordination and treatment outcomes for people with coexisting mental health and substance use disorders. While this Initiative has a focus on the co-occurrence of illicit drug addiction and mental illness its activities are likely to benefit wider cohorts of persons with co-occurring disorders.

The National Comorbidity Initiative's priority areas include:

- facilitating resources and information for consumers;
- providing support to general practitioners and other health workers to improve treatment outcomes for comorbid clients;
- improving data systems and collection methods within the mental health and alcohol and other drugs sectors to manage comorbidity more effectively; and
- Raising awareness of comorbidity among clinicians/health workers and promoting examples of good practice resources/models.

National Alcohol and Mental Health Comorbidity Project: *Mental Health and Alcohol - Managing the Mix.*

In an early stage of its development this substantial project is a collaboration involving the Alcohol Education and Rehabilitation Foundation, the Mental Health Council of Australia, the Australian Government Departments of Health and Ageing and Veterans Affairs, and Australian Divisions of General Practice.
The Project has arisen from 'recognition of the links between alcohol & common mental health problems, the prevalence of such comorbidity and the potential for general practice to identify and treat such comorbidity' (ADGP, 2005).

The Project's objectives are to:

- improve knowledge, skills & capacity of the general practice sector in prevention and management of high prevalence alcohol & mental health comorbidities
- build a critical mass of GPs and practice staff competent in the prevention, management and referral of alcohol and mental health comorbidity

33 Divisions of General Practice across Australia have been funded to implement *Managing the Mix* locally

<u>State-level initiatives</u>

Ongoing initiatives addressing co-occurring disorders exist in the ACT, Victoria and Western Australia.

Victoria appears to have the largest scale initiative, the Victorian Dual Diagnosis Initiative (VDDI). The VDDI is jointly funded by the Victorian Mental Health Branch and the Drugs Policy and Service Branch. It has been operational since 2002 and has placed around 35 specialist workers across Victorian Mental Health and A&OD treatment systems. The VDDI aims to *'support the development of better treatment practices and collaborative relationships between drug treatment and mental health services. The key activities of the initiative are the development of local networks; training, consultation and modelling of good practice through direct clinical intervention, and shared care arrangements'* (Victorian Government, 2005). An evaluation of the VDDI was recently completed (Berends and Roberts, 2004).

Victoria's commitment to improving outcomes for persons with co-occurring disorders has been underlined with the recent formation of a Ministerial Advisory Committee on Mental Health with a specific remit to '*address a need for better coordination between mental health and drug and alcohol services to improve access and develop innovative models of integrated service delivery'* addressing co-occurring disorders (Victorian Government, 2004)

7. Where should we be? Proposed co-occurring disorders goals

Each sector of the service system has differing capacities around its recognition of and response to co-occurring disorders – the following bullet points attempt to identify reasonable goals for each sector given individual sector capacities and the likely prevalences of specific comorbidities within that sector. Various degrees of integrated treatment are proposed as standards for each of the sectors. A central argument of this submission is that Australia health planners should now, given the current level of evidence for integrated treatment allied with consumer, carer and societal demand, much more robustly pursue the goal of greater service system capacity to provide integrated treatment of co-occurring disorders (the breakout box below briefly summarises some of the debate around integrated treatment).

System wide

- Central planning processes occur with a strong awareness of the prevalence of and harms associated with co-occurring disorders and their implications for service delivery.
- Central planning and policy is developed from an integrated, collaborative, central planning process that assigns treatment responsibility for the various cohorts of persons with co-occurring disorders (Minkoff and Cline, 2004)

Primary Care

Note: Many of the following goals are being actively pursued by the *Managing the Mix* project profiled in Section 6.

- Given prevalence data GP's have a high index of suspicion for co-occurring disorders
- Where either substance use or mental health disorders are detected GP's routinely screen for the other disorder
- GP's are aware of the most likely demographic correlates of co-occurring disorders and routinely screen persons with that demographic profile.
- GP's have competence in providing integrated treatment of high-prevalence mental health disorder type co-occurring disorders
- GP's have 'in-house ' mental health referral options for treatment of high-prevalence mental health disorder type co-occurring disorders (such as provided by the innovative Integrated Primary Mental Health Service of Northeast Victoria – see breakout box below.)
- Effective shared care arrangements with specialist mental health services and defined treatment pathways for persons with serious mental illness type co-occurring disorders.
- GP's are aware of likely physical health vulnerabilities of persons with serious mental illness type co-occurring disorders

Integrated Primary Mental Health Service of Northeast Victoria– brief profile

- Operational since 2002 the IPMHS is an innovative mental health service that has achieved collocation of a visiting mental health professional in each General Practice in the Eastern Hume region of North East Victoria and Albury-Wodonga. Visiting mental health professionals are able to provide up to 6 sessions of counselling for high-prevalence mental health disorders and early psychosis
- All staff have received training around the prevalence of co-occurring substance use disorders and in recognising and providing integrated treatment of co-occurring substance use disorders
- Service evaluations have revealed a very high level of service satisfaction from clients and GP's

- Other IPMHS staff are delivering a range of training modules targeting mental health literacy and also providing consultancy to non-General Practice primary care providers
- Auspiced by Mental Health Services, Northeast Health Wangaratta, IPMHS has braided Commonwealth (BOiMH & MAHs) and State (Primary Mental Health Initiative) funding

Mental Health systems

- All mental health clinicians have some level of competence in the recognition, assessment and integrated treatment of co-occurring substance use disorders.
- All persons assessed by mental health agencies are screened for a co-occurring substance use disorder, preferably using a validated tool.
- Where there is an indication of problematic substance use a detailed substance use assessment is integrated into the mental health assessment. The assessment incorporates the client's stage of change in regard to both metal health and substance use disorders.
- Where a person's mental health symptoms qualify them for service from a mental health agency any co-occurring substance use disorder is routinely treated in-house, using recognised, evidence-based practices, by the same clinician or team who is providing treatment for their mental health symptoms, i.e. integrated treatment.
- Substance use or abuse is never used as a criterion for refusing or limiting service.
- Co-occurring substance use disorder diagnoses are routinely recorded with mental health diagnoses
- Individual Service Plans document the strategies to be used to address both mental health disorders and any co-occurring substance use disorders.
- Inpatient unit's operating policies recognise the potential for clients to experience withdrawal (from mild to severe) on admission. Inpatient staff are competent in the use of withdrawal scales.
- Psychoeducation sessions for clients and carers incorporates information around substance abuse and co-occurring disorders
- The mental health agency provides consultation and advice to other agencies who provide services to persons with co-occurring disorders
- Training around co-occurring disorders and substance disorder treatment is ongoing for all staff.
- The mental health agency advocates for clients with co-occurring disorders. For instance, attempts are made to address systemic difficulties around secure, appropriate housing
- Medication prescribers have had specific training around the issues of prescribing to clients with co-occurring substance use disorders.
- Each program within a mental health service has a 'co-occurring disorders champion' with particular expertise in substance abuse treatment.
- Competency in delivering substance abuse treatment is a core criteria in staff appraisal activities
- Levels of competence in substance abuse treatment are key criteria in various position descriptions

- No wrong door policy: In cases where a person is assessed and it is deemed that the person's mental health symptoms do not qualify them for a service from the mental health agency but that service from a drug treatment agency is indicated then that person will still be warmly welcomed and actively and meaningfully assisted in gaining a service from the drug treatment agency. Service recording tools value and 'reward' such clinician activity.

- All service descriptions and operating philosophies refect the service's recognition of the prevalence and impact of comorbidity.

- There is substantial evidence of close, collaborative working relationships with drug treatment agencies. This includes routine staff placements with drug treatment agencies (especially during staff orientation), services routinely being offered from the opposite agencies premises, joint education and training plans, routine management service planning meetings

- Clinicians, medical staff and management have a well-developed understanding of the prevalence and impact of co-occurring disorders.

A&OD Treatment system

- All drug treatment clinicians have training and competence in the recognition and initial assessment of co-occurring mental health disorders.

- All drug treatment clinicians have some level of competence in the integrated treatment of high-prevalence mental health disorder type co-occurring mental health disorders.

- All clients receive some level of screening for mental health symptoms or disorders.

- Where there is an indication of mental health symptoms or a disorder a plan is formulated for facilitating or providing further assessment and/or treatment for that disorder

- All drug treatment clinicians are familiar with pathways to assessment and treatment of mental disorders by primary care and specialist mental health treatment agencies

- Clinicians have training in and competency in providing a suicide risk assessment

- Workforce development initiatives include a substantial component on co-occurring disorders

- Treatment Plans document the strategies to be used to facilitate or provide treatment of co-occurring mental health disorders as well as substance use disorders.

- Training around co-occurring disorders and mental health disorders is ongoing for all staff.

- Each drug treatment agency has a 'co-occurring disorders champion' with particular expertise around mental health treatment

- No wrong door policy: In cases where a person is assessed and it is deemed that the person's substance use does not qualify them for a service from the drug treatment agency but that service from a mental health agency is indicated then that person will still be welcomed and actively and meaningfully assisted in gaining a service from the mental health agency. Service recording tools are modified to reflect and 'reward' such clinician activity.

- All service descriptions and operating philosophies refect the service's recognition of the prevalence and impact of co-occurring disorders and specify the service's approach to detecting, assessing and either providing or facilitating treatment for their client's co-occurring mental health symptoms/disorder

- There is substantial evidence of close, collaborative working relationships with local mental health agencies.

- All staff have an understanding of the prevalence and impact of co-occurring mental health disorders.

The debate around integrated treatment

Substantial research attention has been devoted to determining whether integrated treatment of co-occurring disorders is more effective than non-integrated. The majority of research to date has examined this question around the cohort of persons with Serious Mental Illness type co-occurring disorders. Research endeavours attempting to discover which form of treatment is the more effective are faced with considerable methodological challenges (Kavanagh, Baker and Teesson, 2004).

Significant landmarks in this research include

- Drake, Mercer-McFadden, Mueser, McHugo and Bond's (1998) review of 36 North American research studies into effectiveness of integrated treatment of low-prevalence mental health disorder type comorbidity. Their finding that 10 studies showed improvements in treatment engagement, significant reductions in substance abuse, some cases of remissions and reduction in hospitalisations as well as other improvements in outcome measures has been particularly influential in the USA. The USA's federal Substance Abuse Mental Health Service's Administration promotes integrated treatment of low-prevalence mental health disorder type comorbidity as one of six evidence-based practices identified for mental health services.

- A Cochrane Review of psychosocial treatment programmes for people with severe mental illness and substance misuse, (Jeffery, Ley, McLaren and Siegfried 2004) which examined randomised trials of any programme of substance misuse treatment for persons with low prevalence mental health disorder type co-occurring disorders. Noting the poor quality of study design and failure to report clinically important outcomes the authors concluded that there is no clear evidence supporting the effectiveness of any particular type of substance misuse programme for those with severe mental illness over standard care. Discussing the Cochrane Review finding Ley and Jeffrey (2002) cautioned that '*current lack of evidence of effectiveness is not evidence of lack of effectiveness'* and acknowledged the *'tide of opinion amongst leaders in the field …..that drug/alcohol treatment should be offered in addition to standard mental health care'* & '*encouraging indications that the developments to date are valuable'*

- A 2003 Commonwealth literature review (Dept. of Health & Ageing, 2003) posed the question of: *Are integrated service delivery models better than parallel and sequential models, and is this different for different populations of comorbid clients?* The review concluded that '*an integrated mental health and drug and alcohol treatment for people with a range of dual diagnoses is beneficial across both mental health and substance use outcomes, at least within a North American context. However, it should be recognised that there may be important differences related to whether the integration occurs within mental health services or within drug and alcohol services.'*

- In 2005 Australian researchers Donald, Dower and Kavanagh authored a review of randomised controlled trials comparing integrated with non-integrated treatment of co-occurring disorders. They also identified that numerous limitations in conducting research with people with co-occurring disorders had diluted the evidence around the effectiveness of either form of treatment. In a separate paper Kavanagh stated that whilst there are large gaps in the evidence base about the most effective forms of treatment, especially for specific comorbidities '*there are strong suggestions about both what is and is not likely to be effective. Basic issues such as lack of detection, lack of treatment, and inadequately integrated treatment repeatedly emerge as issues in clinical practice'* (Kavanagh, Baker and Teesson, 2004).

8. How can we get there? Approaches to system change

Much of the following material has been influenced by the author's observations of the strategies, effectiveness and impact of the CCISC model (see CCISC Brief Profile page p. 28). CCISC is in various stages of implementation in a wide range of US and Canadian systems with a wide variety of funding models and organizational structures

Cautions

Attempts to develop treatment system's responses to co-occurring disorders have been developing internationally for some time - the New Hampshire-Dartmouth team of researchers have been implementing co-occurring disorders oriented change processes with clinicians, agencies and entire systems for 20 years. Alongside growing learnings about what works has come recognition of what doesn't work. New Hampshire researchers caution that isolated examples of a shift to integrated treatment, -such as a single worker in a larger agency or an agency that has embraced effective integrated treatment or a specialist worker providing integrated treatment in isolation - do not per se impact significantly on the overall systems capacity or willingness to provide integrated treatment (Croton, 2004a).

Another common strategy has been to develop and deploy a specialist workforce charged only with providing treatment for those with co-occurring disorders, thus creating a defacto third treatment system – 'drug treatment', 'mental health' *and* 'co-occurring disorders'. Such attempts are philosophically, strategically and structurally misguided. They fail to recognise the evidence around prevalence in treated populations and are likely to contribute to, rather than alleviate, system complexity and clients 'falling through the gaps'. Such a strategy sends implied messages that workers do not have to develop their response to co-occurring disorders (as that is the domain of specialists) and that the only clients with co-occurring disorders that the workers need concern themselves with is those in whom the co-occurring disorder is highly-evident and impossible to miss! In fact the greatest room for development in treatment effectiveness, and potential human and financial costs savings, is likely to be with those cohorts where the co-occurring disorder takes some skill and effort to elicit.

Attempts to develop a third treatment stream are potentially stigmatising for clients treated in that system and may lead to definitional disputes and 'turf wars' between clinicians over where a particular client should receive service. Even if there were the funds and political will develop an additional treatment stream how would existing drug treatment and mental health clinicians and agencies occupy their time once they had lost 30 to 70% of their existing clients? There is utility in having a specialist co-occurring disorders workforce but, as with Victoria's approach, their tasks need to be more around capacity building and modelling of detection and effective treatment of co-occurring disorders.

Let's go...

Increasing a system's capacity to provide effective treatment of co-occurring disorders is possible. It requires the strategically-planned, collaborative and robust implementation of top-down and bottom-up strategies towards well-defined, locally-grounded goals (Croton, 2004a)

Deconstructing the above change recipe…

Increasing a system's capacity…

A capacity building approach is the approach most likely to yield *sustained* system change. Strategic flaws in deploying a specialist co-occurring disorders *treatment* workforce, agency or system have been described above.

….to provide effective treatment of co-occurring disorders ….

Effective treatment of co-occurring disorders entails the development of improved screening, assessment and integrated treatment. Indicators of effective treatment of co-occurring disorders are suggested for each treatment sector in Section 6 of this submission.

…strategically-planned, collaborative and robust implementation of ……strategies

- A collaborative, inclusive, cross-systems strategic planning process is necessary to engage all stakeholders and develop consensus at the outset of a systemic change process. Drake et al (2004) state that for integrated dual disorder treatment programs to be implemented successfully all stakeholders must be involved in planning implementing and sustaining the program. Minkoff and Cline (2004b) have developed a stepped approach to the implementation phase of system's adopting their CCISC model that may guide planners facilitating such a strategic planning process.

- A core component of the CCISC model is assigning treatment sector responsibility for different cohorts of persons with co-occurring disorders using the four-quadrant model planning tool (Minkoff and Cline 2004b). Usually
  - Primary Care will be assigned treatment responsibility for Quadrant One
  - Drug Treatment services responsibility for Quadrant Three and
  - Mental Health services responsibility for Quadrants Two and Four

I	III
Less severe mental disorder / Less severe substance use disorder	**Less severe mental disorder / More severe substance use disorder**
II	**IV**
More severe mental disorder / Less severe substance use disorder	**More severe mental disorder / More severe substance use disorder**

- The more that change goals are clearly-stated and explicitly defined at the outset of a change process (along with preferred strategies to achieve those goals) the more likely that the change process will be successful. Clearly defined, detailed goals contribute substantially to effective, cohesive, goal-directed work from the workers assigned the task of implementing the changes; they prevent confusion, 'reinventing the wheel', and multiple varying interpretations of the goals of the initiative and the best strategies to achieve those goals.

- Goals should be derived from a careful evaluation of the best available evidence around improved treatment responses. Strategies to achieve those goals should be developed using a careful assessment of the current treatment situation and an explicit vision of a more effective treatment system.

- Achieving enduring change requires the implementation of a comprehensive array of strategies. Change is more likely to occur when there is *robust* implementation of the strategies chosen.

- Achieving enduring change requires a strategy to meaningfully engage all stakeholders in the change process. In Arizona Regional stakeholder groups charged with implementing integrated treatment of co-occurring disorders mirrored the state's central Arizona Integrated Treatment Consensus Panel (AITCP, 1999)

- Perhaps the most useful tool that can be employed to guide a change process is a Stage of Change analysis of systemic, agency and clinician willingness to address the response to co-occurring disorders. Strategy selection and implementation needs to be informed by recognition that many parts of the system will be ambivalent about change around co-occurring disorders.

… top-down …

- Vision statements: Mental Health and Drug Treatment Central planning bodies should articulate a vision for how their systems will function when they are providing more effective treatment of co-occurring disorders. Such a vision provides a clear goal for agencies and clinicians within that system to strive towards and should include indicators of more effective treatment of co-occurring disorders, perhaps similar to the goals outlined earlier in Section 6. Vision statements may outline various treatment pathways for different cohorts of persons with co-occurring disorders.

- Policy: Policy is one of the most potent levers that central planners have to move a system towards more effective treatment. Policy represents both an incentive and a mandate to agencies and clinicians within a system and should stipulate responsibilities around and preferred responses to co-occurring disorders. Policy may be used to mandate routine screening for co-occurring disorders or to make it clear, as in the UK, that persons with co-occurring disorders are core business for mental health services.

- Expected clinician/worker competencies: Central planning and policy bodies should make clear statements cataloguing necessary clinician competencies required in order to deliver the treatment response defined in the vision and policy statements.

- Education and training strategies, providers and curricula: Central planning and policy bodies should articulate a training strategy for existing workers, integrated centrally into the system's overall workforce development strategy. This strategy should nominate preferred, preferably accredited training providers and define minimum training curricula for the existing workforce. Incentives to participate in training need to be devised (for instance, policy that sets competence in treating co-occurring disorders as necessary criteria for promotion, accredited training).

- It is essential that training addresses clinician attitudes as well as knowledge and skills. Ideally the training strategy will encompass strategies to facilitate co-occurring disorders oriented Clinical Supervision to reinforce to 'work-in' learnings from training initiatives

  A high priority should be placed on devising a training strategy specifically targeting the needs of state-employed psychiatrists. As psychiatrists have oversight of and responsibility for all mental health clinical delivery their support, efforts and enthusiasm are crucial to achieving more integrated treatment from mental health services.

  Investing in the future workforce, central planning and policy bodies should take steps to influence the drug treatment and co-occurring disorders content in a range of health-related undergraduate courses.

- Practical clinician-focused manuals – Complementing policy directives and training approaches a high priority should be placed on funding the development and dissemination of practical, how-to-do-it screening and treatment manuals attuned to the specific needs of each of the drug treatment and mental health workforces

- Other tools – Central Planning and Policy bodies may also consider funding the development of or adopting existing tools that allow agencies or clinicians to self-evaluate and benchmark their competencies in relation to co-occurring disorders (Minkoff and Cline, 2005)

- Outcome measures – Central planning bodies may consider the introduction of incremental, success-oriented outcome measures (Minkoff and Cline, 2004) such as a client's stage of change in regard to each of their disorders

…and bottom-up strategies towards well-defined, locally-grounded goals.

- Time-limited, task-focused, Regional Implementation Groups charged with specific tasks around implementing more effective integrated treatment locally, are a potent device towards
  - grounding central policy directions in local circumstances
  - generating local ownership of a move to more integrated treatment (achieving 'buy-in' from all stakeholders)
  - building links and meaningful partnership between local mental health and drug treatment agencies, management and workers

  Membership of Regional Implementation Groups should include mental health and drug treatment local management, consumers, carers, clinicians (preferably the influential 'opinion-makers' from each agency), specialist co-occurring disorders workers/ portfolio holders

  Tasks for Regional Implementation Groups …

- generating a *Regional profile of issues around co-occurring disorders* including local prevalence estimates, service mapping, other local issues and perceptions of clients who 'fall through the gaps'.
- generating a *Regional integrated treatment implementation plan* including strategies to address specific local barriers to integrated treatment, statements identifying which co-occurring disorders cohorts will be addressed by which agency, treatment pathways for each cohort, local education and training strategy, interagency protocols, plan review mechanisms.
- developing a mechanism for routine cross-program integrated treatment planning for complex clients

- Specialist, co-occurring disorders field workers, attuned to local circumstances and needs, can be a potent force in building local capacity around co-occurring disorders. Specialist workers' effectiveness is dependent upon the enthusiasm and support of local management – central policy directions are the most effective means of ensuring that middle management prioritise addressing improved service delivery to persons with co-occurring disorders. Tasks that may usefully be assigned to specialist workers include
  - Delivery of education and training,
  - Clinical Supervision,
  - Primary and secondary consultation (with an orientation towards developing the referring worker's response to co-occurring disorders)
  - Tertiary consultation
  - Protocol development activities
  - Working co-occurring disorder competencies into all job descriptions and agency descriptions

- Agency co-occurring disorders champions: each agency within a system should nominate a co-occurring disorders portfolio holder or 'champion'. The portfolio holder should be senior enough to and with the personal abilities to meaningfully influence local service delivery. The portfolio holder can be 'hot-housed' around co-occurring disorders by central training and/or regional specialist workers. Portfolio holder should serve as a point of expertise to other workers in the agency as well as evaluating and developing the agency's response to persons with co-occurring disorders.

9. Recommendations

Recommendations

1. That the CCISC model be implemented in an Australian state.

2. That future A&OD and Mental Health National plans reframe as one of their highest priorities the improvement of treatment and services for persons with co-occurring disorders.

3. That future A&OD and Mental Health National plans cover similar time frames and arise from a collaborative, strategic planning process that adequately recognises the prevalence of and harms associated with co-occurring disorders, societal demand for improved treatment outcome for persons with co-occurring disorders and the potential to improve the system's response to co-occurring disorders.

4. That future A&OD and Mental Health National plans make clear statements to the workers within each system about their responsibilities around and desired responses to co-occurring disorders.

5. That an Australian body, (similar to the USA's Co-occurring Disorders Centre of Excellence), is established charged with identifying and disseminating evidence-based practices, for all of the cohorts of persons with co-occurring disorders, to clinicians, agencies and systems that provide services to persons with co-occurring disorders

6. That practical, user-friendly, clinician-focused manuals (describing integrated screening, assessment and treatment approaches) are developed for each of the mental health and A&OD workforces.

7. That tools for Mental Health and A&OD agencies or clinicians to self-assess their competencies in relation to co-occurring disorders are either developed or purchased and widely disseminated.

8. That funding is made available to extend the reach of the National Alcohol and Mental Health Comorbidity Managing the Mix Project.

9. That research into more clearly identifying barriers to improving systems response to co-occurring disorders in Australia is funded. That such research proposes action strategies to address those barriers

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