



## **Victorian Travelling Fellowship**

### **Co-occurring mental health and substance use disorders:**

**An investigation of service system  
modifications and initiatives  
designed to provide an integrated  
treatment response**

**Gary Croton**



# Contents

<b>1. Project Information</b>	<b>3</b>
<b>2. Project Summary</b>	<b>6</b>
- Top three outcomes	7
- Main activities undertaken	7
- Major learnings	8
- Lessons for the Victorian healthcare system	9
- The Victorian Dual Diagnosis Initiative: An appraisal	10
- Indicators of effective treatment of co-occurring disorders in Victoria	12
- Mental Health Services	12
- Drug treatment services	13
- Recommendations	15
<b>3. Description of the study itinerary</b>	<b>29</b>
- Section 3.1: Background notes	30
- Section 3.2: United Kingdom visits	32
- Section 3.3: United States of America visits	47
- Section 3.4: New Zealand Visits	94
<b>4. Improving the Victorian healthcare system</b>	<b>102</b>
<b>5. Sharing and promoting the project</b>	<b>104</b>
<b>References</b>	<b>106</b>
<b>Appendices</b>	<b>110</b>



**Section 1.**  
**Project information**

**Fellow Name:** Gary Croton

**Title of project:** Co-occurring mental health and substance use disorders: an investigation of service system modifications and initiatives designed to provide an integrated treatment response.

**Fellowship study area:** Co-occurring mental health and substance use disorders

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**Terminology:**

This report uses the terms '*dual diagnosis*' and '*co-occurring disorders*' interchangeably to refer to co-occurring mental health and substance use disorders.

**Report Format:**

This report includes many web links. It is hoped that this may be a useful device linking the reader to further information on the work of key informants and agencies.



**Section 2.**  
**Project summary**

### **Top three outcomes**

- ❖ Formed ongoing links with overseas counterparts
- ❖ Compared Victorian and international initiatives addressing co-occurring disorders.
- ❖ Generated recommendations around further developing Victoria's approach to achieving more effective treatment for co-occurring disorders.

### **Main activities undertaken**

- ❖ Negotiated itinerary with a range of clinicians and researchers
- ❖ Researched and wrote background literature review
- ❖ Visits to sites in the United Kingdom, USA and New Zealand.
- ❖ Digitally-recorded interviews with key informants.
- ❖ Compiled the *Co-occurring Mental Health & Substance Use Disorders Resource CD*. Presented each informant with a copy of the CD.
- ❖ Compiled report and clarified details with key informants.
- ❖ Considered learnings from the fellowship and their application to the Victorian healthcare system and used this to inform the recommendations contained in this report.

### **Major learnings**

- Co-occurring disorders are the expectation not the exception for clients of mental health and drug treatment agencies.
- The prevalence of co-occurring disorders and the large attached personal, healthcare and societal costs suggests that more effectively addressing co-occurring disorders should be a high priority for all levels of the Victorian health care system.
- Integrated treatment of co-occurring disorders is an evidence-based best practice that, when robustly implemented, will result in better outcomes for persons with co-occurring disorders and an eventual reduction in the costs of services.
- Integrated treatment is achievable within existing Victorian mental health agencies, under their current structure, with minimal investment of additional resources.
- Integrated treatment of co-occurring disorders is not currently a realistic goal for Victorian drug treatment services; however drug treatment services have a critically important role in achieving better outcomes for persons with co-occurring disorders.
- An implication of the prevalence of co-occurring disorders in Victorian mental health and drug treatment agencies is that attempts to develop up a co-occurring disorders specific treatment system (specialist dual diagnosis inpatient and outpatient clinics) are philosophically and strategically misguided and likely to contribute to system complexity and barriers to treatment.
- Increasing a system's capacity to provide effective treatment of co-occurring disorders requires the strategically-planned, collaborative and robust implementation of top-down and bottom-up strategies towards well-defined, locally-grounded goals.

## **Lessons for the Victorian healthcare system**

The recommendations in this section arose directly from my experiences during the Fellowship and related study. The Fellowship gave me the chance to meet with and observe the work of persons with substantial experience in implementing integrated treatment. Several informants had well-developed knowledge of the improved outcomes and cost-savings that occur when integrated treatment is robustly implemented.

I have prefaced the recommendations with ...

1. A brief appraisal of the Victorian dual diagnosis initiative to date – provided to give context to the recommendations
2. Draft suggestions for indicators of more effective treatment of co-occurring disorders in Victoria

In drafting the recommendations I initially attempted to sort them by whether they involved central or regional planning bodies, drug treatment or mental health agencies or clinicians but found this unworkable. In their sum the recommendations constitute a system-wide approach to achieving better outcomes for persons with co-occurring disorders and involve actions by all stakeholders towards this end.

Notable omissions from the recommendations are recommendations around the form and content of direct clinical delivery. Persons with co-occurring disorders are not a homogenous group and I judged it too ambitious to attempt such recommendations in this current report. However the fellowship did expose me to a range of valuable clinical innovations and approaches and these are described in the sections describing the study itinerary.

## **The Victorian Dual Diagnosis Initiative: An appraisal**

The Victorian Dual Diagnosis Initiative has been operational since mid-2001. This initiative represents a substantial investment in and commitment to achieving better outcomes for persons with co-occurring disorders in a partnership of Victorian Drug Treatment Services and the Mental Health Branch. To date the Victorian initiative is the most comprehensive approach to addressing co-occurring disorders, on a state-wide basis, in Australia or New Zealand.

The stated aim of the Dual Diagnosis Initiative is to improve the responses of mental health and drug treatment services to people with mental illness and substance use problems. Drug Treatment Services have recently underlined their commitment to this aim by funding an evaluation of the initiative (March, 2004). In 2002 the Mental Health Branch also funded Mobile Support and Treatment Team Dual Diagnosis Workers, Youth Dual Diagnosis Workers and other specialist dual diagnosis workers positions.

Since the beginning of the initiative a great deal has been accomplished - the specialist workforce has contributed to the system's collective knowledge and skill around effective treatment of co-occurring disorders and Victorian barriers to effective treatment have been more clearly identified. However there is still much to be discovered about co-occurring disorders and about the nature of an effective treatment response in Victoria. There is much that needs to be done before we may be confident that we are offering system-wide, effective treatment.

By design the initiative funded four discrete metropolitan teams and linked independent rural specialist workers. Each team has developed differently with a different emphasis on the mix of clinical, training and consultation tasks assigned to them. The current evaluation should provide some indication of the relative effectiveness of these approaches. A criticism of the initiative is that the structure has lent itself to a 'silo mentality' amongst the lead agencies with limited opportunities to learn from the collective experience or to function as a 'driver' in developing a Victorian model for more effective treatment of co-occurring disorders.

In the writer's assessment three areas have emerged that need to be prioritised in order for the service system to increase its capacity to provide effective treatment of co-occurring disorders.

1. **Policy** – to date the Victorian initiative has predominantly employed a 'bottom-up' approach. Co-occurring disorders specialists have provided training and consultation to mental health and drug treatment clinicians and services but without incentives, such as 'top-down' policy mandates, for clinicians and agencies to change existing practice.
2. **Goals and indicators** - The initiative has now developed to a stage where there is a need for evidence-based, clearly-defined goals and indicators

for the specialist workforce to work towards -see *Indicators of effective treatment of co-occurring disorders in Victoria* below.

3. **‘Buy-in’** – Currently some key stakeholders, whose understanding, support and enthusiasm is crucial to changing practice, may perceive that the issues around co-occurring disorders are too complex to address successfully. They fail to appreciate the significant potential cost and worker savings in providing effective treatment for co-occurring disorders. There is a need for the implementation of strategies designed to promote ‘buy-in’ by these key stakeholders.

## **Indicators of effective treatment of co-occurring disorders in Victoria**

The following draft indicators are an attempt to provide some of the answer to the question of how the Victorian treatment system might look if it were offering more effective treatment of co-occurring disorders. The indicators are based on goals adopted and strategies employed by service systems that I visited and associated reading. They are not offered as a definitive list of indicators of effective treatment of co-occurring disorders in the Victorian system but as a contribution to the debate around goals for the system.

### **Mental Health Services**

- All persons assessed by mental health agencies are screened for a substance use disorder using a validated tool.
- Where there is an indication of problematic substance use clients receive a detailed substance use assessment. Such assessments incorporate the client's stage of change in regard to their substance use.
- Where a person's mental health symptoms qualify them for service from a mental health agency their co-occurring substance use disorder is routinely treated in-house (using recognised, evidence-based practices) by the same clinician who is providing treatment for their mental health symptoms.
- 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 co-occurring substance use disorders as well as mental health disorders.
- In-patient unit's operating policies recognise the potential for clients to experience withdrawal (from mild to severe) on admission. 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 the group of persons 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 a high prevalence of 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 such as RAPID are modified to reflect and 'reward' such clinician activity.
- All service descriptions and operating philosophies reflect the service's recognition of the prevalence and impact of comorbidity and specify the service's approach to detecting, assessing and providing treatment for a client's co-occurring disorders
- 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 an understanding of the prevalence and impact of multiple disorders.

### **Drug treatment services**

- 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 such as ADIS are modified to reflect and 'reward' such clinician activity.
- All service descriptions and operating philosophies reflect the service's recognition of the prevalence and impact of comorbidity 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 and PDRS agencies.
- All staff have an understanding of the prevalence and impact of multiple disorders.

<b>Recommendations</b>
<b><u>1. Policy</u></b>

***Preamble***

Changing a service delivery system requires policies that provide incentives for adopting innovative changes (ATTC, 2000). That the system is moving to offering more effective, integrated treatment of co-occurring disorders needs to be re-enforced, through a variety of mediums, at all levels of the system. A key objective should be that, once established, a change to providing integrated treatment for co-occurring disorders is an enduring change.

***Recommendations***

**1a) System-wide policy**

That Victorian Drug Treatment Services and the Mental Health Branch draft and disseminate collaborative, co-occurring disorders, systemic guidelines that ...

- Defines co-occurring disorders
- Outlines a Victorian vision for an integrated treatment response.
- Describes the various cohorts of clients with co-occurring disorders
- Suggests which of these cohorts the various agencies have responsibilities for (the four-quadrant severity matrix below may be a useful tool for this purpose)
- Outlines expectations of each workforce in regard to detection, assessment and treatment of the various cohorts
- Describes the role of the Victorian specialist co-occurring disorders workforce in developing integrated treatment
- Describes minimum expectations of both workforces in regards to inter-agency referral, collaboration and consultation.
- Outlines minimum expectations for the development and content of local protocols between drug treatment and mental health agencies

<b>I</b>  <b>Less severe mental disorder /</b> <b>Less severe substance use disorder</b>	<b>III</b>  <b>Less severe mental disorder /</b> <b>More severe substance use disorder</b>
<b>II</b>  <b>More severe mental disorder /</b> <b>Less severe substance use disorder</b>	<b>IV</b>  <b>More severe mental disorder /</b> <b>More severe substance use disorder</b>

**Diagram 1 - four-quadrant severity matrix (SAMHSA, 2003).**

## Recommendation 1 - Policy.

### 1b) Mental Health System policy

That the Chief Psychiatrist, Mental Health Branch release a *Co-occurring Disorders Clinical Practice Guideline* that

- Outlines guidelines and standards for mental health clinicians in regard to detection, assessment and treatment of co-occurring substance use disorders
- Makes it explicit that integrated treatment of co-occurring disorders is the goal of the Victorian mental health system, that is, the principle of...
  - *Where a person's mental health symptoms are sufficient for them to receive a service from a Victorian mental health agency then any co-occurring substance use disorder should also receive treatment by the same clinician who is providing treatment for their mental health disorder.*

### 1c) Drug Treatment System policy

That Drug Treatment Services release workforce guidelines that define an appropriate scope of practice for drug treatment clinicians in regard to persons with co-occurring disorders.

This document should include ...

- Guidelines around appropriate practices and tools for screening for co-occurring mental health disorders
- Guidelines for a range of appropriate responses where symptoms of or an actual mental health disorder is detected
- Guidelines describing worker's responsibilities around assessing suicidality and interventions when suicidality is detected

## Recommendations

### 2. Achieving buy-in from key stakeholders

#### *Preamble*

There are a number of key stakeholders whose knowledge, support and enthusiasm, or 'buy-in', is crucial to the success of an attempt to introduce a system-wide change such as the introduction of integrated treatment for co-occurring disorders.

These stakeholders include...

- Psychiatrists employed in the public sector
- Local mental health and drug treatment administrators
- Opinion leaders in each of the agencies actually delivering the services (not necessarily management).
- Clinicians who will be delivering the services

The more that these stakeholders can be meaningfully engaged in the planning and implementation of a change, the less likely is it that resistance to the changes will be encountered and the more likely is the initiative to succeed.

Psychiatrists have oversight and responsibility for all clinical service delivery in Victorian mental health services and therefore constitute the single most important stakeholder group needing to be engaged in implementing integrated treatment. Without the explicit support of psychiatrists employed in the public sector integrated treatment of co-occurring disorders will not happen. As with other key stakeholders psychiatrists knowledge about and willingness to provide integrated treatment for co-occurring disorders varies from Precontemplation to long-standing Action and innovation. The existing Victorian dual diagnosis initiative has limited ability to address the training needs of psychiatrists.

Recommendation 2a describes a method for maximising stakeholder participation, ownership and knowledge whilst tailoring the implementation of integrated treatment to specific local conditions. It is based on processes followed in the United Kingdom and Arizona.

#### *Recommendations*

##### **2a) Regional Integrated Treatment Implementation Planning Groups**

That the Department of Human Services establish time-limited Regional Integrated Treatment Implementation Planning Groups (RITIPG) in each mental health area.

RITIPGs membership should include persons with substantial ability to shape local service delivery including management from local drug treatment, mental health and PDRSS agencies, consumer and carer representation, local

## **Recommendation 2 - Achieving buy-in from key stakeholders**

specialist dual diagnosis workers, clinical 'dual diagnosis champions' and regional DHS.

Whilst RITIPGs bear some resemblance to the current Victorian Dual Diagnosis Initiative's *Local Advisory Groups* a key difference is that RITIPGs have more defined, goal-focused tasks to do with engaging local stakeholders in collaborative, strategic outcome-oriented actions to maximise the local treatment response to persons with co-occurring disorders.

### **2a -i) Regional profile of issues around co-occurring disorders.**

Each ITIPG is to be initially responsible for generating a regional profile of issues around co-occurring disorders.

This should include

- Local prevalence estimates by co-occurring disorders cohort, or plans to generate such estimates
- Local service mapping
- Local perceptions of client groups that fall through the gaps (fail to receive a service or receive an inadequate or ineffective service)
  
- Description of local barriers to the implementation of integrated treatment
- Other local issues relevant to outcomes for persons with co-occurring disorders such as rurality, local substance use patterns, housing needs
- Local training needs

Note: An ***Agency Co-occurring Disorders Competency Assessment*** tool, developed for Victorian conditions, would have the potential to inform the regional profile.

### **2a – ii) Regional profile dissemination**

Once completed the regional profile of issues around co-occurring disorders should be disseminated to all local stakeholders for further input and comment

### **2a – iii) Regional integrated treatment implementation plan**

On the basis of the regional profile and associated feedback each RITIPG is to be responsible for generating a regional integrated treatment implementation plan

Plans should include ...

- Evidence of consultation and collaboration in the preparation of the plan
- Strategies to address specific local barriers to integrated treatment
- Statements identifying which co-occurring disorders cohorts will be addressed by which agency
- Care pathways for each cohort
- Education and training strategy

## **Recommendation 2 - Achieving 'buy-in' from key stakeholders**

- Interagency protocols
- Mechanisms to review the effectiveness of the strategies and formulate further strategies.

### **2b) Psychiatrist buy-in**

That the mental health branch considers strategies to further engage psychiatrists employed in the public sector in providing integrated treatment of co-occurring disorders. One possible response may be to offer a series of psychiatrist-focused symposiums, with substantial incentives for participation.

### **2c) Co-occurring disorders champions**

That it become routine practice that each mental health, PDRS and drug treatment agency has a 'co-occurring disorders champion' amongst the staff. The criteria for champion selection should include their ability to influence the service delivery and policies of the agency. Ideally the champion will have some expertise in the treatment offered by the opposite agency. Champions should liaise with local specialist co-occurring disorders workers and may receive support and training from specialist workers.

## Recommendations

### 3. Education and training

#### *Preamble*

There is a need for a planned and comprehensive approach to training that systematically addresses the diversity of training needs of different groups whose knowledge and attitudes influence outcomes for persons with co-occurring disorders.

A strength of the current approach of local specialist workers developing training packages in response to identified local needs is that it 'starts where participants are' in regard to improving treatment response to persons with co-occurring disorders. This approach has primarily targeted the drug treatment and mental health workforces.

There is a need for...

- A mechanism to pool and review training packages to ensure that they are evidence-based and contain a defined minimum content
- Training packages for non-drug treatment /mental health agencies which provide services to persons with co-occurring disorders
- Training packages for carer and client groups
- Strategies to engage tertiary education institutions in providing more substantial components on substance use disorders and co-occurring disorders in a wide variety of undergraduate courses.

Training that only provides how-to-do-it, action strategies for providing more integrated treatment is likely to be ineffective. Such training fails to recognise that many participants will be precontemplative about the need to change existing practices.

Persons with co-occurring disorders have two stigmatised, often-relapsing disorders and such individuals may be further stigmatised by behaviours consequent on their multiple disorders. Training around co-occurring disorders that fails to identify and work with participant's attitudes to persons with co-occurring disorders is likely to be less effective than training that addresses participant's attitude as well as their knowledge and skill development.

#### *Recommendations*

##### **3a) Tertiary education providers: drug treatment and co-occurring disorders content**

That Drug Treatment Services and the Mental Health Branch liaise with the tertiary training sector to promote a larger component of education around substance treatment and co-occurring disorders in a wide range of undergraduate courses (Social Work; Medicine; Occupational Therapy; Nursing). One strategy could be to offer an award or bursary, for the institution or course that most substantially addresses this need.

## Recommendation 3 - Education and training

### **3b) Training delivered by the specialist workforce: minimum curricula**

That the dual diagnosis specialist workforce collaboratively defines a minimum set of curriculum elements for training offered by them to the drug treatment and mental health workforces. This recommendation sits alongside the recognition that delivery of this minimum set and further curriculum development will be modified in response to local circumstances and needs analysis. Minimum curricula should be informed by workforce co-occurring disorders guidelines (see recommendations 1a, 1b, 1c)

One means of refining the content of training could be by developing a central repository, such as a website accessible only to members of the specialist workforce, where training modules are posted, reviewed and developed.

### **3c) Addressing workforce attitudes towards persons with co-occurring disorders**

That the dual diagnosis specialist workforce, in delivering training packages to the drug treatment and mental health workforces, incorporate activities that identify and work with participant's attitudes to persons with co-occurring disorders.

### **3d) Stage of change analysis**

That the dual diagnosis specialist workforce, in delivering training packages to the drug treatment and mental health workforces, utilise a stage-of-change analysis around participant's readiness to provide or facilitate treatment of co-occurring disorders.

### **3e) Mobile Support and Treatment Team's dual diagnosis worker's training needs**

That a state-wide Mobile Support and Treatment team dual diagnosis worker training initiative be rolled out with substantial collective input from the specialist co-occurring disorders workforce.

### **3f) Mobile Support and Treatment Team's dual diagnosis worker's support needs**

That further development of guidelines on the relationship between the specialist teams and the Mobile Support and Treatment Team's dual diagnosis workers occur.

### **3d) Multimedia training resources**

That consideration is given to funding the development of multimedia training resources around co-occurring disorders. Such resources may support and supplement the training activities of the specialist workforce.

<b>Recommendations</b>
<b><u>4. Research</u></b>

***Preamble***

To date the literature around co-occurring disorders to date has been largely dominated by North American contributions describing their research and clinical initiatives. While those advances have the potential to inform Australian clinical activity, service planning and research they do not necessarily translate without modification to local conditions and there is a substantial need for research around the spectrum of co-occurring disorders in Australia. A range of research priorities around co-occurring disorders in the Australian context are identified in the Commonwealth Department of Health and Ageing, (2003) [Current practice in the management of clients with comorbid mental health and substance use disorders in tertiary care settings.](#)

***Recommendations***

**4a) Central Register**

That a central register of all completed and in process Australian research around co-occurring disorders be initiated. This register should be web-based in order to offer maximum accessibility to stakeholders

**4b) Prioritising research**

That gaps in our knowledge around co-occurring disorders and effective treatment responses in an Australian context are identified and prioritised.

**4c) Disseminating research outcomes**

That mechanisms be developed to rapidly disseminate research outcomes to Victorian drug treatment and mental health clinicians

**4d) Research opportunities**

That all planning of initiatives to address co-occurring disorders in Victoria prioritises any research opportunities afforded by the initiative.

## Recommendations

### **5. Victorian specialist co-occurring disorders workforce**

#### ***Preamble***

The Victorian specialist co-occurring disorders workforce represents a significant resource with the potential to further develop and refine goals and strategies and resources for the Victorian treatment system around co-occurring disorders. Mechanisms need to be developed to systematically harvest the collective experience of the specialist workforce and more strategically use the workforce in driving a change to treatment of co-occurring disorders.

In pockets there has been a high turnover of members of the Victorian co-occurring disorders specialist workforce – this reflects international experiences and, as this has not been a universal Victorian experience, lends itself to an analysis of those factors that sustain a specialist workforce. A workforce development aspect of staff turnover is that those workers with specialist workforce experience often move to other parts of the system.

High workforce turnover may be related to ...

- Critical mass of the co-occurring disorders specialist team
- The demands and expectations upon specialist workers
- Access to and availability of high quality clinical and project supervision
- Lack of definition of the roles of a specialist worker
- Isolated instances of inadequate managerial understanding of issues around co-occurring disorders and a consequent lack of commitment to supporting and resourcing the specialist workforce.
- The majority of rural workers being solo workers - the United Kingdom's [Dual Diagnosis Good Practice Guide](#) (DOH, 2002) states that '*isolated dual diagnosis specialists will become burned out or disconnected from wider knowledge and developments*'.

#### ***Recommendations***

##### **5a) Mechanisms for communication and collaboration**

That mechanisms be developed to facilitate greater communication and collaboration between specialist workforce teams and clinicians. At a minimum these should include bi-annual meetings of the workforce to communicate about their experiences and approaches, identify barriers to effective treatment and strategies to address those barriers. Another approach may be to encourage specialist workforce clinician placements with other specialist workforce teams. A central website with contributions from all teams may also contribute to collaboration and communication

## **Recommendation 5 - Specialist co-occurring disorders workforce**

### **5b) Support for the specialist workforce**

That the Victorian co-occurring disorders specialist workforce be supported by

- Routine quality clinical and project supervision
- Regular training opportunities targeting the specific needs of the specialist workforce
- A permanent worker whose role is to inform the further development of curriculum for use by all specialist teams and to facilitate the provision of training to specialist dual diagnosis teams across Victoria.

### **5c) Clinical resources development**

That the Victorian co-occurring disorders specialist workforce is charged with developing resources to assist clinicians in treating persons with co-occurring disorders. One example could be found in the development of co-occurring disorders treatment or support guidelines targeting each of the mental health, drug treatment and Psychiatric Disability Rehabilitation and Support Services sectors.

## Recommendations

### 6. Other recommendations

#### *Preamble*

A range of tools have been developed to assist agencies in increasing their capacity to provide routine integrated treatment of co-occurring disorders. Most of these tools have been developed in North America and may not be suitable for local use without modification. Among other tools, Dr Ken Minkoff has developed the '*Compass*' – a tool for an agency to self-assess its competencies in relation to co-occurring disorders (see page 54). New Hampshire's Mueser, Noordsy, Drake and Fox (2003) have developed a '*Dual Disorder Treatment Fidelity Scale*' to measure a service's fidelity to their integrated treatment model (see page 62).

There is a need for a website which can...

- Act as a central access point for clinicians and other stakeholders seeking a wide range of information and resources related to co-occurring disorders
- Profile and link the activities of the Victorian dual diagnosis initiative
- Serve to reduce the isolation of rural specialist workers

A new Victorian co-occurring disorders conference would contribute to the collective Victorian knowledge of effective treatment responses and underline Victoria's commitment to achieving better outcomes for persons with co-occurring disorders.

Many of the key informants that I met with during the study reflected positively on the input and focus provided by external consultants. There are consultants available with substantial expertise in working with whole systems to improve the treatment response to persons with co-occurring disorders (see visits 8, 9, 10, 11, 12, 16, 17, 18, 19).

If central planning bodies were to gather a range of data around the financial and social costs and cross-sector service demands by persons with co-occurring disorders this would promote a wider recognition of the prevalence and impact of co-occurring disorders and provide a powerful argument for modifying the service system to more effectively address the needs of persons with co-occurring disorders.

Such data, gathered at defined intervals, may also provide feedback about the effectiveness of strategies addressing the treatment system's response to co-occurring disorders.

The term 'dual diagnosis' has been criticised by a number of authors (Maslin, 2003; Weaver, Renton, Stimson, Tyrer, 1999; Drake and Wallach, 2000) for its lack of precision and because this client population often has a multiplicity rather than a dyad of disorders (Todd, Sellman, Robertson, 1998).

## Recommendation 5 - Other recommendations

### *Recommendations*

#### **6a) Tools**

That planners consider strategies to promote the development of a *Victorian Agency Co-occurring Disorders Competency Assessment Tool*

#### **6b) Website**

That the Victorian Mental Health Branch and Drug Treatment Services consider strategies to promote the development of a Victorian co-occurring disorders website.

#### **6c) Data collection**

That ADIS and RAPID data collection systems be modified to promote the recognition and recording of multiple diagnoses and to 'reward' clinician activity around improved interagency referral and collaboration.

#### **6d) Conference**

That central planning bodies consider strategies for funding a new conference around co-occurring disorders. That such a conference invites keynote speakers with expertise around system change towards better outcomes for persons with co-occurring disorders. That such a conference has a strong focus on practical, evidence-based clinical responses to the spectrum of co-occurring disorders

#### **6e) External consultants**

That central planning bodies consider engaging an outside consultant to help facilitate system-wide change

#### **6f) Monitoring costs of co-occurring disorders across multiple systems**

That central planning bodies develop a strategy to gather a range of data, at defined intervals, around the financial and social costs and cross-sector service demands by persons with co-occurring disorders. Such data may provide feedback about the effectiveness of strategies addressing the treatment system's response to co-occurring disorders.

#### **6g) Terminology**

That attempts be made to select and promote a more accurate, less ambiguous term than 'dual diagnosis' to describe co-occurring mental health and substance use disorders

**Australia**  
**Further Reading & Resources**

ANCD (2003) [Reports on the 2003 Rural & Regional Comorbidity Workshops](#)  
Australian National Council on Drugs

Bradley, A., Toohey, B. (1999) [The Coffs Harbour project: a violence prevention program for substance misusing mentally ill.](#)  
<http://users.tpg.com.au/users/bradles/DualDisorderStudy.pdf>

Commonwealth Department of Health and Aged Care (2001) [National Comorbidity Project](#). Teeson, M., Burns, L. (Eds.) National Drug and Alcohol Research Centre.  
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**Section 3.**  
**Description of the study itinerary**

## Section 3.1:

### Background notes

There are a number of structural, social and economic differences between the United Kingdom, the United States, New Zealand and Australia relevant to an inquiry about integrated treatment of co-occurring disorders.

Some of these factors include:

Healthcare system structures: The healthcare systems of the United Kingdom, New Zealand and Australia are broadly similar enough to allow comparison. However the USA's managed healthcare system has particular strengths and barriers in regards to integrated treatment that, in parts, may be less relevant to the other three countries. Nonetheless the substantial body of epidemiological research, treatment research and system change technology that has originated in the USA has the potential to inform research and treatment initiatives involving integrated treatment of co-occurring disorders in Australia.

Nature of substance use: Most UK and USA informants cited the ready availability of crack cocaine as having had significant impact on the nature and complexity of presentations to both mental health and drug treatment services. While prevalence studies often fail to show use amongst sub-groups or to distinguish between crack and cocaine, it does appear that crack cocaine use is highly prevalent amongst socially marginalised groups such as the seriously mentally ill. Cocaine is more readily available in the USA than in the UK (EPSAD, 1999).

Focus of drug treatment: Whilst generalisations have risk my impression was that the USA appears to have a more concentrated focus on abstinence goals than do Australia, New Zealand or the United Kingdom. It appears that in the USA harm reduction approaches are more controversial and may be more likely to cause clinician's internal conflict around whether they are 'enabling' substance use.

Deinstitutionalisation: In tracing the history of co-occurring disorders a number of informants from the USA described the de-institutionalisation process as having led to a large, visible, often homeless, population of seriously, mentally ill persons formerly living in institutions who now had access to substances and for whom there were only limited community supports. Deinstitutionalisation was not identified as a key factor by any UK or NZ informants and appears to have been a less pivotal process in those countries.

Assertive Outreach Teams (AOT's): The AOT mental health team model is widespread in the UK and USA but there are few existing examples in Australia with good fidelity to the model. AOT teams are designed to provide intensive support to persons with severe mental illness who would otherwise be difficult to engage with services - many AOT clients will have multiple diagnoses.

Assertive outreach teams should have the following characteristics:

- A team approach rather than case management
- Team caseload smaller than 12 service users for each staff member
- Planned long-term work with clients from a defined client group
- Majority of the work outside a service setting
- Evening and weekend availability / 24 hour access to an on-call system for AOT service users. ([University of Durham](#), n/d)

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## **Section 3.2.**

### **United Kingdom Visits** 26/10/03 to 6/11/03

<b>Visit No: 1</b>	<b>Key informant:</b> <a href="#">Liz Brewin</a> <a href="#">Institute of Psychiatry</a> <a href="#">King's College</a> University of London
<b>Date: 28/10/03</b>	

**Summary of informant's co-occurring disorders-related role/activities:**

**i) COMO Project:**

The Como Project developed after Menezes, Johnson, Thornicroft and Marshall's (1996) prevalence study examining substance use amongst persons with severe mental illness in South London. These researchers found one-year substance abuse prevalence rates amongst person with psychotic disorders of 36%. Clients with co-occurring substance abuse had spent twice as many days in hospital as clients without substance abuse.

In 1999, following the prevalence study, the Maudsley recruited Liz as a co-occurring disorders trainer and researcher for a random control trial evaluating training for mental health workers. Liz devised a 5-day training package which was delivered to Community Mental Health Teams in four London boroughs. The teams serving as a control group received no training.

The researcher's hypothesis was that there would be a change in the clients of those staff who had received training. Clients with co-occurring psychosis and substance use disorders were identified and case notes reviewed. Clients were assessed with a range of instruments pre and post-intervention. Mental health clinicians were rated around attitude, confidence, knowledge and stress and the experimental group were provided with follow-up supervision.

While no significant difference was found between the experimental and control groups of clients difference was found between the experimental and control staff groups. Results will be published in 2004.

**ii) Camden / Islington Project:**

In 2001 the Camden / Islington Health Trust were planning mental health worker co-occurring disorder training. They decided to evaluate different models of training - a 12-day model previously devised by Liz, with the 5-day model used in the COMO project. Liz delivered a large-scale training initiative (9 mental health teams) and provided clinical supervision for staff completing the 5-day course.

Participants were surveyed pre and post education. Data about patients at baseline was collected using case note review and post-intervention data is currently being collected.

**iii) Pan-London Dissemination Project:**

The pan-London Dissemination Project is a train the trainer initiative to disseminate the 5-day training package across London. 33 trainers,

<b>Visit No: 1 cont</b>	<b>Key informant:</b> <a href="#">Liz Brewin</a>
<b>Date: 28/10/03</b>	

nominated by their local trusts, have to date trained over 200 mental health staff. Evaluation is occurring using participant's evaluation forms

**iv) Other discussion themes:**

Much of Liz's work has been concerned with the effectiveness and impact of training initiatives and how best to measure that. Liz described some provisional discussions that have occurred around a National train the trainer's initiative. She described a group that has been established in her local South London Trust to examine how the Trust's services articulate around the needs of persons with co-occurring disorders. Liz described potential implications for persons with co-occurring disorders of the UK's imminent decriminalisation of cannabis.

I asked Liz about how she saw co-occurring disorders developing in the future. She responded that she hopes that we will reach a point where there is no longer a need to compartmentalise around diagnosis, where each clinician is clear on their roles and responsibilities and confident to meet each client as they come

**Activities undertaken during visit:**

I sat in on co-occurring disorders-focused group supervision session facilitated by Elizabeth with an East London Assertive Outreach Team, followed by discussions and an interview with Elizabeth at the Maudsley Hospital

**Key lessons learned:**

Liz's work impresses as a model articulation of co-occurring disorders research, training and evaluation initiatives. Her work highlights the difficulties that are likely to be encountered in attempting to measure the impact of training and supervision interventions.

**Suitability to own practice:**

This visit drew my attention to the need to more rigorously evaluate the impact of training that I provide as well as potential difficulties in attempting to do so. Visiting the Assertive Outreach Team revealed some of the challenges in practice encountered by an agency that is increasing its capacity to provide integrated treatment of co-occurring disorders. The visit demonstrated the practice and value of offering group clinical supervision to supplement training initiatives.

**Suitability to Victorian healthcare system:**

Highlighted the need to evaluate Victoria's range of approaches to training around co-occurring disorders for both the mental health and substance treatment workforces

<b>Visit No: 2</b>	<b>Organisation:</b> <a href="#"><u>Haringey Dual Diagnosis Service</u></a> <b>Haringey</b> <b>London</b> <b>United Kingdom</b>
<b>Date: 29/10/03</b>	

**Summary of organisation’s co-occurring disorders-related role/activities:**

Established in 1999 Haringey Dual Diagnosis Service is a specialist co-occurring disorders service operating from a shared-case management model with referrals from both mental health and drug treatment services. Haringey Dual Diagnosis Service was highlighted as an example of good practice in the [UK Dual Diagnosis Good Practice Guide](#) (DoH, 2002). The service has a multidisciplinary staff of 15-16. Its catchment of 270,000 persons includes areas with significant deprivation, crowding, substance use and racial tension.

Haringey Dual Diagnosis Service’s definition of dual diagnosis embraces all mental health diagnoses, including Personality Disorders, provided that the disorders are severe and enduring (greater than 6 months). The service’s aims include:

- Supporting workers to work with clients with co-occurring disorders
- Linking difficult-to-engage clients back into existing services
- Advocating at individual, policy and systems levels for clients with co-occurring disorders

Haringey Dual Diagnosis services include:

- Comprehensive assessment including re-evaluation of mental health symptoms in the light of addictive behaviour.
- Short term interventions focused around harm minimisation
- Longer term work addressing substance misuse issues.
- Provides an ethnic minorities specific outreach service
- Inpatient and outpatient carer support
- Training for both mental health and drug treatment workers. A recent training initiative with an inpatient unit was aimed at establishing the protocol that each client admitted will have an alcohol assessment.

Haringey Dual Diagnosis Service has had input into both the stand-alone [P.G. Dip /MSc Dual Diagnosis courses](#) and the Dual Diagnosis component of nurse training Courses offered by Middlesex university

**Interview with Kim Moore, Team Manager:**

Kim profiled the service, its genesis, aims, strategies and the demands upon it. She described the service’s particular focus on using engagement strategies to link clients with complex needs back into existing services and the team’s philosophy and approach including the importance of harm minimisation, clinician flexibility and a client-centred, respectful response. Kim described the impact of crack cocaine upon the seriously mentally ill population.

<b>Visit No: 2 cont</b>	<b>Organisation:</b> <a href="#"><u>Haringey Dual Diagnosis Service</u></a>
<b>Date: 29/10/03</b>	

Kim foresees streamlining the services currently offered by HDDS and would like to develop an integrated day program in partnership with substance misuse and mental health services.

**Activities undertaken during visit:**

In a whole-day visit I sat in on the weekly team intake and review meeting, sat in on a client's initial assessment, met with team members and recorded interviews with Kim Moore.

**Key lessons learned:**

This visit underscored the importance of engagement strategies and careful ongoing assessment of persons with multiple disorders and complex needs.

**Suitability to own practice:**

Instructive in range of issues around working with clients with particularly complex needs in a particularly deprived environment

**Suitability to Victorian healthcare system:**

This service developed in the context of a much higher mental health bed ratio than exists in the Victorian mental health system and a significant part of its work has been focused on the needs of a larger inpatient population.

Where agencies utilise a shared case management model clear role definition for the specialist worker is crucial.

<b>Visit No: 3</b>	<b>Key informant: <a href="#">Prashant Phillips</a> University College London</b>
<b>Date: 31/10/03</b>	

**Summary of informant’s co-occurring disorders-related role/activities:**

- Current Research Fellow University College, London
- Honorary Clinical Nurse Specialist - Drug Misuse - Camden & Islington Mental Health NHS Trust.
- Advisor to the [National Association for Mental Health \(MIND\)](#) for dual diagnosis
- Prashant has been involved in co-occurring disorders work since 1995 and is an experienced trainer around co-occurring disorders
- Current PhD thesis: *‘Understanding drug and alcohol use among the mentally ill - an investigation of the context and motivations for drug and alcohol use among an in-patient sample of individuals with psychotic illnesses’*.
- See Appendix 2 for a list of Prashant’s co-occurring disorders related papers and publications.

**Activities undertaken during visit:**

Recorded interview with Prashant

**Key lessons learned:**

Prashant traced the UK’s ‘co-occurring disorders history’, discussed possible systemic responses to co-occurring disorders and described his research activities.

**Systemic responses to co-occurring disorders:**

Initiatives targeting the mental health workforce’s capacity to provide integrated treatment are widespread in the United Kingdom and have usually been developed by the drug treatment arm of local health trusts. Most often these initiatives are based on a training, consultation and liaison model, similar to Victoria’s dual diagnosis initiative, with only limited direct service delivery. There are issues of a shortage of people with the qualifications for these roles and high turnover of workers. This may be related to a lack of clinical supervision or, in some instances, expectations that specialist workers will manage all of the clients identified as having co-occurring disorders.

Co-occurring disorders capacity building initiatives have been substantially strengthened by policy directives stipulating that addressing co-occurring substance use disorders is core business for mental health services (see Louis Appleby in the [UK Dual Diagnosis Good Practice Guide](#) - DoH, 2002). In Prashant’s assessment there is still some resistance from some mental health workers to providing integrated treatment for co-occurring substance use disorders however there has been considerable movement in this regard over the past 3 to 4 years. Mental health clinicians appear more alert to and knowledgeable about the impact of client’s substance use.

<b>Visit No: 3 cont</b>	<b>Key informant:</b> <a href="#">Prashant Phillips</a>
<b>Date: 31/10/03</b>	

Prashant discussed the systemic options of ...

- Developing existing mental health and substance treatment services so that they are more effective in addressing co-occurring disorders

or

- Developing dual diagnosis specific services or a dual diagnosis specific service system.

Prashant's assessment is that the first option is preferable as there are neither the funds nor the will to develop up a third treatment system and it is relatively easy to skill up mental health workers with drug treatment knowledge and skills. Prashant stated that the second option fails to adequately recognise the size of the population of persons with a mental disorder who have a co-occurring substance use disorder.

Prashant also noted that crack cocaine has had a significant impact over the last 7 years on the co-occurring disorders presentations to UK mental health services.

### **Prashant's co-occurring disorders research:**

#### **Epidemiology**

Rates of problematic substance use amongst persons who have mental health admissions may be higher than amongst those who only receive community services. Prashant's recent study of mental health inpatients substance use ( $n=264$ ) used staff ratings to determine substance use disorders and found that 49% of inpatients met criteria for substance abuse or dependence. In comparison London studies of persons treated in the community have found rates of substance use disorders among persons receiving mental health treatment of around 35%

Substance use during inpatient admissions may be higher than expected – the same study found that 87 % of clients had used during any admission, 81% had used during their current admission and 52% had used cannabis on the wards. 46% of the sample had bought drugs from another inpatient.

#### **Motivations for substance use**

Client's reasons for use and beliefs about their substance use are central to treatment planning. In Prashant's study, socialisation followed by hedonism was the main reasons identified by clients for their substance use. Self-medication appeared to account for only a small percentage of substance use.

#### **Substance use amongst older persons**

There are unanswered questions around substance use in older persons including prevalence, reasons for use, substances used, beliefs about substance use, health outcomes and substance use by carers.

<b>Visit No: 3 cont</b>	<b>Key informant:</b> <a href="#">Prashant Phillips</a>
<b>Date: 31/10/03</b>	

**Future directions**

Prashant would like to see more evidence about effective treatment responses for particular comorbidities and more service development to improve the response to the needs of persons with high-prevalence, low-impact type co-occurring disorders. In this regard Prashant identified the need for a more flexible response from some addiction treatment services.

Prashant feels that there may be a need for some specialist dual diagnosis services for clients with particularly complex needs but there is some risk that such units may become 'dumping grounds'. Prashant sees value in the development of a central repository that compiles together and sets curricula for co-occurring disorders in particular and substance treatment in general. He would like to see the development of minimum qualifications and standards for addiction workers.

**Suitability to own practice:**

This contact brought home to me that I need to develop strategies to promote and incorporate research into the activities of the Eastern Hume Dual Diagnosis Service (EHDDS). Another realisation was that I need to focus more on the distinction between 'use without impairment' and a 'substance use disorder' in the training offered by EHDDS.

**Suitability to Victorian healthcare system:**

This visit underlined the importance of top-down policies to complement and support the bottom-up activities of a specialist co-occurring disorders workforce.

Specifically the needs for

- Central guidelines around individual mental health worker's and agencies response to co-occurring substance use disorders.
- Consideration of the service system's response to persons with non-psychotic type co-occurring disorders
- Measure of the nature of and strategies to address substance use in inpatient units
- Research around problematic substance use in older persons

Visit No: 4	<b>Organisation:</b> <a href="#">COMPASS Dual Diagnosis Programme</a> <b>Birmingham</b> <b>United Kingdom</b>
Date: 03/11/03	

**Summary of organisation's co-occurring disorders-related role/activities:**

**Background**

In 1998 a Northern Birmingham Mental Health Trust prevalence study found that 24% of clients with severe mental illness had used alcohol and/or drugs problematically in the previous year (Graham, Maslin, Copello, Birchwood, Mueser, McGovern and Georgiou, 2001). Substances used most commonly were alcohol followed by cannabis. Key workers identified pleasure enhancement and coping as the most common reasons for use (Graham and Maslin, 2002).

**COMPASS**

Developing since 1998 COMPASS is a 'specialist multidisciplinary team that aims to train and support existing mental health and substance misuse services to provide treatment that covers both the mental health and substance use difficulties of service users' (Graham, 2002). COMPASS has a focus on the severely mentally ill type co-occurring disorder population and the Assertive Outreach Teams (AOT) because of the prevalence and complexity of persons with co-occurring disorders in that arm of the mental health system. Professor Kim Mueser from New Hampshire acted as an external consultant in the development of the COMPASS model.

The key principle underpinning COMPASS's integrated approach is that '*both mental health and substance use problems and the relationship between the two are addressed simultaneously by the mainstream mental health clinician*' (Graham, 2002). COMPASS states that their 'integrated shared care' model is in opposition to creating a third, specialist dual diagnosis, service.

The 6-member team comprises a service director, research psychologist, three senior community psychiatric nurses, a senior occupational therapist and sessional input from a consultant psychiatrist in addictions. Until recently COMPASS was headed by [Dr Hermine Graham](#) (see Appendix 2 for a list of Dr Graham's co-occurring disorders related publications).

The COMPASS team has developed a manualised cognitive-behavioural integrated treatment approach for co-occurring disorders (C-BIT) that serves as a basis for their training around co-occurring disorders. The comprehensive treatment manual describes cognitive-behavioural treatment approaches tailored to client's phase of treatment. Dr Graham has recently published a related text [Cognitive Behavioural Integrated Treatment \(C-BIT\): A Treatment Manual for Substance Use in persons with Severe Mental health Problems](#) (2003).

<b>Visit No: 4 cont</b>	<b>Organisation:</b> <a href="#"><u>COMPASS Dual Diagnosis Programme</u></a>
<b>Date: 03/11/03</b>	

**COMPASS services:**

The COMPASS programme offers three integrated-treatment orientated, services to substance misuse and mental health services:

**(1) Training & clinical work with Assertive Outreach Teams**

This training is around COMPASS's manualised cognitive-behavioural approach and is supplemented by team supervision/case discussion sessions. The intervention is being evaluated using a quasi-experimental research design in which 3 Birmingham AOT teams have received the C-BIT package while another 2 AOT teams served as a control group (see Research section below).

**(2) Consultation/Liaison: Brief Intervention**

COMPASS offers training in specialist assessment and brief motivational interviewing to key staff in other mental health and substance misuse teams within the trust with the aim of building client's motivation to address mental health and substance misuse problems. COMPASS will, on occasion, provide the specialist assessment and treatment brokering. A research-based evaluation is occurring.

**(3) Consultation/Liaison: Group Programme**

The COMPASS team conducts group-work with clients at both inpatient mental health and substance misuse units. The focus of the groups is on engagement, harm reduction, psychoeducation and the exploration of relationships between client's substance use and mental health.

**Research:**

A large scale evaluation of the effectiveness of an integrated, shared care approach to the treatment of co-existing severe mental health and substance use problems within the five AOT's was completed in August, 2003. AOT teams were evaluated each six months for 36 months with the purpose of establishing whether an integrated treatment approach is workable and effective within existing mainstream mental health services and, if so, whether it has a positive impact on service user outcome ( $n=58$ ). The results are currently being analysed (late-2003) and outcomes will be published.

COMPASS hosts bi-monthly visitor information sessions on service development issues for other health trusts seeking to develop similar services for clients with co-occurring disorders. The COMPASS programme was highlighted as an example of good practice in the [UK Dual Diagnosis Good Practice Guide](#) (DoH, 2002).

<b>Visit No: 4 cont</b>	<b>Organisation:</b> <a href="#"><u>COMPASS Dual Diagnosis Programme</u></a>
<b>Date: 03/11/03</b>	

**Activities undertaken during visit:**

On this visit I was able to sit in on a morning's training with members of an AOT team. This session focused on a component of COMPASS's cognitive-behavioural integrated treatment manualised approach. I spent the remainder of the day with the team's manager, Mike Preece and other team members including an outreach visit to a client in a newly-built, acute inpatient unit and an evening meal with the COMPASS team.

**Key lessons learned:**

This visit broadened my understanding of the staged application of cognitive-behavioural interventions for persons with severe mental illness.

Regarding the evaluation of substance misuse interventions in psychosis Copello et al. (2001), based on the experience at COMPASS, argue that one should evaluate changes in the mental health team involved rather than in client/s.

**Suitability to own practice:**

An outcome of this visit is that my own practice, and any training that I offer, will incorporate more stage-matched use of cognitive-behavioural approaches for persons with severe mental illness and substance use.

**Suitability to Victorian healthcare system:**

COMPASS's development was informed by the recognition that 'integrated treatment approaches developed in the USA cannot be wholly imported because of contextual factors that guide service provision in the two countries' (Graham et al, 2003) and this also holds true for Victoria.

COMPASS's approach of incorporating research into the effectiveness of their integrated-shared care approach will contribute to the evidence base around effective responses to co-occurring disorders and may serve as a model for Victorian initiatives addressing co-occurring disorders.

COMPASS's refinement of cognitive-behavioural approaches for persons with severe mental illness and substance use should inform the training offered by the Victorian specialist co-occurring disorders workforce.

<b>Visit No: 5</b>	<b>Key informant: Jood Gibbins</b> <a href="#"><u>Dorset Dual Diagnosis Service</u></a> <b>Bournemouth</b> <b>United Kingdom</b>
<b>Date: 06/11/03</b>	

**Summary of informant’s co-occurring disorders-related role/activities:**

Jood Gibbins has been the solo, specialist co-occurring disorders worker with the Dorset Dual Diagnosis Service since the service’s establishment in 1996. The service has a mixed metropolitan and rural catchment including the Bournemouth, Dorset and Poole regions.

Dorset Dual Diagnosis Service was one of the first co-occurring disorders initiatives established in the United Kingdom. As a pioneering service it has provided consultation to a number of similar services established since 1996. One result of this demand upon Dorset Dual Diagnosis Service was the establishment of the National Dual Diagnosis Network. The network offers members a regular, email-based magazine and membership is free by [contacting Moksha Darnton](#).

**Services:**

Dorset Dual Diagnosis Service offers education and training, clinical supervision and some direct service delivery.

**Education and Training**

Jood has trained in motivational interviewing with William Miller in the USA and much of the training that she offers has a focus on motivational interviewing. Until recently Jood offered a 4-day motivational interviewing skills course supplemented by 3-monthly update afternoons for course completers.

Jood’s 2004 training plan is to vary this format to a series of 1-day ‘tasters’ that focus on the spirit of motivational interviewing and encourage workers to re-evaluate their ideas about working with clients with substance use disorders. From the ‘taster’ sessions clinicians will be able to undertake a 2-day skills-focused module and an advanced coaching course for completers of the 2-day module.

Jood also coordinates and lectures for the co-occurring disorders component the University of Southampton’s addiction courses. Jood recently organised a 1-day co-occurring disorders training specifically for psychiatrists.

**Clinical**

Jood maintains a caseload of 5 clients with severe and enduring mental illness, referred from mental health and usually seen with their case coordinator. Services range from a one-off, intensive assessment with comprehensive report to longer-term work. Jood plans to streamline this service into a regular clinic.

<b>Visit No: 5 cont</b>	<b>Key informant: Jood Gibbins Dorset Dual Diagnosis Service</b>
<b>Date: 06/11/03</b>	

### **Other themes**

Jood described an early initiative of the service in which she was placed 2-days per week for 6 months with a Community Mental Health Team. At the conclusion of the placement an independent evaluation, using a focus group, found that the team members felt that they had lost their focus on co-occurring disorders once Jood left the team. The clinician's strongest message was that they need to have a permanent worker on the team whose role is to facilitate their working with client's substance use.

We discussed the high co-occurring disorders specialist worker turnover and the difficulties in finding staff qualified to work in this role. Jood feels that high quality supervision is a key element in retaining staff in this field. The [UK Dual Diagnosis Good Practice Guide](#) (DoH, 2002) recommended that planners '*provide supervision for all specialist staff whether they form part of a specialist team or not*'.

Jood described a Sainsbury Centre study of six specialist co-occurring disorders teams. The study found high staff and service attrition and concluded that such services should not have workers working in isolation.

### **Future directions**

Jood would like to see...

- The growth of early intervention services that recognise and incorporate evidence based responses to client's substance use
- At least one staff member in each mental health service with drug treatment expertise
- That mental health services have clear treatment pathways for clients with substance misuse
- An increase in the evidence base around the impact of motivational approaches to the substance use of clients with severe mental illness

### **Activities undertaken during visit:**

Interview with Jood Gibbins and a conversation with Moksha Darnton, the projects assistant and National Dual Diagnosis Network Coordinator

### **Key lessons learned:**

This visit highlighted

- The need to have a person with substance abuse expertise employed as a 'co-occurring disorder's driver' working on each mental health service.
- The need to engage psychiatrists in providing integrated treatment and the importance of a training initiative tailored to psychiatrist's specific needs.
- The importance of clinical supervision for members of specialist co-occurring disorders workforce
- The need for strategies to increase the drug treatment component and the co-occurring disorders component of a wide range of undergraduate courses.

<b>Visit No: 5 cont</b>	<b>Key informant: Jood Gibbins</b>
<b>Date: 06/11/03</b>	

**Suitability to own practice:**

There were a number of parallels between the Dorset specialist service and the specialist service that I am employed by. Jood's reflections on identifying which elements of a specialist service are effective and on dealing with the multiple demands upon a specialist worker were particularly valuable for me.

**Suitability to Victorian healthcare system:**

The Dorset Dual Diagnosis Service offers broadly similar services to those of the Victorian dual diagnosis initiative but has been running for around six years longer.

**United Kingdom**  
**Further Reading & Resources**

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<http://www.rcpsych.ac.uk/cru/complete/ddip.htm>

Social Care Institute for Excellence (2003) [Families that have alcohol and mental health problems: A template for partnership working](#).  
<http://195.195.162.67/sciesproducts/resourceguides/resourceguides.htm>

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## **Section 3.3**

### **USA Visits**

**7/11/03 to 29/11/03**

<b>Visit No: 6.</b>	<b>Key informant:</b> <u><a href="#">Dr Bert Pepper</a></u> <b>Psychiatrist</b> <b>New City</b> <b>New York State</b>
<b>Date: 10/11/03</b>	

**Summary of informants co-occurring disorders-related role/activities:**

Dr Pepper has had a long and very distinguished career in psychiatry. In private practice for 40 years, Dr. Pepper has faculty appointments to New York University College of Medicine and Harvard Medical School. He is a former Commissioner of Mental Hygiene for the State of Maryland and for the Rockland County, NY Community Mental Health Centre (see online [curriculum vitae](http://www.bertpepper.com/cv.html)). <http://www.bertpepper.com/cv.html>

Dr Pepper was an early pioneer in recognising co-occurring disorders. Over the past two decades he has made a substantial and significant contribution to flagging the issues around and achieving better outcomes for persons with co-occurring disorders. Dr Pepper was one of the first to propose many of the responses to co-occurring disorders that are now cornerstones of an evidence-based approach. His work stands out for its relevance, breadth of vision, wellsprings of scholarship and huge clinical experience, and its underpinning of considerable humanity and concern for others. Dr Pepper is an [accessible expert](#) widely recognised for his particular expertise around youth with co-occurring disorders. [http://www.drugstory.org/experts.html#mental\\_disorders](http://www.drugstory.org/experts.html#mental_disorders)

Dr Pepper was founder and executive director of *The Information Exchange*, a not for profit agency whose mission was to improve treatment for mentally ill and emotionally troubled persons, especially those who also have substance abuse/alcohol disorders. From 1995 to 1996 Dr Pepper was consultant to the United States, Federal, Substance Abuse and Mental Health Services Administration (SAMHSA) on co-occurring mental health and substance-related disorders.

Dr Pepper has published extensively around co-occurring disorders (see Appendix 2). Dr Pepper frequently [presents](#) on co-occurring disorders at major conferences.

**Activities undertaken during visit:**

Dr Pepper spent an afternoon with me including lunch, a tour of local mental health facilities, a forest walk and an interview at Dr Pepper’s offices.

**Key lessons learned:**

Dr Pepper outlined a history of the recognition of and response to co-occurring disorders. He discussed the current structural barriers to providing effective, integrated treatment in the USA. These barriers include funding mechanisms; separation of agencies; different professional jargons between mental health and substance abuse providers; stigma of both disorders

<b>Visit No: 6 cont</b>	<b>Key informant:</b> <a href="#">Dr Bert Pepper</a> <b>Psychiatrist</b>
<b>Date: 10/11/03</b>	

individually and collectively (perhaps compounded by the stigma of forensic involvement arising from inadequate treatment); systemic, agency and clinician level resistance to change

**On integrated treatment**

Dr Pepper has been a long-term advocate for integrated treatment (Ryglewicz and Pepper, 1996; Pepper, 1997) stating that integration is vital because the commonest cause of mental health relapse in persons with co-occurring disorders is substance abuse and the commonest cause of relapse to substance abuse is untreated mental health issues (Pepper, 2001). Dr Pepper has proposed a range of strategies to facilitate access to and evaluation of integrated treatment (Pepper, 1997)

**Youth with co-occurring disorders**

Dr Pepper has a focus on the confluence of trauma, emotional disorders and substance use. He notes that persons who have experienced trauma are much more likely to develop substance abuse (and more likely again if the trauma was repeated or perpetrated by someone close to the child) and to experience disruption of personality development, psychiatric problems, suicide attempts and forensic involvement.

He argues that by focusing on the abuse and neglect of children and adolescents, we can build a foundation for integrated treatment and find opportunities for the prevention of co-occurring disorders. Dr Pepper cites the National Co-Morbidity Survey which revealed that, of the ten million persons in the USA identified as having co-occurring disorders, 90% had developed the emotional disorder first, at a median age of 11 years and then gone on to develop substance abuse between the ages of 17 and 21 – suggesting an opportunity for comorbidity prevention if we can focus on troubled 11 to 13-year olds.

**Transinstitutionalisation**

Dr Pepper traced the impact of deinstitutionalization in the USA. In 1955 the nation had 559,000 public mental health hospital beds. By 2000 only 60,000 beds were left while, at the same time, the population had risen by 100,000,000 persons. Demand for existing beds and funding mechanisms ensure that admissions are necessarily brief – Dr Pepper concludes that the USA has moved from too many beds and over-hospitalisation to too few beds and under-hospitalisation (Pepper, 2001)

At the same time as the above changes there has been an explosion in the size of the USA’s incarcerated population – moving from a total size of 200,000 persons in 1972 to 2 million persons in 2000. There is evidence that a substantial percentage of these persons may be mentally ill with only limited treatment available to them (Teplin, 1994; Teplin, Abram and McClelland, 1996). Dr Pepper has proposed a typology to classify criminal acts where they involve substance use and/or mental disorder (Pepper, n/d).

<b>Visit No: 6 cont</b>	<b>Key informant: <a href="#">Dr Bert Pepper</a> Psychiatrist</b>
<b>Date: 10/11/03</b>	

### **Cannabis and psychosis**

Dr Pepper makes a case that there may be some persons whose psychotic disorder is caused primarily by their abuse of cannabis. Dr Pepper outlined a case in which a client that he worked with who had apparent, well-established psychosis went into complete, long-term, remission once he became abstinent from substances. This case is [outlined online](#)  
<http://www.wideopenwest.com/~ngersabeck/addition.html>

Dr Pepper referred to two papers [Cannabis and schizophrenia. A longitudinal study of Swedish conscripts](#) (Andreasson, Allebeck, Engstrom, Rydberg, 1987) and [Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study](#) (Zammit, Allebeck, Andreasson, Lundberg, Lewis, 2002 ) which showed that ‘cannabis use is associated with an increased risk of developing schizophrenia, consistent with a causal relation’

[http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list\\_uids=2892048&dopt=Abstract](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=2892048&dopt=Abstract) and  
[http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list\\_uids=12446534&dopt=Abstract](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12446534&dopt=Abstract)

### **Co-occurring physical disorders**

One of Dr Pepper’s concerns is the inadequate treatment for physical disorders often received by persons with mental disorders. See [on-line article](#) which quotes Dr Pepper on this subject. (Lipton, 2000)  
<http://www.psych.org/pnews/00-11-17/physical.html>

### **Other topics**

Dr Pepper discussed some of the components of effective treatment, outlined a model for analysing an individual’s social network and discussed the model’s implications for therapeutic relationships. Dr Pepper has authored a biopsychosocial analysis of a range of mental disorders and abuse (Ryglewicz and Pepper, 1996)

### **Suitability to own practice:**

Dr Pepper’s insights about the genesis of, and interventions for, persons with co-occurring disorders have contributed substantially to my knowledge and practice.

### **Suitability to Victorian healthcare system:**

Dr Pepper highlights a number of issues around co-occurring disorders that are relevant to a wide-range of Victorian healthcare providers. His thoughts on opportunities for prevention and early intervention for co-occurring disorders are particularly relevant to Victorian healthcare planners and researchers.

<b>Visit No: 6 cont.</b>	<b>Key informant: <a href="#">Dr Bert Pepper</a> Psychiatrist</b>
<b>Date: 10/11/03</b>	

**Some on-line reports and articles by Dr Pepper**

[Action for mental health and substance related disorders: Improving services for individuals at risk of, or with, co-occurring substance related and mental health disorders](#). Conference Report and Recommended National Strategy of the SAMHSA National Advisory Council. 1997  
<http://www.toad.net/~arcturus/dd/peptoc.htm#toc>

[Blamed and Ashamed: The Treatment Experiences of Youth with Co-occurring Substance Abuse and Mental Health Disorders and Their Families](#)  
<http://www.mentalhealth.org/publications/allpubs/KEN02-0129/pepper.asp>

[Developing A Cross Training Project For Substance Abuse, Mental Health And Criminal Justice Professionals Working With Offenders With Co-Existing Disorders \(Substance Abuse/Mental Illness\)](#)  
<http://www.toad.net/~arcturus/dd/cttoc.htm>

[Mentally Ill Alcohol and Substance Abuser Overview](#) <http://www.healthieryou.com/j22.html>

[Interfaces between Criminal Behaviour, Alcohol and Other Drug Abuse, and Psychiatric Disorders](#) <http://www.treatment.org/Communique/Comm93/pepper.html>

**Consensus Panel Member for**  
[Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse](#) *Treatment Improvement Protocol (TIP) Series 9*  
<http://www.health.org/govpubs/bkd134/default.aspx>

[National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders 1998](#)  
[http://www.nasadad.org/Departments/Research/ConsensusFramework/national\\_dialogue\\_on.htm](http://www.nasadad.org/Departments/Research/ConsensusFramework/national_dialogue_on.htm)

<b>Visit No: 7</b>	<b>Organisation: <a href="#">Connecticut Outreach-West Centre for Human Development</a> Holyoke Connecticut</b>
<b>Date: 12/11/03</b>	

**Summary of organisation's co-occurring disorders-related role/activities:**

The Centre for Human Development (CHD), founded in 1972, is a social service agency that serves children at risk, people with psychiatric and developmental disabilities, the elderly and the homeless. Much of CHD's early work was around supporting institutionalised persons to live in the community. Connecticut Outreach-West, as an arm of CHD, contracts with the [Connecticut Department of Mental Health and Addiction Services](#) (CDMHAS) to provide a variety of services to persons in need.

In 1995 Connecticut Outreach-West commenced a long term, intensive residential support program specifically for persons with co-occurring disorders of mental illness and substance abuse. This service utilises a team approach to help people to find and maintain apartments and to support them in their homes. It is not founded on an abstinence model, and has a current capacity of 26 clients. CDMHAS had specified that the contractor for this project had to be familiar with the Drake/ New Hampshire approach to integrated treatment of co-occurring disorders. Thomas and Melinda Fox from the New Hampshire Dartmouth Psychiatric Research Centre provided consultation to CHD and urged them to adapt the New Hampshire approach to local needs.

In adapting the Drake/New Hampshire approach Connecticut Outreach-West developed their own, staged, model for working with persons with co-occurring disorders - the 'Pyramid' model. Ascending stages in the Pyramid model are ...

- Community Stabilisation
- Engagement
- Persuasion
- Active Treatment and
- Relapse Prevention.

In the clinically-focused document describing the Pyramid model Connecticut Outreach-West identified

- Goals for each stage,
- Client issues most likely to be present at this stage,
- Staff responsibilities and interventions appropriate to the stage,
- Indicators of client progress &
- Outcome measures

Connecticut Outreach-West is re-drafting the Pyramid model into an easily-carried clinician reference and focusing on the model in their worker training.

<b>Visit No: 7 cont.</b>	<b>Organisation: Connecticut Outreach-West</b> <b><u><a href="#">Centre for Human Development</a></u></b>
<b>Date: 12/11/03</b>	

Connecticut Outreach-West also run 'Pilots'- a subsidized housing program for persons with co-occurring disorders or a substance use disorder alone. To qualify participants must have 90 days verified 'clean-time' and be homeless or at risk of homelessness.

**Activities undertaken during visit:**

On this visit I was able to interview the Program Director, Milton Jones and Rebekah Logue-Palomba. I accompanied outreach workers on visits to 3 clients in their individual apartments and attended a management meeting and met with management staff from the various teams.

**Key lessons learned:**

The importance of establishing and maintaining engagement with a client regardless of how their circumstances change and of a longitudinal perspective in measuring client change.

**Suitability to Victorian healthcare system:**

The work of the Psychiatric Disability Rehabilitation and Support Services (PDRSS) sector of the Victorian mental health system is closest in nature to that of Connecticut Outreach-West. A PDRSS worker focused text that analyses client's stage of change and indicates possible worker's responses would be valuable.

<b>Visit No: 8</b>	<b>Key informants: <a href="#">Dr Kenneth Minkoff</a> &amp; <b>Dr Christie A. Cline</b></b>
<b>Date: 13/11/03</b>	

**Summary of informant's co-occurring disorders-related role/activities:**

(abbreviated with Dr Minkoff's permission from <http://www.kenminkoff.com> )

Dr Minkoff is a psychiatrist widely recognised for his expertise around integrated treatment of individuals with co-occurring disorders and on the development of integrated systems of care for persons with co-occurring disorders. Dr Minkoff has provided training and consultation in all but two states of the USA as well as in Canada, Europe, and New Zealand.

Dr Minkoff's [Comprehensive Continuous Integrated System of Care](#) (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.

Dr. Minkoff and his consulting partner, Dr Christie A. Cline, Medical Director, Behavioural Health Services Division, New Mexico Department of Health, currently provide, or have provided, consultation for CCISC implementation in over 15 states of the USA and 3 Canadian provinces. Often, they are contracted by the individual state's central health planning /funding authority to work with the whole system to improve the services offered to person with co-occurring disorders - see Visit 12.

Drs. Minkoff and Cline have developed a variety of CCISC-related tools (see [www.zialogic.org](http://www.zialogic.org)). They include ...

- [Compass](#)- a tool for an individual agency to self-assess its competencies in relation to co-occurring disorders
- [Co-occurring Disorders Educational Assessment Tool](#) which spells out core clinical competencies to be focused on in training and a format for supervisor or clinician self-evaluation of these competencies

A number of other tools are in development

Dr. Minkoff participated in a national task force, chaired by [Dr David Mee-Lee](#) to create the American Society of Addiction Medicine Patient Placement Criteria. These addiction triage criteria incorporated 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 for use in the design of a system of care for individuals with co-occurring disorders (see Appendix 1 – ASAM criteria).

See appendix 2 for a list of Dr Minkoff's co-occurring disorders-related publications.

<b>Visit No: 8</b>	<b>Key informants:</b> <a href="#">Dr Kenneth Minkoff</a> <a href="#">Dr Christie A. Cline</a>
<b>Date: 13/11/03</b>	

### **Activities undertaken during visit:**

I attended the Vermont Co-occurring Disorders CCISC Trainers Meeting, a day-long training facilitated by Drs Minkoff and Cline for representatives from each of Vermont's ten designated community mental health agencies. During the day I had conversations with Dr Minkoff and with Beth Tanzman, Director of Adult Community Mental Health Programs for the Vermont Department of Developmental and Mental Health Services. I also spoke with clinicians participating in the training series.

### **Key lessons learned:**

Drs Minkoff and Cline knowledge of integrated treatment and their ability to practically and meaningfully apply the CCISC model to all levels of the service system was most impressive. Their ability to work through clinician's perceived barriers to integrated treatment and to engender enthusiasm for providing integrated treatment was extraordinary.

### **Comprehensive Continuous Integrated System of Care model (CCISC)**

*(Abbreviated, with Dr Minkoff's permission, from <http://www.kenminkoff.com>)*

Dr Minkoff's CCISC model has been very influential and there are a number of readily available overviews of the model. ([here](#) or [here](#) or [here](#) or [here](#))  
<http://www.samhsa.gov/reports/NewMexico/newmex-05.htm> or  
<http://www.cwru.edu/med/psychiatry/changing.ppt> or  
<http://www.kenminkoff.com/ccisc.html> or  
<http://www.zialogic.org/CCISC.htm>

In these overviews Dr Minkoff usually describes...

- \* The four basic characteristics of the CCISC model
- \* The eight principles of treatment for the CCISC model
- \* Twelve steps for CCISC implementation

**See textboxes below**

### **The four basic characteristics of the CCISC model**

#### **1. System level change:**

- CCISC is designed for implementation throughout an entire system of care
- All programs within a system are given a specific assignment to provide services to a particular cohort of individuals with co-occurring disorders.
- The model integrates system change technology with clinical practice technology at all levels of the system to create comprehensive change.

#### **2. Efficient use of existing resources:**

- CCISC does not require additional resources beyond those for planning, technical assistance, and training.
- CCISC provides strategies to improve services without requiring blending or braiding of funding streams.

**3. Incorporation of best practices:**

- CCISC model recognised by SAMHSA as a best practice model
- Evidence based treatment for all types of persons with co-occurring disorders throughout a service system

**4. Integrated treatment philosophy:**

**The eight principles of treatment for the CCISC model**

**1. Dual diagnosis is an expectation, not an exception:**

- The prevalence of co-occurring disorders together with associated poor outcomes and high costs across multiple systems suggests that the entire system must be designed to use all resources around this expectation.
- An integrated system planning process is required in which each funding stream, each program, all clinical practices, and all clinician competencies are designed to address individuals with co-occurring disorders

**2. The four quadrant model for categorizing co-occurring disorders can be used as a guide for service planning on the system level.**

<b><u>Quadrant 1 :</u></b> Less severe mental disorder / less severe substance abuse disorder	<b><u>Quadrant 3 :</u></b> Less severe mental disorder / more severe substance abuse disorder
<b><u>Quadrant 2 :</u></b> More severe mental disorder / less severe substance abuse disorder	<b><u>Quadrant 4 :</u></b> More severe mental disorder / more severe substance abuse disorder

Commonly Quadrant 1 individuals are seen in outpatient and primary care settings, Quadrant 2 individuals and some Quadrant 4 individuals are seen within the mental health system. Quadrant 3 individuals are engaged in both systems but served primarily in the substance system.

**3. Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting. Provision of continuous, integrated treatment is an evidence-based, best practice for individuals with the most severe combinations of psychiatric and substance difficulties.**

The system needs to prioritise ...

- The development of clear guidelines for how clinicians in any service setting can provide integrated treatment
- Access to continuous integrated treatment of appropriate intensity and capability for individuals with the most complex difficulties.

**4. Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.**

**5. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary**

diagnosis-specific treatment is recommended.

**6. Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model"** (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery). Interventions should be both diagnosis-specific and specific to the client's phase of recovery and stage of change.

**7. There is no single correct intervention for persons with co-occurring disorders.** For each individual interventions must be individualised according to quadrant, diagnoses, level of functioning, external constraints or supports and phase of recovery/stage of change.

**8. The measurement of clinical outcomes must also be individualised.**

Outcome measures that reinforce incremental treatment progress and promote the experience of treatment success may include:

- reduction in symptoms or use of substances,
- increases in level of functioning,
- increases in disease management skills,
- movement through stages of change,
- reduction in "harm" (internal or external),
- reduction in service use

### **Twelve steps for CCISC implementation**

**1. Integrated system planning process:**

Implementation of CCISC requires a comprehensive, system-wide, integrated strategic planning process

**2. Formal consensus on CCISC model:**

The system must ...

- Develop a mechanism for articulating the CCISC model including the principles of treatment and the goals of implementation
- Develop a formal process for obtaining consensus from all stakeholders,
- Identify barriers to implementation and an implementation plan
- Disseminate this consensus to all stakeholders.

**3. Formal consensus on funding the CCISC model:**

CCISC implementation involves a formal commitment that each funder will promote integrated treatment within the full range of services provided through its own funding stream

**4. Identification of priority populations, and locus of responsibility for each:**

Using the four-quadrant model, the system must develop a written plan for identifying priority populations within each quadrant, and locus of responsibility within the service system.

**5. Development and implementation of program standards.**

**6. Structures for inter-system and inter-program care coordination:**

Creation of routine structures and mechanisms for addiction programs and providers and mental health programs and providers to participate in shared clinical planning for complex cases whose needs cross traditional system boundaries.

**7. Development and implementation of practice guidelines:**

- That address assessment, treatment intervention, rehabilitation, program matching, psychopharmacology, and outcome.
- Guidelines should be developed with clinician input.
- Practice guidelines must be supported by regulatory changes and by clinical auditing procedures.

**8. Facilitation of identification, welcoming, and accessibility:**

This requires several specific steps...

- Developing the system's capacity to identify report and track the treatment of persons with co-occurring disorders.
- Development of a "no wrong door" policy mandating a welcoming approach to persons with co-occurring disorders in all system programs
- Establish universal screening for co-occurring disorders at initial contact throughout the system.

**9. Implementation of continuous integrated treatment:**

Developing the expectation that clinicians in every treatment setting are responsible for developing and implementing an integrated treatment plan in which the client is assisted to follow diagnosis-specific and stage-specific recommendations for each disorder simultaneously.

**10. Development of basic dual diagnosis capable competencies for all clinicians:**

Creating the expectation of universal competency, including attitudes and values, as well as knowledge and skill.

**11. Implementation of a system wide training plan:**

Training must be ongoing, and tied to expected competencies in the context of actual job performance. This requires an organized training plan to bring training and supervision to clinicians on site.

**12. Development of a plan for a comprehensive program array:**

The CCISC model requires development of a plan in which each existing program is assigned a specific role or area of competency with regard to provision of .... services for people with co-occurring disorders. This plan should also identify system gaps that require longer range planning and/or additional resources to address, and identify strategies for filling those gaps.

<b>Visit No: 8</b>	<b>Key informants:</b> <a href="#">Dr Kenneth Minkoff</a> <a href="#">Dr Christie A. Cline</a>
<b>Date: 13/11/03</b>	

**Suitability to own practice:**

This visit increased my appreciation of the need to address co-occurring disorders at all levels of a treatment system. Drs Minkoff and Cline wealth of experience in working with systems, their strategies to do so and knowledge of the possibilities of integrated treatment will be of considerable benefit to my own practice.

**Suitability to Victorian healthcare system:**

The CCISC model has been developed largely in the North American context of managed health care however many of the principles and strategies in the model are relevant to the Victorian situation. The overall approach of whole of system service planning and addressing co-occurring disorders at all levels of a treatment system is necessary to achieve enduring, substantial improvements in the Victorian system's capacity to provide effective treatment to the range of person's with co-occurring disorders.

Principles and strategies of the CCISC model that impress as having particular relevance to the Victorian situation include ...

**System-wide:**

- Dual diagnosis is an expectation not an exception
- Integrated treatment philosophy
- Development of a "no wrong door" policy that mandates a welcoming approach to persons with co-occurring disorders in all system programs

**System planning:**

- Comprehensive, system-wide, integrated strategic planning process for system level change.
- All system planning needs to be underpinned by a recognition of the prevalence of co-occurring disorders as well as associated poor outcomes and high costs across multiple systems
- Assigning responsibility for particular cohorts of persons with co-occurring disorders to particular agencies within the system. Using the four-quadrant model for categorizing co-occurring disorders as a guide for service planning the system must develop a written plan for identifying priority populations within each quadrant, and locus of responsibility within the service system
- Development of integrated treatment oriented clinician guidelines
- The system must develop a mechanism for articulating the principles of treatment and the goals of implementation
- The system must develop a formal process for obtaining consensus from all stakeholders and then disseminate this consensus to all stakeholders
- The system must identify barriers to implementation and an implementation plan
- Creation of routine mechanisms for drug treatment agencies and clinicians and mental health agencies and clinicians to participate in shared clinical planning for complex cases whose needs cross traditional system boundaries.
- Development and implementation of practice guidelines with clinician input

<b>Visit No: 8</b>	<b>Key informants:</b> <a href="#">Dr Kenneth Minkoff</a> <b>Dr Christie A. Cline</b>
<b>Date: 13/11/03</b>	

- Implementation of an organised system-wide training plan that is ongoing, tied to expected competencies and delivers on-site training and supervision to clinicians.

**Clinical:**

- Establish universal screening for co-occurring disorders at initial contact throughout the system.
- When psychiatric and substance disorders coexist both disorders should be considered primary and primary diagnosis-specific treatments should be provided in response
- Evidence based treatment for all types of persons with co-occurring disorders throughout a service system
- Focus on empathic, hopeful, integrated treatment relationships
- Access to continuous integrated treatment of appropriate intensity and capability for individuals with the most complex difficulties.
- Case management and care balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, in each service setting.
- Stage wise approach to treatment
- Wide range of possible treatment responses to co-occurring disorders
- Use of success-oriented outcome measures
- Developing the ability to identify, reporting, and track the treatment of persons with co-occurring disorders.
- Expectation that clinicians in every treatment setting are responsible for developing and implementing an integrated treatment plan in which the client is assisted to follow diagnosis-specific and stage-specific recommendations for each disorder simultaneously.
- Development of basic dual diagnosis capable competencies for all clinicians

**Visits 9 to 11**  
**New Hampshire Dartmouth Psychiatric Research Centre**  
**Background Information**

Since 1987 the New Hampshire Dartmouth Psychiatric Research Centre (NHDPARC) has, under [Dr Robert Drake](#), conducted the world's largest and most authoritative body of research into co-occurring disorders.

The team at NHDPARC, currently has [6 large-scale projects](#) studying dual diagnosis

- 10 year Follow-up of Dual Diagnosis Treatment 1998-2002
- Assertive Community Treatment for Dual Diagnosis: Continuation 2000 – 2005
- Public Academic Fellows Program in Substance Abuse Services Research 2001 – 2003
- Family Intervention for SMI and Substance Use Disorders 2001 – 2005
- Developing a Fidelity Scale for Dual Diagnosis Program Capability in Addiction Treatment 2003 – 2005
- D.C. Integrated Services Project 2002 – 2003

[Completed Projects](#) include

- Assertive Case Management for Dual Diagnosis 1989- 1992
- Boston Severe Mental Illness Study 1984-1994
- Treatment of Dual Diagnosis and Homelessness 1990 – 1993
- Assertive Community Treatment for Dual Diagnosis 1994- 1999
- Identifying Substance Abuse Disorders in the Mentally Ill 1993-1996
- Evaluation of Texas Dual Diagnosis Services 1996- 1998
- Riverbend Family Dual Diagnosis Program 1997 – 2000
- The Housing Continuum Model for Persons with SMD 1997 – 1999
- Vermont Mental Health and Substance Abuse Integrated Treatment Model Development Project 2000 – 2001

The NHDPARC team has published over [225 papers](#) and at least [5 texts](#) relating to co-occurring disorders (See appendix 2). Their most recent publication [Integrated Treatment for Dual Disorders: A Guide to Effective Practice](#) (Mueser, Noordsy, Drake, Fox, 2003) is the most comprehensive currently-available clinical handbook on co-occurring disorders. It examines individual, group, and family interventions and offers guidelines for developing integrated treatment programs, performing assessments and psychopharmacology. Of particular interest is the Dual-Disorder Treatment Fidelity Scale.

The NHDPARC team has developed the [Dartmouth Assessment of Lifestyle Inventory \(DALI\)](#) instrument for assessing alcohol and other drug substance use disorders in persons with severe mental illness (limited applicability in Australia because of different drug use and social circumstances). The team has developed a number of [other instruments](#) relevant to substance abuse and mental health assessment, treatment and research.

NHDPARC team's New Hampshire-Dartmouth **Integrated Dual Disorder Treatment (IDDT) model** 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. The model combines

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. See [here](#) for an overview of the model. (Ohio SAMI CCOE, n/d) or [here for a brief description of the model](#)

<http://www.ohiosamiccoe.cwru.edu/library/media/iddtooverview2003.pdf> or [http://www.mentalhealthpractices.org/iddt\\_about.html](http://www.mentalhealthpractices.org/iddt_about.html)

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.

Mueser, Noordsy, Drake and Fox (2003) list core components of integrated treatment ...

- Shared decision making between all stakeholders
- Services addressing both disorders are provided at the same time by clinicians from the one agency
- There is a comprehensive array of services to address the multiple impairments and needs that can occur with severely mental illness type co-occurring disorders
- Assertive engagement and follow-up of clients
- Harm-minimisation, non-judgemental approach
- Clinicians adopt a long term perspective
- Motivational enhancement strategies including staged treatment approaches and use
- Multiple psychotherapeutic modalities such as individual, group and family therapy approaches.

Mueser, Noordsy, Drake and Fox (2003) have developed a 'Dual Disorder Treatment Fidelity Scale' that uses the latter seven components to measure a service's fidelity to their integrated treatment model.

<b>Visit No: 9</b>	<b>Key informants:</b> <b>Melinda Fox and <a href="#">David Lynde</a></b> <b>New Hampshire Dartmouth Psychiatric</b> <b>Research Centre</b> <b>Concord offices</b>
<b>Date: 14/11/03</b>	

**Summary of informants co-occurring disorders-related role/activities:**

**Lindy Fox** is a long-standing Research Associate with NHDPRC who has taught, researched and published extensively around co-occurring disorders. Lindy is co-author of the recent text [Integrated Treatment for Dual Disorders: A Guide to Effective Practice](#) (2003). Lindy co-leads co-occurring disorders treatment groups and provides consultation and training for professionals and families.

See Appendix 2 for a list of Lindy’s co-occurring disorders related papers & publications.

**David Lynde** is Training Coordinator for the [West Institute](#), a branch of the NHDPRC. David coordinates training around Evidence-Based Practices (including IDDT) for adults with severe mental illness.

See Appendix 2 for a list of David’s co-occurring disorders related papers & publications.

**Activities undertaken during visit:**

I interviewed Lindy and David at their Concord offices.

**Key lessons learned:**

**IDDT model**

Ohio has made a system-wide commitment to the IDDT model. Preliminary results from there indicate that, after an initial increase in service demand when integrated treatment is established, there is a significant decrease in service demand and costs - as much as a 20% reduction in costs over one year and an 18% reduction in emergency services contacts. See [here](#) for an overview of Ohio’s system wide approach to implementing integrated treatment.  
[www.ohiosamiccoe.cwru.edu/about/aboutus.html](http://www.ohiosamiccoe.cwru.edu/about/aboutus.html)

As a whole the New Hampshire mental health treatment system doesn’t currently offer integrated treatment. While some individual agencies provide quality integrated treatment it appears that when the research went so did the treatment teams. This may be related to funding, supervision, a lack of clinical champions, monitoring and re-enforcement issues. A current research focus is around identifying the factors that maintain integrated treatment once established (see Visit 11- Paul Gorman). In this regard David discussed the continuation and growth improvement period subsequent to an integrated treatment model being established. He drew an analogy with Relapse Prevention and highlighted the need for careful attention to this phase.

<b>Visit No: 9 cont.</b>	<b>Key informants:</b> <b>Melinda Fox and <a href="#">David Lynde</a> , NHDPRC</b>
<b>Date: 14/11/03</b>	

The process for influencing a whole system to change is different to that for an individual agency or program and it is unlikely that instituting integrated treatment in one or two agencies will have much influence on the whole system's ability or willingness to provide integrated treatment. David stressed the importance of being absolutely clear at the outset what the target of change is. Data such as the costs and multiple-services demands associated with persons with co-occurring disorders, gathered systematically, can create a strong case for moving to an integrated treatment model.

### **Clinician training and education.**

Lindy observed that any time that you ask a clinician to learn something new you are asking them challenge their belief systems and methods of operating, to learn a new language and new value systems and it is natural that this will prompt resistance. David observed that clinicians receiving training may feel that there is an implication that their current practice is 'wrong' - he counters this by promoting the training in a context of evolving treatment approaches.

Lindy identified the stigma of the client population and the attitudes that clinicians have towards that client population as barriers to integrated treatment of co-occurring disorders. David observed that clinician attitude is central to their willingness to provide integrated treatment. David suggested that part of the process of getting ready to address our client's substance use involves addressing our own substance use and he will float this idea with clinicians in training around integrated treatment.

David employed a Stages of Change analysis around clinician's willingness to provide integrated treatment. He described the mismatch of their early efforts when they, as trainers, would be providing integrated treatment Action-oriented steps whilst the clinicians receiving training were actually in a Precontemplation stage - *'Does this have value for me?'... 'Do I need to change?'.... 'Why do I need to change?'* David reflected that more appropriate strategies to work with precontemplative clinicians would have been along the lines of *... 'We need to talk about change. We need to talk about how you're feeling about working with clients. We need to talk about the outcomes you're seeing. We need to talk about what is the mission of your agency, what is your mission in that agency'.*

A lesson learnt across all the practices has been that getting people ready to change is a bigger step and takes much more time and effort than was originally envisaged. David described an exercise which attempts to tap into clinician's personal introspection by asking them to think of all of the members of their family who had a mental illness and then list the effects that this had upon the family. Part B of the exercise requires participants to think of all of the members of their family who had a substance use disorder and then list the effects that this had upon the family – commonly Part B is much more significant than Part A.

<b>Visit No: 9 cont.</b>	<b>Key informants:</b> <b>Melinda Fox and <a href="#">David Lynde</a> , NHDPRC</b>
<b>Date: 14/11/03</b>	

### **Outcome measures**

David described the USA's mental health system's reliance on process rather than outcome measures and the importance of systems gaining agreement on the outcome measures to be used. One of the NHDPRC's preferred outcome measures is the client's stage of change. In comparison to other outcome measures, stages of change presents less methodological complications. Some of the measures adopted in Ohio include stage of treatment / housing stability / employment / forensic involvement / involuntary hospitalisations.

### **Family Intervention for Serious Mental Illness (SMI) and Substance Use Disorders program (FID)**

This study is currently comparing the outcomes of a 15-month intervention incorporating psychoeducation and problem solving with a 6-week intervention of psychoeducation alone. We discussed carer specific trauma and stigmatisation and the psychoeducation needs of carers. Lindy observed that the family appear to go through parallel stages of treatment to the client and hence their approach to behavioural family therapy in the FID program is as a stage-wise treatment.

### **Suitability to own practice:**

David and Lindy's stage of change analysis of clinician resistance will inform future training offered by my local co-occurring disorders initiative.

### **Suitability to Victorian healthcare system:**

Some of the issues highlighted by Lindy and David include ...

### **Victorian healthcare planners**

- Recognition that moving to integrated treatment may initially see an increase in service utilisation but has the potential of decreasing costs and presentations as people with complex co-occurring disorders receive effective treatment
- Importance of strategies to ensure any change to offering integrated treatment is an enduring change
- The importance of gathering data around costs and cross-sector service demands by persons with co-occurring disorders
- Importance of clear definition of Victorian treatment system goals around co-occurring disorders.
- Consideration of client's stage of change as a recognised outcome measure

### **Victorian co-occurring disorders specialist workforce:**

- Importance of recognising clinician resistance and incorporating stages of change analysis / motivational strategies in addressing such resistance
- Promoting and developing carer-specific, stage-wise initiatives addressing carer's trauma and loss

<b>Visit No: 10</b>	<b>Key informant:</b> <a href="#">Dr Douglas L Noordsy</a>
<b>Date: 14/11/03</b>	<b>New Hampshire Dartmouth Psychiatric Research Centre Lebanon offices</b>

**Summary of informant's co-occurring disorders-related role/activities:**

Dr Noordsy is Associate Professor of Psychiatry and Associate Director of Education and Training in the Department of Psychiatry, Dartmouth Medical School and Chief of Clinical Research at the Mental Health Centre of Greater Manchester. Till recently Dr Noordsy was also Medical Director of [Westbridge](#) – a private, non-profit organisation providing services to individuals with dual disorders and their families

Dr Noordsy has an extensive list of publications on co-occurring disorders and other mental health topics to his credit (see Appendix 2 for Dr Noordsy's dual disorder related publications). He is co-author of the recent '[Integrated Treatment for Dual Disorders: A Guide to Effective Practice](#)' (2003). His research interests include evidence based practices for persons with co-occurring disorders.

Dr Noordsy is an active clinician having provided psychiatric care on model dual diagnosis teams from 1990 to 2003. In 2001 Dr Noordsy was awarded the Exemplary Psychiatrist Award from the National Alliance for the Mentally Ill

**Activities undertaken during visit:**

I interviewed Dr Noordsy at NHDPRC Lebanon offices.

**Key lessons learned:**

**Challenges in providing training around integrated treatment**

Dr Noordsy noted that training is easier to do when participants come from an agency that is well-structured to treat both disorders simultaneously. He also observed that if a clinician has predominant experience in one arena or the other they will often need greater support to acquire the other skill set and also the sense of responsibility for both disorders – that, if they are most comfortable with treating mental illness, the sense that substance abuse is also an appropriate responsibility and target for them and vice versa.

**Primary/secondary typology**

Dr Noordsy observed that medical training tends to the view that one disorder will be primary and one secondary. An implication of this is that one should exclude, for instance, substance induced psychosis or depression. A danger of this primary /secondary typology is that it tends towards a treatment focus on only one of the disorders with the risk that the under-treated other disorder may then undermine the effectiveness of treatment for the first disorder.

<b>Visit No: 10 cont</b>	<b>Key informant: <a href="#">Dr Douglas L Noordsy</a> NHDPRC</b>
<b>Date: 14/11/03</b>	

The need to let go of the primary/secondary distinction was evidenced by a series of studies of patients with depression and alcohol dependence. They found that, if started on an antidepressant, client's depressive symptoms improved within a week of detoxification and those who received antidepressants were less likely to relapse into alcohol use – the emerging principle is that if you treat you get better outcomes. Dr Noordsy advocates the same pragmatic approach of treating what a person presents with in treating psychotic disorders. Most often it is virtually impossible to be confident about which disorder is primary, rather both disorders are there and both require treatment.

The best way to establish if a person has a substance-induced mental syndrome is to treat them, get them well and then, if they're sober and their mental syndrome is in remission for a time, you may taper off the psychiatric medication at that point and establish whether it's needed. This approach is more likely to get an effective response, and the ability to test that, than stating 'I'll wait until you're sober to treat your mental disorder'.

### **Prescribing to people who are using substances**

Dr Noordsy discussed 'defensive prescribing' for fear of a dangerous interaction between psychotropics and substances. He made the point that there is not a lot in the literature about interactions between psychotropics and substances of abuse. Dr Noordsy referred to the chapter on pharmacology in ['Integrated Treatment for Dual Disorders: A Guide to Effective Practice'](#).

Among many other points the pharmacology chapter notes that...

- 'Newer antidepressant and anti-psychotic medications (except Clozapine) are safer than older compounds'
- 'It is best to avoid prescribing medications with a high potential for abuse'
- 'It is best to avoid medications with high potential for interactions with substances of abuse such as MAOI's'
- The approach of the authors is to 'encourage careful adherence to medication regimes' and they 'actively avoid discouraging clients from taking their medications when they are using substances'

Dr Noordsy observed that it is often at the point when a clinician becomes actively engaged in treating both the mental illness and the substance disorder that it becomes much easier to say: *'well of course I need to treat this psychosis in order to stabilise the illness and to support the substance abuse work that we're trying to do. There may be some risks involved in that and I will carefully educate the patient about that so that they can make choices that are safe.'* He stressed the importance of providing clients with information about medication, the effects of substances and any possible interactions and of carefully documenting in the client's notes that this has occurred – the client is then making an informed decision where they choose to use substances whilst taking medication.

Visit No: 10 cont	Key informant: <a href="#">Dr Douglas L Noordsy</a> NHDPRC
Date: 14/11/03	

### **Benzodiazepines**

Dr Noordsy discussed their recent paper (Brunette, Noordsy, Xie, Drake, 2003) - *Benzodiazepine use and abuse among patients with severe mental illness and co-occurring substance use disorders*— in which the authors examined benzodiazepine use and outcomes in a six-year longitudinal study of patients with co-occurring disorders. Dr Noordsy stressed that the study was done in the context of their large trial in which there was very close observation of clients and close-monitoring of medication by a team who are particularly aware of the risks. Within that context the team did not see a huge amount of abuse of benzodiazepines. Nor did they see significant destabilisation of client's other addictions. 15% of those prescribed benzodiazepines developed benzodiazepine abuse as against only 6% of clients who weren't prescribed benzodiazepines. The paper concluded that '*physicians should consider other treatments for anxiety in this population*'.

### **Challenges in providing integrated treatment**

Most clients aren't motivated for abstinence at the point where we start working with them. Therefore we need to tolerate a deal of substance use in order to get far enough into their world to get their trust to allow us to do the motivational work to help the client. This needs to be the approach of all members of the team. If a clinician has a rigid abstinence orientation, is very medical/authoritative in their thinking or doesn't have patience for the work then it will be much harder for the clinician to meet the patient where they are. The time course for seeing improvement may be in years.

The best position to be in is to have clients reporting honestly to the clinician - if client's experience a clinician as having a judgemental attitude they are likely to decide not to report honestly about substance use. Clinicians may have to work with their own comfort with client's choices, even where those choices may seem against the client's best interests.

### **Future directions:**

Dr Noordsy would like to see more uniform availability of high quality, evidence-based, services. He would like to see further growth in our understanding of and knowledge about effective treatment. A research area of particular interest is the neurobiology of addiction, especially in regard to co-occurring disorders.

Around schizophrenia as a whole Dr Noordsy described the next step as being to bring our expectations to a similar level as our expectations for depression or anxiety disorders – that is, going beyond rehabilitation into remission, changing the goal from stabilisation to a return to full functioning.

Doing the job well requires resources. A change in expectations, among the treaters and the political world, is likely to lead to increased resources that will further contribute to providing a higher level of care than just stabilisation.

<b>Visit No: 10 cont</b>	<b>Key informant: <a href="#">Dr Douglas L Noordsy</a> NHDPRC</b>
<b>Date: 14/11/03</b>	

**Suitability to own practice:**

Dr Noordsy succinctly described a number of core issues around co-occurring disorders and, for each issue, proposed clear, clinically-focused principles to negotiate the issue. The pharmacology principles described by Dr Noordsy are especially valuable to me as they suggest clear guidelines for negotiating a controversial co-occurring disorders issue which, till now, has had only limited attention in the literature.

**Suitability to Victorian healthcare system:**

Dr Noordsy's synopsis of co-occurring disorders issues and suggestions to negotiate those issues comes from a psychiatrist's perspective. That perspective undoubtedly has particular interest for Victorian psychiatrists engaged in treating persons with co-occurring disorders as well as the broader drug treatment and mental health workforces. Dr Noordsy's analysis of the pitfalls of the primary/secondary typology and his guidelines about psychopharmacology for persons with co-occurring disorders represent significant landmarks for all persons engaged in the treatment of persons with co-occurring disorders.

<b>Visit No: 11</b>	<b>Key informant:</b> <b><a href="#">Dr Paul Gorman</a></b> <b>Director</b> <b><a href="#">West Institute</a></b> <b>New Hampshire Dartmouth Psychiatric Research Centre</b>
<b>Date: 14/11/03</b>	

**Summary of informant's co-occurring disorders-related role/activities:**

Paul has worked in management of mental health systems in both the public and private sector for thirty years. He is currently the Director of the [West Institute](#) at the New Hampshire-Dartmouth Psychiatric Research Center. The West Institute was founded in 2000 to promote the implementation of research-developed, Evidence-Based Practices in public mental health systems across the country whilst studying the process of implementation. <http://www.dartmouth.edu/~westinst/index2.htm>

Currently, the six identified Evidence-Based Practices identified and promoted by the institute are ...

- Assertive community treatment
- **[Integrated dual disorders treatment](#)**  
<http://www.dartmouth.edu/~westinst/iddt.htm>
- Supported employment
- Effective medication practices
- Family psychoeducation
- Illness management and recovery.

The West Institute's goal is to assist mental health systems and agencies to successfully implement Evidence Based Practices. To this end their services include describing the research findings, describing service models and providing skills training and education to implement the practices effectively. They have a strong focus on the sustainability of the practices once implemented.

See Appendix 2 for a list of Paul's co-occurring disorders related papers & publications.

**Activities undertaken during visit:**

Interview with Paul Gorman at NHDPRC's Lebanon offices.

**Key lessons learned:**

Paul described a current, large-scale, multi-site study investigating the sustainability of the integrated dual disorders treatment model once implemented. Each state involved in the study ...

- Chose a number of sites in their state in which to implement the model
- Appointed a steering committee for the implementation of the model (all stakeholders including consumers and carers)
- Engaged a state-trainer who participated in a train the trainer process with a 'super-trainer' from NHDPRC. Each state-trainer then provided training to their Community Mental Health Facilities

<b>Visit No: 11 cont.</b>	<b>Key informant:</b> <a href="#">Dr Paul Gorman</a>
<b>Date: 14/11/03</b>	<b>NHDPRC</b>

- Appointed a monitor whose role is to observe and gather qualitative data on what occurs during implementation and after the trainers are withdrawn. Monitors are to remain in place for a further year after the training is completed and to employ the IDDT fidelity scale to assess fidelity to the IDDT model. It is hoped that this study will shed light on what are the factors are that mitigate for and against the sustainability of the IDDT model

**Suitability to own practice:**

The interview with Paul left me reflecting on what are the factors that tend towards any systemic change being an enduring change.

**Suitability to Victorian healthcare system:**

This visit highlighted the importance of service planners

- Engaging stakeholders in clearly describing the goals for the treatment system in regard to integrated treatment
- Developing and promoting a defined treatment model
- Developing or selecting a tool to measure fidelity to that model
- Considering strategies to promote the sustainability of any change to the treatment systems capacity to provide routine integrated treatment
- Ensuring that the 'dual diagnosis champions' in any service have sufficient 'clout' to influence service delivery and direction.

<b>Visit No: 12</b>	<b>Key informant:</b> <b>Linda Kaufman</b>
<b>Date: 19/11/03</b>	<b>Director of Organizational Development</b> <a href="#"><u>Department of Mental Health</u></a> <a href="#"><u>Washington DC</u></a>

**Summary of informant's co-occurring disorders-related role/activities:**

Washington DC's Department of Mental Health is responsible for providing comprehensive mental health services to more than 7,500 adults, children and adolescents annually as well as clients referred through the criminal justice system.

Over the past two years Linda, as Director of Organizational Development for the Department, has been closely involved with the planning and implementation of Washington's strategies to better address the treatment needs of persons with co-occurring disorders.

**Activities undertaken during visit:**

Interview with Linda at her offices

**Key lessons learned:**

Linda described the evolution of mental health services in the USA, including transinstitutionalisation – persons with mental disorders ending up in the forensic, custodial system. Linda described a growing recognition in Washington DC, over the past several years, that persons with co-occurring disorders were falling through the gaps between the mental health and substance abuse treatment systems. An observation was that the system was acting as though persons had either a mental health disorder or a substance abuse disorder when in reality the majority had both disorders.

When system planners began looking at models to address co-occurring disorders they kept hearing of [Dr Minkoff](#) and his ability to work with a whole system. Drs. Minkoff and Cline were asked to be consultants and have been active in that role since late 2002. Linda described Dr Minkoff's view that, rather than being an obstacle, bureaucracy can be a main agent of change if approached correctly. The Department responded to initial reluctance expressed by management of some agencies by promoting the perspective that integrated treatment had the potential to be helpful rather than an added burden.

Drs. Minkoff and Cline's activities have included ....

- An initial presentation to CEO's of all agencies
- An initial open training for anyone interested in co-occurring disorders
- Two-monthly train the trainers program with representatives from each of the mental health and some of the substance treatment agencies. Each of these sessions has comprised a full day of training followed by a day of technical assistance in which either Dr Minkoff or Dr Cline will visit individual agencies.

<b>Visit No: 12 cont</b>	<b>Key informant: Linda Kaufman</b>
<b>Date: 19/11/03</b>	<b><u><a href="#">DC Dept of Mental Health</a></u></b>

Each individual trainer's responsibilities have included...

- Completing a self-assessment of their agencies competencies in relation to co-occurring disorders using Minkoff and Cline's '[Compass](http://www.zialogic.org/tool_no_5.htm)' tool
- Generating an agency Action Plan
- Hosting Dr Minkoff or Dr Cline on day-long technical assistance visits to their agency in which the consultants will work from the 'Compass' assessment with the team involved.

The cadre of trainers has recently indicated that they would like to take more of a leadership and planning role around co-occurring disorders

Linda has sat in on a number of technical assistance visits and reports that clinicians, in the course of the day, will often move from concern about the difficulties in implementing integrated treatment to enthusiasm about this making their work easier. Linda notes the consultants' breadth of knowledge about integrated treatment and their strong sense of how it has changed the systems that they have worked with.

Other recent local developments include

- The State Mental Health Planning Council devoted their annual conference to co-occurring disorders.
- Drs. Minkoff and Cline wrote a City Charter on directions in co-occurring disorders
- Washington's Mayor and the heads of the Health and Mental Health Departments signed off on the Charter as a city commitment.
- Since then the city has completed its first comprehensive substance abuse strategy including a section on co-occurring disorders.

Reflecting on the above developments Linda observed that while it sounds like a tidy, sequential process it has at times been quite a struggle for participants to find the time and funds to devote to the initiative. She notes that they are becoming more able to drive the process themselves.

#### **Suitability to own practice:**

My interview with Linda increased my understanding of the challenges faced by central planning bodies as well as their potential for instigating and facilitating system-wide change.

#### **Suitability to Victorian healthcare system:**

Washington DC's efforts in addressing co-occurring disorders provide a good example of a 'top-down, bottom-up' approach that appears to have had a significant impact on practice in a short time. Consideration should be given to engaging an outside consultant to help facilitate system-wide change.

<b>Visit No: 13</b>	<b>Organisation:</b> The Metropolitan Washington Council of Governments <a href="#"><u>Co-occurring Disorders Committee</u></a> Washington DC
<b>Date: 20/11/03</b>	

**Summary of organisation's co-occurring disorders-related role/activities:**

In existence since 1990, the Co-occurring Disorders Committee is composed of mental health and substance abuse management and direct service staff from the public and private sector in the Washington DC region and the adjoining states of Maryland and Virginia.

The Committee's aims include...

- To promote effective treatment services for individuals with co-occurring disorders.
- To promote interagency and collegial communication and collaboration among public and private treatment programs and their staff providing these services.
- To provide low-cost trainings for professionals providing treatment for individuals with co-occurring disorders. Since 1990, the committee has sponsored more than 20 workshops and seminars on co-occurring disorders topics.

**Activities undertaken during visit:**

I attended and addressed a monthly meeting of the Co-occurring Disorders Committee followed by lunch with participants

**Key lessons learned:**

The Committee provides substantial, regular training on co-occurring disorders related topics. On my visit the committee was planning a day-long training on [Medical Conditions: Implications for treating co-occurring disorders](#). Recent trainings have included *Creating & managing residential programs for individuals with co-occurring disorders* and [How to identify and assist an individual with co-occurring disorders: Strategies to maximize success](#)

[http://www.mwcog.org/services/health/dualdiagnosis/mc\\_workshop\\_brochure.pdf](http://www.mwcog.org/services/health/dualdiagnosis/mc_workshop_brochure.pdf)  
<http://www.mwcog.org/uploads/event-documents/y1xWVw20031022150238.pdf>

The committee produces a bi-annual newsletter, The Forum, aimed at keeping clinicians up to date on policy, legislation, research and treatment information, local training, and policy positions taken by the committee.

Back copies of the Forum can be downloaded from [here](#)

[http://www.mwcog.org/publications/departamental.asp?CLASSIFICATION\\_ID=5&SUBCLASSIFICATION\\_ID=30](http://www.mwcog.org/publications/departamental.asp?CLASSIFICATION_ID=5&SUBCLASSIFICATION_ID=30)

<b>Visit No: 13 cont.</b>	<b>Organisation:</b>
<b>Date: 20/11/03</b>	<a href="#"><u>Co-occurring Disorders Committee</u></a>

Other committee achievements include...

- Producing two local community resource guides of co-occurring disorder's treatment services,
- Producing a policy report with recommendations concerning the most effective co-occurring disorder's treatment services,
- Providing testimony at public hearings concerning the need for co-occurring disorder's treatment services
- Providing consultations to local programs concerning the implementation and improvement of their co-occurring disorder's services.

**Suitability to own practice:**

The committee impressed as a model of productive collaboration between representatives of various government and non-government agencies across three adjoining states of the USA. I was particularly impressed with the quality of the newsletter and the range and depth of topics covered in the training

**Suitability to Victorian healthcare system:**

This committee's collaborative activities would constitute a valuable resource to any healthcare system attempting to achieve better outcomes for persons with co-occurring disorders.

<b>Visit No: 14</b>	<b>Key informant:</b> <b>Gary Lupton</b> <b>Organisation:</b> <b>Fairfax County</b> <b>Day Treatment Program for Co-occurring Disorders</b>
<b>Date: 20/11/03</b>	

**Summary of organisation's / informants co-occurring disorders-related role/activities:**

**Gary Lupton:**

Gary is the Mental Health Manager, Adult Comprehensive Day Treatment and Site Director for Mount Vernon Community Mental Health in Fairfax County, Virginia. He chairs the Metropolitan Washington Council of Governments, Co-Occurring Disorders Committee and the Fairfax County Substance Abuse and Mental Health Committee. Gary has extensive experience in working with people with co-occurring disorders in outpatient, residential, and correctional settings

**Fairfax County Day Treatment Program for Co-occurring Disorders**

This service provides an intensive, 4-day per week day program designed for persons in crisis, at risk of hospitalisation or post-discharge. The program has a 25-year history with a 15-year focus on co-occurring disorders. A paper describing the service is available [here](#) (Marr, n/d) <http://www.toad.net/~arcturus/dd/treat1.htm>. The service runs on a 5-person staff complement with sessional psychiatrist input.

**Activities undertaken during visit:**

On this visit I conducted an interview with Gary Lupton, was taken on an inspection of the centre and engaged in an hour-long group discussion with day treatment team staff.

**Key lessons learned:**

**Day treatment program**

Most clients have serious mental illness and staff estimate that usually around two-thirds will have co-occurring substance use disorders. Clinicians pay careful attention to engaging clients and utilise a stepwise model around engagement, persuasion, active treatment and relapse prevention. Each client has an individually negotiated treatment plan and clients are required to formulate daily goals.

The program's approach incorporates recognition of parallel process between client and staff groups as an important, central therapeutic tool. Substance use treatment is well-integrated into overall treatment. A wide range of groups are offered. I was struck by the day program staff's dedication to and belief in the service that they offer.

<b>Visit No: 14 cont.</b>	<b>Key informant: Gary Lupton</b>
<b>Date: 20/11/03</b>	<b>Organisation: Fairfax County Day Treatment</b>

**Other Fairfax County Co-occurring Disorders Initiatives**

Fairfax County (population = c.1million) has a range of treatment options specifically for persons with co-occurring disorders

- Cornerstones Program is a co-occurring disorders specific, integrated residential and aftercare program with staff from both mental health and drug treatment (Quadrant 4 of the four-quadrant model)
- Franconia Road treatment centre is a dual diagnosis specific group home where male clients stay for 18 months to 2 years.
- REDD program – women specific group home similar to Franconia Road

The Fairfax County Substance Abuse and Mental Health Committee is a cross-agency initiative designed to serve as a resource for staff to bring difficult cases to. The committee, with management representatives from mental health and drug treatment agencies, attempts to generate creative treatment options for clients with particularly complex needs.

**Suitability to own practice:**

I was particularly struck by the day treatment program clinician’s use of engagement strategies, the diversity and flexibility of their program and their ability to analyse and therapeutically employ the parallel process of staff and client groups.

**Suitability to Victorian healthcare system:**

The day treatment program appears to meet some of the needs that step-down initiatives address in the Victorian mental health treatment system. The structure and function of the Substance Abuse and Mental Health Committee could serve as a useful model for local agencies collaboratively trying to achieve better outcomes for clients with particularly complex needs.

<b>Visit No: 15</b>	<b>Organisation: Avery Road Combined Care Montgomery County Maryland</b>
<b>Date: 21/11/03</b>	

<b>Key informants:</b>	
<b>Richard L. Kunkel</b>	Behavioural Health Operations Manager <a href="#">Montgomery County Department of Health and Human Services</a> , Maryland
<b>Laura Burns-Heffner</b>	Program Monitoring Unit Montgomery County
<b>Scott McMillian</b>	Executive Director Maryland Treatment Center
<b>Lynn Smith</b>	Program Director Avery Road Combined Care
<b><a href="#">Eric Morse</a></b> (PDF)	Medical Director / Psychiatrist Avery Road Combined Care

**Summary of organisation’s co-occurring disorders-related role/activities:**

The Avery Road Combined Care program provides intensive outpatient and residential treatment services to individuals with co-occurring disorders. Avery Road sits in Montgomery County’s drug treatment continuum of care rather than its mental health continuum. A treatment vendor, Maryland Treatment Center, operates this program for the county in a county owned facility.

Client’s mental health disorders are commonly the high frequency disorders (Depression, Anxiety, Post Traumatic Stress Disorder and Antisocial Personality Disorder) and clients with severe mental illness need to be quite stable to be admitted. Using American Society for Addiction Medicine (ASAM) criteria Avery Road views itself as Dual Diagnosis Capable but as moving towards Dual Diagnosis Enhanced (See Appendix 1: ASAM criteria). Having a co-occurring mental health disorder is not an essential criterion for admission to the program.

**Activities undertaken during visit:**

On this visit I recorded an interview and had lunch with key informants.

<b>Visit No: 15 cont.</b>	<b>Organisation: Avery Road Combined Care Montgomery County</b>
<b>Date: 21/11/03</b>	

**Key lessons learned:**

We discussed the structural factors that have contributed to the drug treatment system providing a co-occurring disorders initiative. Some of the factors identified included ...

- Substance treatment services have always dealt with Axis 11 disorders (DSM-IV, 1994)
- Mental health deinstitutionalisation contributed to a significant, visible co-occurring population. The mental health service system has not had the infrastructure to deal with this population so many of them have fallen to addictions.
- Over the past 10 years crack cocaine has had significant impact on the complexity of the needs that clients are presenting with

Many of the admissions to Avery Road have been homeless and with a long history of relapse. Treatment may last between 6 and 12 months and uses a therapeutic community model. The main treatment modality is group work. The program targets physical and mental health problems, vocational guidance, job preparedness, social and family dysfunction, leisure and recreation skills.

Clients work through three levels of treatment...

- Entry and orientation (30 - 60 days)
- Core treatment (3 - 6 months)
- Live in and re-entry (2 - 4 months)

Clients have frequently reported that this is their first experience of having their mental health and substance use addressed concurrently and commonly report positively about this experience.

**Suitability to own practice:**

This visit underlined that providing integrated treatment of co-occurring disorders is more likely to be effective than treating substance use disorders in isolation.

**Suitability to Victorian healthcare system:**

Initiatives targeting clients with high-prevalence mental health disorders type co-occurring disorders are an important part of the continuum of care.

**Visits 16 to 19**  
**State of Arizona**  
**Background Information**

Arizona's health service planners face particular challenges related to poverty and rurality. Despite these challenges Arizona was a fellowship highlight for its cohesive, strategically-planned, system-wide commitment to providing an effective, integrated treatment response to persons with co-occurring disorders.

**Arizona's approach to co-occurring disorders**

In the latter half of the 1990's recognition of the prevalence of co-occurring disorders and of the limitations of sequential/parallel models of care led Arizona's service planners to conclude that a major change in the behavioural health system was necessary. It was felt that a limited number of specialised "dual diagnosis" programs would not address the needs of a majority of the clients with co-occurring disorders' (AITCP, 1999).

In January 1999 a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) was used to form the [Arizona Integrated Treatment Consensus Panel](#) (AITCP) with representation from Arizona's substance abuse and mental health service systems, consumers and carers.

The panel adopted an inclusive definition of co-occurring disorders and attempted to devise a model that addressed the continuum of co-occurring disorders (AITCP, 1999).

The Panel's definition of co-occurring disorders embraced...

- Substance abuse (DSM definitions) and/or dependence disorders and a general mental health disorder or a serious mental illness.
- Serious mental illness and substance abuse or substance dependence;
- Psychiatrically complicated substance abuse or substance dependence

**Panel objectives included:**

- Convening an advisory group of key stakeholders on a monthly basis
- Conducting knowledge exchange sessions with local and national experts in order to identify exemplary practices regarding integrated treatment
- Using group consensus process building methods to identify the local model and barriers to implementing integrated treatment
- Developing a work plan to overcome the barriers and implement the integrated treatment model
- Disseminating the results state-wide, and
- Monitoring implementation and results (AITCP, 1999).

**AITCP actions :**

- Identified, reviewed and discussed the literature addressing the methodology, skills and philosophy needed to effectively treat and support persons with co-occurring disorders.

- Participated in training provided by [Dr. Ken Minkoff](#). Dr. Minkoff reviewed the Arizona principles and draft goals and objectives and provided recommendations for enhancements (see below).
- [Dr. Kim Mueser](#), from New Hampshire Dartmouth Psychiatric Research Centre, provided training on the IDDT model <http://www.dartmouth.edu/~psychrc/kimm.html>).

The AITCP developed the overall vision, principles, goals, objectives, and strategies for implementation of integrated treatment services in Arizona. For each goal and strategy the AITCP developed 'hallmarks of success' to measure the system's effectiveness in achieving the particular goal /objective.

Four subcommittees were charged with developing specific implementation recommendations around ...

- Department of Health Services policy,
- The continuum of care,
- The competencies for providing integrated treatment and
- Funding mechanisms.

The University of Arizona was contracted to develop eight, co-occurring disorders, training videos. Presenters included Drs Kim Mueser and Patricia Penn. The modules are described [here](#). <http://www.hs.state.az.us/bhs/aitcpnews5.pdf>

Modules included:

- Dual diagnosis101
- Integrated treatment – how do we do it?
- Integrated treatment 201: medications & integrated treatment
- 5 module series on motivational based treatment for co-occurring disorders.

In late-2000 the AITCP project was awarded the Arizona Governor's Award for Excellence, the highest commendation in Arizona state government.

#### **Further reading:**

There are a number of web-based documents that provide further information on Arizona's approach to co-occurring disorders.

These include...

Arizona Integrated Treatment Consensus Panel

[Final Report \[PDF 111K\]](#)

<http://www.hs.state.az.us/bhs/finalreport.pdf>

[Appendix \[PDF 92K\]](#)

<http://www.hs.state.az.us/bhs/appendix.pdf>

[Implementation Plan \[PDF 20K\]](#)

<http://www.hs.state.az.us/bhs/finalplan.pdf>

[Newsletter Fall 2002](#)

<http://www.hs.state.az.us/bhs/aitcpnews5.pdf>

[Practice Improvement Protocol 6: Co-occurring Psychiatric and Substance Disorders](#) – Arizona Dept of Health Services Division of Behavioural Health Services

[http://www.hs.state.az.us/bhs/guidance/co\\_occur.pdf](http://www.hs.state.az.us/bhs/guidance/co_occur.pdf)

Minkoff, K. (2000) [State of Arizona service planning guidelines co-occurring psychiatric and substance disorders](#)

[http://www.treatment.org/topics/dual\\_documents.html](http://www.treatment.org/topics/dual_documents.html) )

<b>Visit No: 16</b>	<b>Key informant:</b> <b>Michelle Ryan</b> <a href="#">Arizona Department of Health</a> <a href="#">Division of Behavioural Health</a> <a href="http://www.hs.state.az.us/bhs/index.htm">http://www.hs.state.az.us/bhs/index.htm</a>
<b>Date: 24&amp; 25 Nov. 2003</b>	

**Summary of informant’s co-occurring disorders-related role/activities:**

The Division of Behavioral Health Services serves as the single state authority providing coordination, planning, administration, regulation and monitoring of all facets of Arizona’s public behavioral health system. The Division contracts with each of six Regional Behavioral Health Authorities (RBHA) to administer behavioral health services in their region. RBHAs then sub-contract with a network of more than 350 service providers to deliver a full range of behavioral health care services, including prevention programs for adults and children, and a full continuum of services for adults with substance abuse and general mental health disorders, adults with serious mental illness, and children with serious emotional disturbance

The Division’s comprehensive approach to addressing co-occurring disorders is described in the above panel, *State of Arizona, Background information*.

**Activities undertaken during visit:**

Michelle organised and hosted a packed 2-day visit. She introduced me to key informants, provided background information and an overview of Arizona’s approach to co-occurring disorders.

**Key lessons learned:**

See text box above and visits 17 to 19.

Michelle noted that the Arizona Integrated Treatment Consensus Panel members made use of [The Change Book: A Blueprint for Technology Transfer](#) (see textbox, page 89) and endorse it strongly.

**Suitability to own practice:**

My experiences in Arizona, having the opportunity to see a system that has made substantial progress in increasing its capacity to offer integrated treatment and to review the strategies employed to achieve that progress, will inform my activities with Eastern Hume Dual Diagnosis Service.

**Suitability to Victorian healthcare system:**

As described above Arizona provides a model for a collaborative, inclusive, multi-level, carefully-planned, system-wide approach to achieving better outcomes for persons with co-occurring disorders.

<b>Visit No: 17</b>	<b>Organisation:</b> <a href="#">ValueOptions</a> <b>Maricopa County</b> <b>Regional Behavioral Health Authority</b> <b>Arizona</b>
<b>Date: 24/11/03</b>	
<b>Key informants:</b> <b>Eric Raider</b> <b>Manager, ValueOptions.</b> <b>Arizona Integrated Treatment</b> <b>Consensus Panel member</b>	
<b>David Olivarez</b> <b>Co-occurring Disorders Specialist</b> <b>ValueOptions</b>	

**Summary of organisation's / informants co-occurring disorders-related role/activities:**

ValueOptions is one of the largest, for-profit, managed behavioural health care firms in the USA. In Arizona ValueOptions is contracted by the Department of Behavioural Health to serve as the Regional Behavioral Health Authority for Maricopa County. Maricopa County's population is over 3 million. ValueOptions provides services, such as drug treatment and mental health case management to children and adults unable to afford such services through insurance or other means. They provide services to over 60,000 Maricopa County residents through more than 85 behavioral healthcare providers and 21 case management sites.

**Activities undertaken during visit:**

On this visit I conducted an interview with Michelle Ryan, Eric Raider and David Olivarez in the offices of ValueOptions.

**Key lessons learned:**

**System change**

I asked informants if they could identify any local factors accounting for Arizona's comprehensive approach to providing integrated treatment. The informants identified three factors...

- The initial impetus provided by the State and its higher level support and action in mandating integrated treatment to its contractors was felt to have been the most significant factor
- Having a inclusive, effective state planning panel
- From the field the recognition of the prevalence of dual disorders combined with an appreciation that there are likely cost-savings in providing effective, integrated treatment.

Thus far it has not been possible to measure changes in outcomes as a result of integrated treatment (but has been possible to chart changes in services). A

<b>Visit No: 17 cont.</b>	<b>Organisation: <a href="#">ValueOptions</a> Maricopa County, Arizona</b>
<b>Date: 24/11/03</b>	

new system-wide assessment/outcome package is currently being rolled out with which it will be possible to measure changes.

The local co-occurring disorder's panel still meets and is active in working towards the co-occurring disorders initiative enduring. All informants reflected positively on the input provided to the Arizona initiative from all outside consultants /trainers

### **Service planning**

ValueOptions have incorporated American Society for Addiction Medicine criteria for levels of care (see Appendix 1) as a central planning tool. A focus has been to ensure their programs meet the criteria for either Dual Diagnosis Capable or Dual Diagnosis Enhanced. In 2003, for the first time, ValueOptions providers had their target populations and ASAM criteria written into their contracts. A planning focus has been around the principle of a 'no wrong door philosophy' for consumers seeking services from ValueOption's providers.

### **Training**

Lack of training around integrated treatment was initially identified as the largest barrier to providing integrated treatment. ValueOptions approach was to enlist 100 clinicians, drawn from all agencies, aiming for them to be the 'co-occurring disorders champions' in their respective agencies. ValueOptions contracted [Dr David MeeLee](#) to provide 60-hours training (2-day brackets over 4-months) to these workers. <http://www.dmlmd.com/index.html>

ValueOptions hired David Olivarez as a specialist trainer and another worker to provide on-ground technical assistance to workers post-training. David developed an initial 8-hour training package that he has delivered to most clinicians providing mental health or drug treatment services. He is currently rolling out a 20-hour motivational interviewing follow-up package. Technical assistance involves the specialist worker working on-site with agencies or clinicians to work through any in-practice difficulties in delivering integrated treatment.

### **Suitability to own practice:**

David very kindly provided an overview of his training packages and these will contribute to training offered by Eastern Hume Dual Diagnosis Service. David sees benefit in cross-training substance treatment and mental health clinicians. I thought that the strategy of having a worker dedicated to providing technical assistance was valuable.

<b>Visit No: 17 cont.</b>	<b>Organisation: <a href="#">ValueOptions</a> Maricopa County, Arizona</b>
<b>Date: 24/11/03</b>	

**Suitability to Victorian healthcare system:**

This visit further underlined that top-down support, directives and incentives serve to complement bottom-up initiatives and are crucial to achieving system change.

Use of a range of outside consultants has substantially informed and expedited Arizona's efforts to provide improved treatment for co-occurring disorders.

Whilst the ASAM criteria may not translate unmodified to the Victorian context the development of similar criteria tailored to the Victorian situation has the potential to provide goals for agencies to work towards in seeking to improve their responsiveness to co-occurring disorders. Such criteria may also contribute to a common language across mental health and drug treatment service providers and agencies.

There may be value in developing and refining Victoria's ability to monitor the costs across multiple systems associated with persons with co-occurring disorders in order to provide a benchmark against which we can measure the effects of changes in the treatment system's response to co-occurring disorders.

<b>Visit No: 18</b>	<b>Key informant:</b> <a href="#">Melissa Smith</a> <b>Manager</b> <b>Co-occurring Disorders Treatment Programs</b> <a href="#">EMPACT Suicide Prevention Centre</a>
<b>Date: 24/11/03</b>	

**Summary of organisation's co-occurring disorders-related role/activities:**

EMPACT is a community, non-profit behavioural health agency that provides counselling, crisis intervention, prevention and aftercare services to Arizona, adolescents, adults and families. EMPACT have developed a range of programs targeting co-occurring disorders in adults and adolescents. All programs target the high frequency type co-occurring mental health disorders and EMPACT views these programs as Dual Diagnosis Capable rather than Dual Diagnosis Enhanced (see Appendix 1 - ASAM criteria)

**Activities undertaken during visit:**

On this visit I conducted an Interview with Melissa Smith and Michelle Ryan, was taken on a tour of EMPACT's facility and, in the evening, sat in on an adolescent's group

**Key lessons learned:**

EMPACT's treatment approaches include cognitive-behavioural therapy and motivational enhancement therapy from a strengths-based, solution-focused, family systems perspective.

Melissa provided an overview of EMPACT's range of co-occurring disorders programs ...

**Adolescent programs:**

1. [Teen Substance Abuse Treatment Program \(TSAT\)](#)

TSAT targets adolescents with co-occurring disorders with 3-months of intensive outpatient services. Services include group, individual, and family counselling, urinalysis and transportation. Psychiatric and 24-hour crisis services are available and there is a 6-month aftercare component.

TSAT has been evaluated by the University of Arizona (Stevens, Estrada, Carter, Reinardy, Seitz, Swartz, 2003)

A manual for TSAT, co-authored by Melissa Smith, is downloadable from [here](http://www.chestnut.org/LI/bookstore/Blurbs/Manuals/ATM/ATM109-EMPACT.html)

2. [Healthy Connections](#)

Aims to decrease incidence of blood borne viruses amongst high-risk youth using an education and awareness approach (3 group and 4 individual sessions)

3. [Families F.I.R.S.T.](#)

Run in partnership with [TERROS](#), Families F.I.R.S.T. is a component of a collaboration of substance abuse treatment professionals with child welfare specialists to provide services to families in the child welfare system. The

<b>Visit No: 18 cont.</b>	<b>Key informant: <a href="#">Melissa Smith</a> <a href="#">EMPACT</a></b>
<b>Date: 24/11/03</b>	

service provides intensive outpatient services to clients with co-occurring mental health and substance related disorders as part of a continuum of community-based substance abuse treatment services.

4. The A.W.A.R.E. Program

AWARE is a 12-week program for adolescents in need of outpatient substance related and behavioural health services. AWARE offers weekly group counselling and fortnightly individual/family therapy, psychiatric evaluations and medication monitoring. The AWARE program aims to enhance resiliency and hence decrease substance use.

5. Drug Diversion Program

The diversion program is a 10-week substance abuse program for teens referred by their Probation Officers for services because of a felony offense due to substance use. Typical presenting issues include: marijuana use, truancies, fighting in school, anger management difficulties, poor family relationships, depression, and impulsivity.

**Adult programs**

6. Adult Substance Abuse Treatment Program

4-month intensive outpatient program for person with co-occurring disorders offering individual, group and family counselling, psychiatric assessment, medication monitoring, transportation, case management, stress management, peer mentoring, life skills training, family support services, anger management, employee assistance, coping skills/awareness of triggers, and connecting the client into the community.

7. C.O.O.L. Program

10-week program targeting high-risk offenders on parole from the Arizona Department of Corrections (ADC) with substance abuse and mental health disorders needs. Clients index-offence must have been substance related.

**Suitability to own practice:**

It was a learning experience for me to have an overview of and observe the work of an agency that has developed particular expertise in engaging and providing services to adolescents with complex needs.

**Suitability to Victorian healthcare system:**

The [TSAT program model](#) could inform the design of Victorian initiatives seeking to engage and treat adolescents with complex needs.

<b>Visit No: 19</b>	<b>Key informant:</b> <b>Samantha Scheiss</b>
<b>Date: 25/11/03</b>	<a href="#"><u>Northern Arizona Regional Behavioural Health Authority</u></a>

**Summary of organisation’s / informants co-occurring disorders-related role/activities:**

The Northern Arizona Regional Behavioural Health Authority (NARBHA) is a non-profit, managed behavioral health care organization that serves as the Regional Behavioral Health Authority for northern Arizona. Its role is to plan, develop, implement and administer comprehensive mental health and substance abuse services to adults and children through a provider network in the five northern counties of Arizona. NARBHA covers a huge geographic area - over 62,000 square miles with large distances between centres.

Samantha Scheiss has overseen the implementation of Arizona Integrated Treatment process for NARBHA.

**Activities undertaken during visit:**

I interviewed Samantha via video conference from the offices of the Arizona Department of Health, Division of Behavioural Health. Michelle Ryan participated in the interview and we discussed NARBHA’s approach to, and experiences in, facilitating integrated treatment for co-occurring disorders in a substantially rural and remote environment.

**Key lessons learned:**

Samantha has a strong focus on stakeholder ‘buy-in’ to an initiative, describing buy-in as stakeholder investment and enthusiasm for an initiative. She notes that it will not necessarily be management in an individual agency that will have the most buy-in to a new initiative and that skills in managing upwards as well as downwards may be important.

NARBHA instituted a regional integrated treatment panel within a month of the commencement of the statewide panel. The regional panel was charged with developing a regional implementation plan that fitted local needs and structures. The regional plan took a full year to develop with participation from all stakeholders. While the statewide implementation plan was a valuable resource in the development of the regional plan the local panel participants decided to set two, achievable goals to focus on initially. They broke these goals up into steps, with outcome indicators, to end up with a compact, achievable starting area.

NARBHA also employed a train the trainer model for their training rollout. Samantha hand-selected participants from individual agencies on the basis of their ‘buy-in’ to the philosophy of integrated treatment. Trainers then went back and trained their own and one other agency using a model of each training team comprising a substance abuse and a mental health worker.

<b>Visit No: 19</b>	<b>Key informant: Samantha Scheiss NARBHA</b>
<b>Date: 25/11/03</b>	

The trainers group purchased the University of Tucson co-occurring disorders training videos and edited those to versions to be used in their own training activities. A local strategy has been to incorporate some measure of co-occurring disorders training into the routine orientation process for new workers.

A local strategy was to target the clients with the most complex needs first. Samantha noted that measurable successes such as fewer admissions and enhanced compliance are influential in encouraging providers to offer routine integrated treatment.

Samantha noted that psychiatrists are an essential group to target to ensure that they have sufficient buy-in to providing integrated treatment. It may be necessary to have specific initiatives targeting their particular training needs. The Arizona conference with speakers such as Dr Minkoff and Dr MeeLee was influential in achieving psychiatrist buy-in.

Samantha also noted that Arizona's Division of Behavioural Health top-down commitment to integrated treatment had been instrumental in the success of the initiative. She framed system change as a process in which agencies will be at different stages at any one time. It is important to address agencies where they are at any one time; to celebrate successes at the same time as looking to what the next goal is and what are the achievable steps to reach that goal.

Samantha also cited [The Change Book: A Blueprint for Technology Transfer](#) as a particularly valuable resource in planning system change (see textbox page 90) Many of the local cadre of trainers and management attended training facilitated by one of the authors, Dr Dennis McCarty, at the University of Arizona. <http://www.nattc.org/resPubs.html>

**Suitability to own practice:**

I have been impressed by the clear strategies offered in The Change Book and Samantha's analysis of stakeholder buy-in as crucial to effecting systemic change.

**Suitability to Victorian healthcare system:**

The model of regional integrated treatment panels being charged with developing a regional implementation plan appears to be an effective manner of gaining widespread stakeholder buy-in and tailoring the adoption of integrated treatment to local conditions.

Samantha described psychiatrists as the most crucial group to have buy-in to providing integrated treatment because of their oversight and responsibility for clinical delivery and this appears to be as true for Victoria as for Arizona. Psychiatrist-specific co-occurring disorders training initiatives should be considered a priority for Victorian psychiatrists

**Addiction Technology Transfer Centers**  
**[The Change Book: A Blueprint for Technology Transfer](#)**

- The Change Book is a free-to-[download](#) text from the Addiction Technology Transfer Centers. Go to <http://www.nattc.org/resPubs.html>
- The Change Book is designed to help implement change initiatives aimed at improving prevention and treatment outcomes. The manual is designed for administrators, staff, educators and policy makers to build their skills in implementing change within agencies.
- Whilst it has wide applicability the manual has arisen from the drug treatment field (SAMHSA grant). Some of the material uses initiatives addressing co-occurring disorders as case studies. The manual offers *Principles, Steps, Strategies* and *Activities* for achieving effective change
- The manual lists a number of elements necessary for the adoption of change. These include policies that provide incentives for adopting innovative changes.
- The manual rests on a *stages of change* analysis of each level of a system. It suggests strategies for addressing multiple levels of an organisation, addressing resistance to change and maintaining changes once they are established.

<b>Visit No: 20.</b>	<b>Organisation:</b> <a href="#">The Village Integrated Services Agency</a> Los Angeles <a href="#">California</a>
<b>Date: 26/11/03</b>	

<b>Key informants</b>	
<b>Gary Barbagallo</b>	<b>Personal Service Coordinator The Village Integrated Services Agency</b>
<b>Guyton Colantuono</b>	<b>Director Transition Age Youth Program The Village Integrated Services Agency</b>
<b>John Travers</b>	<b>Community Integration Specialist The Village Integrated Services Agency</b>
<b>Paul Barry, M.Ed., CPRP</b>	<b>Associate Director The Village Integrated Services Agency</b>
<b>Rob Shapiro</b>	<b>Personal Service Coordinator The Village Integrated Services Agency</b>
<b>Sara Ford</b>	<b>Training Coordinator The Village Integrated Services Agency</b>

**Summary of organisation’s co-occurring disorders-related role/activities:**

The Village is a large, inner-city, [multi-award winning](#), mental health, psychosocial rehabilitation and treatment agency. The Village was initially established around 1990 as a demonstration of the best mental health service possible and, since then, has been one of the USA’s most innovative mental health providers. It has a focus on integrating the delivery of services to meet each member's distinct employment, housing, psychiatric, health, recreation and financial choices. The Village operates from a strengths-based, whole-person, health-focused philosophy. Its website offers [a range of resources and information around its integrated service model](#).

The Village has 3 Intensive Case Management teams each staffed by 6 Personal Service Coordinators and each with a case load of about 17 people. Working in a collaborative, non-hierarchical style Village workers aim to create a high-risk/high-support environment that promotes hope and the recovery process (Ragins, n/d). The Village employs a comprehensive suite of outcome measures for people with severe and persistent mental illness. The Village offers training on a variety of topics including co-occurring disorders - "[The Jedi Master Approach to Dual Diagnosis](#)"

**Activities undertaken during visit:**

On this visit I attended a whole-of-community meeting; conducted an interview with Paul Barry; an interview and lunch with Guyton Colantuono, Rob Shapiro, and John Travers; an interview with Gary Barbagallo and conversations with Sara Ford.

<b>Visit No: 20 cont.</b>	<b>Organisation:</b> <a href="#">The Village</a> <b>Los Angeles</b>
<b>Date: 26/11/03</b>	

**Key lessons learned:**

I found The Village to be quite an extraordinary place to visit; the substantially upbeat, pervading culture is one of optimism, celebration, collaboration and partnership between members and service providers. Service providers work from a perspective of the members, their own and the agencies interacting journeys. Guyton, John and Rob traced for me the Village's evolution in its approach to member's co-occurring substance use disorders. They described moving from a strong abstinence focus to a more flexible, harm-reduction approach (that may ultimately result in abstinence) and reflected positively on the health-benefits, honesty and engagement with members that resulted from the latter approach. Guyton, John and Rob have used a range of strategies to promote a flexible staff approach to member's substance use disorders.

The Village has employed the four-stage (engagement, persuasion, active treatment and relapse prevention) model to address co-occurring disorders and have identified co-occurring disorders as the most important area on which to focus future staff trainings.

**Suitability to own practice:**

The Villages positive, collaborative approach to integrated psychosocial rehabilitation has substantially broadened my appreciation of possible approaches to psychosocial rehabilitation.

**Suitability to Victorian healthcare system:**

The Villages approach to psychosocial rehabilitation, incorporating a comprehensive integrated array of services, has the potential to inform and enhance Victorian psychosocial rehabilitation initiatives.

**United States of America**  
**Further Reading & Resources**

Arizona Department of Health Services, Division of Behavioural Health Services. (2002) [Practice Improvement Protocol 6 Co-occurring psychiatric and substance disorders](http://www.hs.state.az.us/bhs/guidance/co_occur.pdf)  
[http://www.hs.state.az.us/bhs/guidance/co\\_occur.pdf](http://www.hs.state.az.us/bhs/guidance/co_occur.pdf)

Louis de la Parte Florida Mental Health Institute (2002) [Co-occurring Disorders Treatment Manual](http://mhlp.fmhi.usf.edu/sparc/documents/manuals.htm) and the [Co-occurring Disorders Treatment Workbook](http://mhlp.fmhi.usf.edu/sparc/documents/manuals.htm) University of South Florida.  
<http://mhlp.fmhi.usf.edu/sparc/documents/manuals.htm>

Minkoff, K. (2001) [Behavioural health recovery management: Service planning guidelines - Co-occurring psychiatric and substance disorders](http://www.bhrm.org/guidelines/Minkoff.pdf)  
<http://www.bhrm.org/guidelines/Minkoff.pdf>

National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors. (2002). [Exemplary Methods of Financing Integrated Service Programs for Persons with Co-Occurring Mental Health and Substance Use Disorders](http://www.samhsa.gov/reports/congress2002/App_III.pdf). Final Report of the NASMHPD-NASADAD Task Force on Co-Occurring Disorders. Authors: Alexandria, VA and Washington, D.C.  
[http://www.samhsa.gov/reports/congress2002/App\\_III.pdf](http://www.samhsa.gov/reports/congress2002/App_III.pdf)

SAMHSA (2003) [Strategies for Developing Treatment Programs for People With Co-Occurring Substance Abuse and Mental Disorders](http://www.nccbh.org/cooccurringreport.pdf) U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration  
<http://www.nccbh.org/cooccurringreport.pdf>

SAMHSA (2002) [Report to congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders](http://www.samhsa.gov/reports/congress2002/) U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration  
<http://www.samhsa.gov/reports/congress2002/>

SAMHSA (1998) [Implementing Interventions for Homeless Individuals With Co-Occurring Mental Health and Substance Use Disorders](http://pathprogram.samhsa.gov/pdf/implementing_interventions.pdf)  
[http://pathprogram.samhsa.gov/pdf/implementing\\_interventions.pdf](http://pathprogram.samhsa.gov/pdf/implementing_interventions.pdf)

Treatment Improvement Protocol (TIP) Series [Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse,](#)

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## **Section 3.2.**

### **New Zealand Visits**

**1/12/03 to 6/12/03**

<b>Visit No: 21.</b>	<b>Organisation:</b> <a href="#"><u>Odyssey Residential Dual Diagnosis Programme</u></a> <b>Auckland</b> <b>New Zealand</b>
<b>Date: 02/12/03</b>	

<b>Key informants</b>	
<b>Odyssey residents</b>	<b>Dual Diagnosis Programme</b>
<b>Duncan Paul</b>	<b>Team Leader, Dual Diagnosis Programme</b>
<b>John Challis</b>	<b>General Manager, Odyssey, New Zealand</b>

**Summary of organisation’s co-occurring disorders-related role/activities:**

Odyssey New Zealand provides specific therapeutic communities for adolescents, general adults and persons with co-occurring disorders in Auckland. Odyssey Residential Dual Diagnosis Programme is a modified therapeutic community designed for persons with co-occurring disorders. The programme requires a commitment to abstinence.

The Dual Diagnosis Programme has a capacity for 15 resident adults plus 3 to 4 clients in the re-entry phase who live in the community. The program incorporates groups, individual counseling, family therapy, and behaviour modification. Each resident is responsible for daily tasks, engages in vocational projects, and is involved in recreational activities. Urine tests are conducted 3 times per week.

**Activities undertaken during visit:**

On this visit I conducted individual interviews with 2 residents, an interview with John Challis, an interview with Duncan Paul. I sat in on a participant’s meeting and on a staff client review/supervision session.

**Key lessons learned:**

**Interview with John Challis, General Manager, Odyssey, New Zealand:**

John has been closely involved with the Dual Diagnosis Programme since its inception and he outlined the history of the unit to me. Since Odyssey House began in the 1960’s it has had a focus on addressing whatever mental health disorder were co-existing with client’s substance use disorders. Two distinct client subsets have been those with Axis II disorders (DSM-IV, 1994) and those with serious mental illness. Tensions about the different expectations on these two client groups provided some of the impetus for the development of a specialist, modified therapeutic community for persons with serious mental illness-type co-occurring disorders. The Dual Diagnosis Programme has been operational since 1995.

<b>Visit No: 21 cont.</b>	<b>Organisation:</b> <a href="#"><u>Odyssey Residential Dual Diagnosis Programme</u></a>
<b>Date: 02/12/03</b>	

### **Interviews with residents**

One of the residents was a senior member of the community while the other was in the late-assessment phase. One of the residents had substantial experience of New Zealand mental health facilities and the other resident had experience of previous, substance-specific, residential rehabilitation facilities.

Both residents reflected positively about their involvement with the dual diagnosis programme.

Positives identified about the program included...

- The stepped, graduated, approach – *“always feels as though you are moving and there is a clear goal to be going for”*
- The consistency of the rules – *“as against mental health places where it feels as though the rules are being made up as you go along”...“you’re going to get pretty much the same response whichever staff member you approach”*
- There is a structure and a process to deal with any issues that arise. Both clients were very positive about the conflict resolution process, framing it as a skill-acquisition opportunity.
- The length of the program. One client felt that his previous 3-month, substance-treatment programs had been too brief to gain an enduring benefit from.
- Addressing both disorders together was cited by both informants as unusual and a positive experience.
- Staff commitment
- Development of an individual relapse prevention plan as a living document addressing both disorders was considered to be a valuable, practical working tool.

### **Interview with Duncan Paul**

Duncan described the evolution of the community since 1995. He observed that, in initially modifying the structure, they moved too far away from some of the key therapeutic principle of therapeutic communities and had now moved back to becoming more linked with those key principles.

Duncan cited examples of...

- the approach of having senior community members acting as role models, fully involved in and responsible for the process of supporting people and dealing with issues within the community,
- the approach of having very clear explicit criteria for people moving through treatment, of having high expectations around resident’s progress and their behaviour in the community.

Both of these approaches have been emphasised much more strongly over the last 5 to 6 years, more in line with a traditional therapeutic community.

They have found that the community responds well to such expectations.

Duncan observed that the community culture has developed into a very strong prosocial culture over that period – able to deal with new people coming in, to deal suitably with any antisocial or self defeating behaviours and to get new people on board and engaged with treatment quickly.

<b>Visit No: 21 cont.</b>	<b>Organisation:</b> <u><a href="#">Odyssey Residential Dual Diagnosis Programme</a></u>
<b>Date: 02/12/03</b>	

Duncan discussed the speciality skills needed to work with clients with serious mental illness in a therapeutic community environment and the reasons why non-speciality therapeutic communities struggle to incorporate persons with severe mental illness. Duncan noted the importance of staff having the skills to recognise the differences between behaviours, symptoms and the 'bits in between'. He observed that it is easier to do this consistently in a smaller community - in a larger community it may be difficult to do this or staff with these skills may be spread too thinly.

Duncan described the treatment pathway....

- Referrals are most commonly from Community Mental Health Teams but also from forensic facilities, private psychiatrists and self-referral
- Initial assessment phase lasts 4 to 8 weeks. Phase-specific tasks include assessment and stabilisation of mental state, working with resident's motivation and any behavioural issues. At the end of this phase clients meet a representative sample of the community and put their case for joining the community. Some level of insight into both disorders and commitment to the process is required.
- Levels 1 to 4: From that point the resident will graduate through four levels of treatment over a 13-month to 2-year period. These levels have been designed using a psychosocial development model and each level has specific developmental tasks associated with it. In Level 4 clients will move out into the community while remaining in treatment.
- Graduates group is held once a month and graduates are welcome to drop-in.

Whilst there is some flexibility the average length of stay is around 18 months. A maximum stay of 2 years is in place for both therapeutic and economic reasons.

Duncan described the importance of attending to getting the staff culture right and maintaining consistency – good outcomes are dependant upon having a well trained and experienced staff team who can sustain and develop that culture within the community. He noted that such a therapeutic community 'will never be a franchise operation' because the personalities of the persons directing the process has such a large effect on the outcomes

Duncan observed that while it is important to get consistency with the key rules and the application of those rules that too many rules will only serve to wear people out – part of the process is encouraging people to work out their own strategies for dealing with situations.

In concluding Duncan noted that the work can be very satisfying because of the opportunity to see the whole person. He reflected that while the team currently operate with a strong sense of confidence they are always seeking new ideas to enhance the process.

<b>Visit No: 21 cont.</b>	<b>Organisation:</b> <a href="#"><u>Odyssey Residential Dual Diagnosis Programme</u></a>
<b>Date: 02/12/03</b>	

**Suitability to own practice:**

I was particularly struck by staff observations around members responding well to high-expectations and of the approach of providing clear criteria and expectations for each phase of treatment.

**Suitability to Victorian healthcare system:**

There are currently few Victoria programmes run on therapeutic community principles that offer integrated treatment of co-occurring serious mental illness and substance use disorders. The establishment of such a facility in Victoria would contribute substantially to the continuum of treatment options for persons with co-occurring disorders. The success of establishing such a facility would depend on its ability to attract staff with experience and expertise in facilitating a programme with good fidelity to the therapeutic community model.

<b>Visit No: 22.</b>	<b>Key informant: Joanne Labrow Clinical Nurse Specialist Lakes District Health Board Rotorua</b>
<b>Date: 04/12/03</b>	

**Summary of informant's co-occurring disorders-related role/activities:**

Joanne provided dual diagnosis training for MIND in the United Kingdom and co-authored the MIND guide: [Understanding Dual Diagnosis](#) (Phillips, Labrow, 1998). Joanne has recently authored a proposal to Lakes District Health Board for a specialist co-occurring disorder's project (Labrow, 2003)

**Activities undertaken during visit:**

On this visit I sat in on Lakes DHB training on methamphetamine and conducted an interview with Joanne

**Key lessons learned:**

**New Zealand co-occurring disorders initiatives**

Joanne described how New Zealand drug treatment and mental health services articulate. Funding comes from a single central agency to local District Health Boards who allocate funding to (usually) structurally-divided, local mental health and drug treatment agencies. Whilst there are specialist dual diagnosis workers in New Zealand these positions are usually initiatives of local District Health Boards. Most of these positions have a strong clinical focus, working from a case management rather than a co-case management model. Most also provide some amount of consultation and training services.

Joanne described the Odyssey Residential Dual Diagnosis Programme and also cited the NZ Ministry of Health guidelines for the management of patients with co-existing psychiatric and substance use disorders ( [available here](#) ) (MoH, 1994)

[http://www.moh.govt.nz/moh.nsf/c7ad5e032528c34c4c2566690076db9b/abbcbd786b0d972bcc256b7f00781d04/\\$FILE/Guiddisor.pdf](http://www.moh.govt.nz/moh.nsf/c7ad5e032528c34c4c2566690076db9b/abbcbd786b0d972bcc256b7f00781d04/$FILE/Guiddisor.pdf)

**Proposed facilitative model**

Joanne described the model that she has proposed to Lakes District Health Board. The model aims to assist generic services in dealing with persons with co-occurring disorders.

The model incorporates

- consultation /liaison to primary and secondary services
- education and training
- clinical supervision
- research around the effectiveness of the training

Because of Rotorua's size the project has the potential to provide some level of training to most of the key agencies that provide services to persons with co-occurring disorders. The project has been approved and job ads will be posted soon. It is hoped that the project will highlight any service gaps.

<b>Visit No: 22 cont.</b>	<b>Key informant: Joanne Labrow Rotorua</b>
<b>Date: 04/12/03</b>	

### **Other topics**

Joanne stated that in her assessment the success of any initiative attempting to promote integrated treatment is dependent on its ability to obtain 'buy-in' from medical staff and psychiatrists.

Joanne described a conflict in the philosophies of drug treatment and mental health systems that may be a tension in bringing the systems closer together – drug treatment necessarily has a focus on self-responsibility whereas mental health services can tend towards a more paternalistic approach. Drug treatment tools such as decisional matrixes are likely to be valuable to mental health treatment services.

We discussed the systemic differences between the USA's health system and the more nationalised systems of New Zealand, Australia and the United Kingdom. Joanne's perception is that these differences limit the generalisability of some of the co-occurring disorders research and treatment models that have come from the USA.

Dr Minkoff lectured in New Zealand in 1999 and this visit continues to be influential in New Zealand deliberations around co-occurring disorders. An [overview of Dr Minkoff's New Zealand presentations](http://www.alcohol.org.nz/resources/newsletters/saywhen/may99-1.html) is available on the web. <http://www.alcohol.org.nz/resources/newsletters/saywhen/may99-1.html>

Joanne described her approach to providing dual diagnosis training for MIND in the UK. She would incorporate demonstrations of drug use and found that such approaches, for some audiences, took some of the mystery out of substance use and contributed to clinician's sense of self-efficacy in treating substance use disorders.

Joanne identified deficiencies in either drug treatment or co-occurring disorders components in a range of undergraduate courses.

Joanne's hope for co-occurring disorders is that it will eventually melt into a more holistic approach where service providers are able and willing to meet people where they are rather than by the diagnosis that they have been given.

### **Suitability to own practice:**

Joanne's observations around co-occurring disorders, informed by her experiences working in a number of healthcare systems, helped clarify some of the issues faced by different countries in addressing co-occurring disorders.

### **Suitability to Victorian healthcare system:**

As with a number of other key informants Joanne identified the issue of incorporating more drug treatment and co-occurring content in a range of undergraduate courses as crucial to improving the longer-term system response to persons with co-occurring disorders

**New Zealand**  
**Further Reading & Resources**

New Zealand Ministry of Health (1994) [Guidelines for the management of patients with co-existing psychiatric and substance use disorders](http://www.moh.govt.nz/moh.nsf/c7ad5e032528c34c4c2566690076db9b/abbcbd786b0d972bcc256b7f00781d04/$FILE/Guiddisor.pdf)  
[http://www.moh.govt.nz/moh.nsf/c7ad5e032528c34c4c2566690076db9b/abbcbd786b0d972bcc256b7f00781d04/\\$FILE/Guiddisor.pdf](http://www.moh.govt.nz/moh.nsf/c7ad5e032528c34c4c2566690076db9b/abbcbd786b0d972bcc256b7f00781d04/$FILE/Guiddisor.pdf)

Selman, D., Todd, F., Robertson, P. (1998) [Assessment and management of co-existing substance use and mental health disorders](http://www.chmeds.ac.nz/departments/psychmed/treatment/research.html)  
A comprehensive and informative report on a dual diagnosis project conducted by of New Zealand's National Addiction Centre. The report provides practical guidelines for clinicians and services.  
<http://www.chmeds.ac.nz/departments/psychmed/treatment/research.html>

Taranaki District Health Board [Coexisting Disorders and Dual Diagnosis](http://www.mentalhealthinsight.org.nz/drugs_alcohol/dual_diagnosis.html)  
Fact sheet. [http://www.mentalhealthinsight.org.nz/drugs\\_alcohol/dual\\_diagnosis.html](http://www.mentalhealthinsight.org.nz/drugs_alcohol/dual_diagnosis.html)



**Section 4**

**Improving the Victorian healthcare system**

### **What impact will the study have on my own practice/on my organisation?**

I am employed by the Division of Psychiatry, Northeast Health, Wangaratta as part of the state-wide specialist co-occurring disorders workforce. My role is to provide consultation, education and training and some direct service delivery to drug treatment and mental health agencies and clinicians in the North East of Victoria. The overall aim of the service is to achieve better outcomes for persons with co-occurring mental health and substance use disorders.

The study has given me the opportunity to compare a range of approaches to improving the treatment responses to co-occurring disorders; to analyse their strengths and assess how they may fit in the context of the North East Victorian and Victorian treatment systems. I have a more defined vision of the possible improved outcomes and potential cost savings associated with implementing integrated treatment and of strategies to achieve integrated treatment. The learning that the study has provided will be pivotal to my future approaches to achieving better outcomes.

As a direct result of my fellowship experiences my practice will incorporate

- a range of strategies to promote the buy-in of key stakeholders in moving to more integrated treatment of co-occurring disorders
- more global use of the stages of change model in analysing systemic and clinician readiness to provide integrated treatment of co-occurring disorders
- an increased focus on strategies to address precontemplation / assist change
- a greater focus on evaluation of the effects of my practice

### **What steps will you undertake in the short to medium term to improve the Victorian healthcare system?**

I am attempting to work relevant strategies and approaches gleaned from fellowship visits and associated study into the Eastern Hume Dual Diagnosis Initiative. I will describe and disseminate outcomes of this activity as they occur.

As a result of fellowship activities I have identified a quantity of resources that may contribute to co-occurring disorders capacity building and have distributed these resources to relevant local, Victorian and Australian stakeholders. I am maintaining links with a number of key informants and continuing our discussions around approaches to improving the response to persons with co-occurring disorders. I shall continue to disseminate resources and approaches, identified as a result of this activity, to relevant stakeholders.

See section 5: *Sharing and promoting the project.*



## **Section 5**

### **Sharing and promoting the project**

**What are the activities that I will undertake to share and promote the outcome of the fellowship?**

Since my return from fellowship travel I have discussed study outcomes with a range of Victorian and Australasian workers involved in healthcare system co-occurring disorders capacity building. I have been asked to speak to a variety of Victorian groups about study activities and findings. I shall respond to such requests where possible.

I have submitted an abstract to the Australian and New Zealand College of Mental Health Nurses International 30<sup>th</sup> Conference around integrated treatment.

I shall electronically disseminate this current report to local, Victorian, Australasian and international stakeholders and informants.

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**Section 6**  
**Appendices**

# Appendices

## Appendix 1

<b>American Society of Addiction Medicine ASAM Patient Placement Criteria Overview</b>	112
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## Appendix 2

### **Key informant's co-occurring disorders-related publications**

Prashant Phillips	114
Hermine Graham	115
Dr Bert Pepper	117
Dr Ken Minkoff	119
New Hampshire Dartmouth Psychiatric Research Centre	122
Melinda Fox	135
David Lynde	136
Dr Doug Noordsy	137
Paul Gorman	140

## American Society of Addiction Medicine

### ASAM Patient Placement Criteria

The Patient Placement Criteria of the American Society of Addiction Medicine (ASAM PPC) 2000 edition offered guidelines to programs on how to improve the assessment process, staff expertise, and service design to better meet the needs of persons with co-occurring disorders. Primarily focused on addiction services these criteria have been widely-adopted and are influential in the USA as a service planning tool.

Program capabilities are defined as being of three types:

- Addiction-Only Services (AOS),
- Dual Diagnosis Capable (DDC)
- Dual Diagnosis Enhanced (DDE)

**AOS services** cannot treat persons with psychiatric illnesses no matter how stable the illness.

**DDC services** *routinely accept individuals who have co-occurring disorders so long as their psychiatric disorders are sufficiently stabilized and the individuals are capable of independent functioning to such a degree that their mental disorders do not interfere with participation in addiction treatment* (MeeLee, n/d)

Measurable criteria defining DDC status include:

- the agencies mission and philosophy
- routine screening for comorbidity
- assessment\_incorporating psychiatric illness
- access to mental health treatment beyond the capabilities of the program
- diagnosis and treatment planning incorporating the psychiatric diagnoses
- documentation indicating monitoring of the psychiatric disorder
- programming including sessions addressing mental illness
- medication policies
- psychiatric emergency policies
- access to mental health consultation
- collaboration with mental health provider agencies
- competencies
- discharge planning ([Minkoff, 2001](#))

**DDE services** *“can accommodate individuals with dual diagnoses who may be unstable or disabled to such an extent that specific psychiatric and mental health support, monitoring and accommodation are necessary in order for the individual to participate in addiction treatment... not so acute or impaired as to present a severe danger to self or others, nor do they require 24-hour, intensive psychiatric supervision”* (MeeLee, n/d)

To meet criteria for DDE status agencies must:

- meet all DDC criteria
- have higher staffing levels including specialist mental health staff and a

licensed prescriber with training in psychopharmacology.

- on site availability of mental health supervision
- smaller group sizes and more flexible expectations
- specific mental health symptom management
- documentation of interventions targeting client's mental health symptoms
- collaboration with mental health treaters, and involvement of those treaters in treatment planning
- program materials adapted to individuals with psychiatric impairment
- policies supporting welcoming return for individuals unable to complete treatment
- increased availability of individual counseling and case management.

([Minkoff, 2001](#))

Dr Kenneth Minkoff has proposed the creation of parallel categories for mental health programs: **Dual Diagnosis Capable- Mental Health** (DDC- MH) and **Dual Diagnosis Enhanced – Mental Health** (DDE-MH) together with measurable criteria for such programs ([Minkoff, 2001](#) ).

<b>Appendix 2</b> <b>Key informant's co-occurring disorders-related publications</b>
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<b>Prashant Phillips</b>
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A more complete list of Prashant Phillip's publications is [available here](http://www.ucl.ac.uk/psychiatry/staff/rejupph.htm)  
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<b>Appendix 2</b> <b>Key informant's co-occurring disorders-related publications</b>
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<b>Hermine Graham</b>
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A more complete list of Hermine Graham's publications is [available here](#)

<http://147.188.20.137/staff/FMPro?-db=staff.fp5&-format=wp.htm&-lay=main&-sortfield=sc2&-op=neq&sc2=xx&-max=2147483647&-recid=32915&-find>

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Maslin, J., Graham, H., Cawley, M., Copello, A., Birchwood, M., Georgiou, G., McGovern, D., Mueser, K., Orford, J. (2001). Combined severe mental health and substance use problems: What are the training and support needs of staff working with this client group? Journal of Mental Health, 19 (2), 131-140.

Graham, H., Maslin, J. (2002). Problematic cannabis use amongst those with severe mental health problems in an inner city area of the UK. Addictive Behaviors, 26, 261-273.

Graham, H., (2002). Project update: The combined psychosis and substance use (COMPASS) programme. Acquire, Alcohol Concern, 33.

Graham, H., Copello, A., Birchwood, M., Orford, J., McGovern, D. Georgiou, G., Godfrey, E. (2003). Co-existing severe mental health and substance use problems: Developing integrated services in the U.K. Psychiatric Bulletin, 27,183-186

<b>Appendix 2</b> <b>Key informant's co-occurring disorders-related publications</b>
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<b>Dr Bert Pepper</b>
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A more complete list of Dr Pepper's publications is [available here](http://www.bertpepper.com/cv.html)  
<http://www.bertpepper.com/cv.html>

### **Books**

Ryglewicz, H., Pepper, B. (1996) [Lives at risk: Understanding and treating young people with dual disorders](#). Free Press, New York.

### **Booklets**

Ryglewicz, H., Pepper, B. Alcohol, Drugs, and Mental/Emotional Problems: What You Need To Know to Help Your Dual Disorder Client. The Information Exchange. New York.

Ryglewicz, H., Pepper, B. Alcohol and street drugs: What parents need to know. The Information Exchange. New York.

Ryglewicz, H., Pepper, B. Alcohol and Street Drugs: Time for a Choice. (Client version). The Information Exchange. New York.

### **Reports**

Pepper, B. (1997) [Action for mental health and substance related disorders: Improving services for individuals at risk of, or with, co-occurring substance related and mental health disorders](http://www.toad.net/~arcturus/dd/pepptoc.htm#toc). Conference Report and Recommended National Strategy of the SAMHSA National Advisory Council.  
<http://www.toad.net/~arcturus/dd/pepptoc.htm#toc>

### **Chapters in books**

Rahav, M., Pepper, B., et al. (1997) Homeless, mentally ill, chemical abusing men in different, community-based treatment programs Chapter in The effectiveness of innovative approaches in the treatment of drug abuse.

Pepper, B., Hendrickson, E. (1996). Working with seriously mentally ill substance abusers, Chapter in Responding to the mental & substance abuse health care needs of persons on community corrections.

Rahav, M., Pepper, B., et al. Bringing experimental research designs into existing treatment programs: The case of community-based treatment of the dually diagnosed. Chapter in Drug Abuse Treatment, Edited by Fletcher, et al.

Drake, R., McLaughlin, P., Pepper, B., Minkoff, K. (1991) [Dual diagnosis of major mental illness and substance disorder](#). Chapter in Minkoff, K., Drake, R.(Eds) New Directions for Mental Health Services Series, No. 50. Josey Bass

McLaughlin, P., Pepper, B. (1991) Modifying the therapeutic community to treat the dually disordered. Chapter in Minkoff, K., Drake, R.(Eds) New Directions for Mental Health Services Series, No. 50. Josey Bass

### **Papers**

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Rahav, M., Pepper, B. (1995). Characteristics and treatment of homeless, mentally ill, chemical-abusing men. Journal of Psychoactive Drugs. Jan.-March, 1995.

Ryglewicz, H., Pepper, B. The dual-disorder client: Mental disorder and substance use. Innovations in Community Mental Health.

Pepper, B. (1991). Mentally ill alcohol & substance abusers: Overview. Lead article in special issue on that topic; The Journal of the California Alliance for the Mentally Ill. Served as issue editor.

Pepper, B. (1991). The information exchange: A resource for diagnosis and treatment of young adults with severe co-morbid disorders. Synapse, November - December

Pepper, B. (1991). The young adult chronic patient and substance abuse. Forum, journal of the Rockland County Mental Health Association, September

<b>Appendix 2</b> <b>Key informant's co-occurring disorders-related publications</b>
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<b>Dr Kenneth Minkoff</b>
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A more complete list of Dr Minkoff's publications is [available here](http://www.kenminkoff.com/pubs.html)  
<http://www.kenminkoff.com/pubs.html>

### **Audiovisual**

Minkoff K. (2000). Integrated model of treatment for dual diagnosis (videotape). Mental Illness Education Project, Boston, MA..

### **Papers**

Minkoff, K. (1987) Resistance of mental health professionals to working with the chronic mentally ill. New Directions for Mental Health Services, Jossey-Bass, 33, 3-20, 1987.

Minkoff, K. (1987). Beyond deinstitutionalization: A new ideology for the post-institutional era. Hospital and Community Psychiatry, 38 (9), 945-950,

Minkoff, K. (1989) Development of an integrated model for the treatment of patients with dual diagnosis of psychosis and addiction. Hospital and Community Psychiatry, 40 (10), 1031-1036, October.

Batten, H., Bachman, S., Higgins, R., Manzik, N., Parham, C., Minkoff, K. (1989). Implementation issues in addictions day treatment. Hospital and Health Services Administration, 34 (3), 427-439. Fall

Drake, R., McLaughlin, P., Pepper, B., Minkoff, K. (1991) Dual diagnosis of major mental illness and substance disorder: An overview. New Directions for Mental Health Services, Jossey-Bass, 50, 3-13,.

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Bachman, S., Batten, H., Minkoff, K., Higgins, R., Manzik, N., Mahoney, D. (1992). Predicting success in a community treatment program for substance abusers. American Journal on Addictions, 1 (2), 155-167.

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Minkoff, K. (2000). An integrated model for the management of co-occurring psychiatric and substance disorders in managed care systems. *Disease Management & Health Outcomes*, 8:250-257.

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Minkoff, K. (2001) Developing standards of care for individuals with co-occurring psychiatric and substance disorders. *Psychiatric Services*, 52:597-99.

Minkoff, K. (2001). Level of care determination for individuals with co-occurring psychiatric and substance disorders. *Psychiatric Rehabilitation Skills*, 5:163-196.

Minkoff, K., Zweben, J., Rosenthal, R., Ries, R. (2002). Developing service intensity criteria and program categories for individuals with co-occurring disorders *Journal of Alcohol and Drug Abuse*. *In press*.

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Minkoff, K. (1996). Dual diagnosis in seriously and persistently mentally ill individuals: An integrated approach. In Vaccaro, J., Clark, G. (eds.) Practicing psychiatry in the community. Washington, DC: American Psychiatric Press, Inc., 221-253.

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Minkoff, K. (1996). Integration of addiction and psychiatric treatment in Miller, N. (Ed.). The principles and practice of addictions in psychiatry. Philadelphia, PA, 191-199.

Minkoff, K. (1997). Resistance of mental health professionals to working with people with serious mental illness. In Spaniol, L., Gagne, C., Koehler, M. (eds.) Psychological and social aspects of psychiatric disability. Boston, MA: Centre for Psychiatric Rehabilitation, 334-347.

Minkoff, K. (1997). Integration of addiction and psychiatric services. In Minkoff, K., Pollack, D. (Eds.). Managed mental health care in the public sector: A survival manual. Amsterdam. The Netherlands: Harwood Academic Publishers, 223-246.

## **Books and Monographs**

Minkoff, K., Drake, R. (eds.) Dual diagnosis of serious mental illness and substance disorder. San Francisco, CA: Jossey-Bass, 1991.

Panel on co-occurring psychiatric and substance disorders, Centre for mental health services managed care initiative (K. Minkoff, Chair). Annotated Bibliography, July 1997.

Panel on co-occurring psychiatric and substance disorders, Centre for mental health services managed care initiative (K. Minkoff, Chair). Co-occurring psychiatric and substance disorders in managed care: Standards of care, practice guidelines, workforce competencies and training curricula, January 1998.

**Appendix 2**  
**Key informant's co-occurring disorders-related publications**

**New Hampshire Dartmouth Psychiatric Research Centre**

**This is an abbreviated, co-occurring disorders-focused, list of NHDPRC publications. A more complete list of NHDPRC publications is [available here](#)**

<http://www.dartmouth.edu/~psychrc/pubs.html>

**Papers and chapters in books:**

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Drake, R., Wallach, M. (1989). Substance abuse among the chronic mentally ill. *Hospital and Community Psychiatry*, 40, 1041-1046.

Osher, F., Kofoed, L. (1989). Treatment of patients with psychiatric and psychoactive substance use disorders. *Hospital and Community Psychiatry*, 40, 1025-1030.

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Drake, R. (1991) Management of schizophrenic patients with substance abuse disorders. Relapse, 1, 3-4.

Drake, R., Antosca, L., Noordsy, D., Bartels, S., Osher, F. (1991). New Hampshire's specialized services for the dually diagnosed. In K. Minkoff & R. Drake (Eds.), Dual Diagnosis of Major Mental Illness and Substance Disorders. (pp. 57-67). San Francisco: Jossey-Bass.

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Drake, R., Osher, F., Wallach, M. (1991). Homelessness and dual diagnosis. American Psychologist, 46, 1149-1158.

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<b>Appendix 2</b> <b>Key informant's co-occurring disorders-related publications</b>
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<b>Melinda Fox</b>
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The following is an abbreviated list of Melinda Fox's co-occurring disorders related publications.

**Papers and chapters in books:**

Noordsy, D., Fox, L. (1991). Group intervention techniques for people with dual disorders. Psychosocial Rehabilitation Journal. Vol 15(2) Oct 67-78.

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Mueser, K., Noordsy, D., Drake, R., Fox, M. (2003). Integrated Treatment for Dual Disorders: A Guide to Effective Practice. New York: The Guilford Press

<b>Appendix 2</b>
<b>Key informant's co-occurring disorders-related publications</b>
<b>David Lynde</b>

Drake, R., Essock, S., Shaner, A., Carey, K., Minkoff, K., Kola, L., Lynde, D., Osher, F., Clark, R., Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. Psychiatric Services. Vol 52(4) Apr. 469-476.

Torrey, W., Drake, R., Cohen, M., Fox, L., Lynde, D., Gorman, P., Wyzik, P. (2002). The challenge of implementing and sustaining integrated dual disorders treatment programs. Community Mental Health Journal. Vol 38(6) Dec. 507-521.

Mueser, K., Torrey, W., Lynde, D., Singer, P., Drake, R. (2003). Implementing evidence-based practices for people with severe mental illness. Behavior Modification. Vol 27(3) Jul. 387-411.

<b>Appendix 2</b> <b>Key informant's co-occurring disorders-related publications</b>
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<b>Dr Doug Noordsy</b>
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A more complete list of Dr Noordsy's publications is [available here](http://www.dartmouth.edu/~psychrc/dougn.html)  
<http://www.dartmouth.edu/~psychrc/dougn.html>

**Books and Monographs:**

Minkoff, K., Noordsy, D., et al. (1998). Co-Occurring psychiatric and substance disorders in managed care systems: Standards of care, practice guidelines, workforce competencies and training curricula. Philadelphia: The Centre for Mental Health Services

Mercer-McFadden C, Drake, R., Clark, R., Vervon, N., Noordsy, D., Fox, T. (1998) Substance abuse treatment for people with severe mental disorders: A program manager's guide. Concord, NH: New Hampshire-Dartmouth Psychiatric Research Centre.

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Noordsy, D., Schwab, B., Fox, L., Drake R. (2002). The role of self-help programs in the rehabilitation of persons with severe mental illness and substance use disorders. In A Comprehensive Guide for Integrated Treatment, edited by D.D. Pita & L. Spaniol. Boston, MA: Centre for Psychiatric Rehabilitation.

### **Journal Articles:**

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Noordsy, D., Drake, R., Teague, G., Osher, F., Hurlbut, S., Beaudett, M., Paskus, T. (1991). Subjective experiences related to alcohol use among schizophrenics. Journal of Nervous and Mental Disease, 179:410-414

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Brunette, M., Noordsy, D., Drake, R. (2003). Benzodiazepine use and abuse by clients with severe mental illness and substance use disorders, *Psychiatric Services* , 54:1395-1401.

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Noordsy, D., Mueser, K., Xie, H., O'Keefe, C. Combining olanzapine, case management and vocational rehabilitation in community mental health care: Symptom, psychosocial and service utilization outcomes.

<b>Appendix 2</b>
<b>Key informant's co-occurring disorders-related publications</b>
<b>Dr. Paul Gorman</b>

Essock, S., Goldman, H., Van Tosh, L., Anthony, W., Appell, C., Bond, G., Dixon, L., Dunakin, L., Ganju, V., Gorman, P., Ralph, R., Rapp, C., Teague, G., Drake, R. (2003) Evidence-based practices: Setting the context and responding to concerns. *Psychiatric Clinics of North America*. Vol 26(4) Dec. 919-938.

Torrey, W., Drake, R., Cohen, M., Fox, L., Lynde, D., Gorman, P., Wyzik, P. (2002) The challenge of implementing and sustaining integrated dual disorders treatment programs. *Community Mental Health Journal*. Vol 38(6) Dec., 507-521.

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