Contrasting approaches to dual diagnosis from Australia and other countries

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VDDI Forum WHAT’S OLD IS NEW AGAIN?
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My 14 years with SUMITT & VDDI

• Primary & Secondary Consultation
• Mentoring & Supervision
• Tertiary Consultation
  – Policy & Procedure development
  – Screening & Assessment
  – Integrated treatment planning
  – “No Wrong Door” service systems
  – Service audits & evaluation
• Training & Education
• 2 websites

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www.dualdiagnosis.org.au
www.dualdiagnosis.ning.com
Victorian Health Department responses to dual diagnosis

- 2007: Victorian Dual Diagnosis Policy
  - Dual diagnosis: Key directions and priorities for service development

- 2012: Chief Psychiatrist’s investigation of inpatient deaths
  - 2008–2010

- 2013: Victorian strategic directions for co-occurring mental health and substance use conditions

- 2014: Victoria’s new Mental Health Act 2014

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I grew up in 2 silos in Victoria

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Parallel treatment

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Exclusion Criteria ‘NOT OUR BUSINESS!’

Routine SCREENING

multi-agency, Joint -ISP

INTEGRATED TREATMENT

Little recognition of co-occurring disorders

Routine INTEGRATED ASSESSMENT

‘1-stop shop’ INTEGRATED TREATMENT

NO WRONG DOOR Service system
Victorian Dual Diagnosis Initiative when I finished up at SUMIT 2014

• High profile
  – High prevalence, ‘the expectation, rather than the exception’

• Widespread screening & assessment

• Low adoption of integrated treatment models
  – Psychiatrists’ and other clinicians attitudes
  – Stigma of AOD misuse
  – Reluctance to adopt ‘No Wrong Door’ or DD as ‘core business’
  – Interprofessional cultural conflicts
  – Few resources to support government policy

Roberts & Mayberry (2014)
What assists clinical services in becoming dual diagnosis capable?

• Clinical leadership
  – Clinical practice changes

• Training & education
  – Acquiring new competencies

• Communication
  – Partnerships & agreements between services

• Institutional support
  – Policies, resource allocation

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What is the international approach to dual diagnosis & integrated treatment ???
Zurich, Basel, Monza, Modena, Bologna, Pisa, Leeds, Birmingham & Vancouver

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Features of integrated approaches

• Resourcing
  – Human
  – Financial
• Integration or co-location of AOD & MH services
• Clinical programmes

• Supervision
• Workforce development
• University affiliation
• Research
Good resourcing

• Human
  – Physicians as clinical leaders
  – Psychiatrists, GPs, addiction & infectious disease physicians
  – Nursing & Allied health: psychology, social work, health assistants, ‘Recovery practitioners’

• Financial
  – State-funding often inadequate
  – Insurance schemes
Integration or Co-location of MH & AOD services

• Shared governance structures
• Functioning collaborative agreements & protocols
• Facilities
  – Inpatient/outpatient
  – Residential
  – Pharmacy

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Clinical programmes

• Longer-term options
  – Stabilisation, detox & rehab
  – Diagnostic clarification
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• Outreach
Clinical programmes

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• Day hospital

• General medical e.g. BBV
Clinical programmes

• Longer-term options
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  – Diagnostic clarification
• Outreach
• Day hospital
• General medical e.g. BBV
• Forensic
• Supervised consumption rooms
• Links with mutual help groups e.g. AA/NA/Smart
Supervised drug consumption rooms

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Psychosocial therapies

• Individual & group
• Multi-modes
  – CBT, Mindfulness
  – DBT
  – MI
  – Contingency management (Circle trial)
  – Integrated ‘Social Behaviour & Network Therapy’ (Leeds)
  – Cognitive-Behavioural Integrated Treatment (Birmingham)

• Personality disorder
• Trauma-focused
• Recovery
• Role of UDS?

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Pharmacotherapies

• Low v medium threshold OST
  – Methadone v Suboxone v LA Morphine

• Tobacco cessation

• Novel therapies
  – Heroin substitution
  – GHB
  – Ropinirole
Supervision & Workforce development

• Dual diagnosis teams
  – ‘Compass’ in Birmingham
  – When integrated services not present

• Supervision of staff & trainees

• Training & education
  – Multiple levels: basic compulsory, advanced targeted, specialist embedded in specific teams e.g. Early Intervention
  – Addiction psychiatry specialty not widespread
University affiliation & Research

• Neuroscience of addiction
• Clinical treatments
  – Psychosocial
  – Pharmacotherapies
• Collaboration with other departments
• Teaching
  – Under-graduate & post-graduate
Barriers & future challenges

• Stigma
• Silo structures, separate clinical databases
• Disinterested clinical leaders
• Government policy
• Lack of family/carer involvement or initiatives
• Inconsistent approaches to tobacco
• Integration with physical health initiatives
  – E.g. Metabolic syndrome
• Gambling initiatives

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Conclusions

• Good centres
• Resourcing important
• Vision & work of leaders
• Victoria’s attempts → silo systems with some adoption of integrated principles

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Search for the *Holy Grail of Integrated Treatment* continues!

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Thank you!

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