Queensland Health

dual diagnosis clinical guidelines

co-occurring mental health and alcohol and other drug problems

Tomorrow's Queensland:
strong, green, smart, healthy and fair

Toward Q Tomorrow's Queensland

Queensland Government

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Queensland Health

dual diagnosis

clinical guidelines

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Foreword

In September 2008, Queensland Health implemented the Queensland Health Dual Diagnosis Policy Service delivery for people with a dual diagnosis (co-occurring mental health and alcohol and other drug problems) which mandates a collaborative and integrated service response between Mental Health Services (MHS) and Alcohol, Tobacco and Other Drugs Services (ATODS) in the provision of services for people with a dual diagnosis.

National and state priorities to meet the needs of this population have resulted in significant investment in policy, programs, and service delivery to enhance service capability to respond to the needs of people with dual diagnosis. The Queensland Drug Strategy 2006–2010 provides a framework for all Queensland Government agencies to address drug related harms and emphasises the care of people with dual diagnosis as a key priority for treatment. The Queensland Plan for Mental Health 2007–2017 emphasises mental health care for people with co-occurring alcohol and drug problems as a priority and has invested $2.92 million to establish dual diagnosis coordinator positions to facilitate coordination between MHS and ATODS. The development of statewide guidelines to ensure routine screening and the provision of integrated care for these consumers is a priority for both service sectors.

Queensland Health has made a commitment to the improvement of care for this client group through the establishment of a statewide partnership between the service sectors, and more recently, the amalgamation of the Mental Health Directorate and the ATOD Treatment Strategy Unit at the policy level. This partnership has led the development of this cross-sector resource. The establishment of the partnership body, the Alcohol, Other Drugs and Mental Health Collaborative (AOD&MHC) to oversee the implementation of Queensland Health Dual Diagnosis Policy, demonstrates the commitment to a collaborative approach to improving the Queensland Health service response to the needs of these individuals.

The *Queensland Health Dual Diagnosis Clinical Guidelines* and *Queensland Health Dual Diagnosis Clinician Tool Kit* have been developed to guide Queensland Health MHS and ATODS clinicians in the provision of safe, effective and holistic care for people with a dual diagnosis. The *Clinician Tool Kit* that accompanies the guidelines provides practical assistance for clinicians in the day to day care of these consumers. I strongly encourage you to use these resources to ensure a 'no wrong door' approach to treatment and the provision of routine screening, assessment and delivery of integrated care and cross-sector collaboration between MHS and ATODS.

The high prevalence of dual diagnosis is a significant issue for clinicians in both service sectors. The use of alcohol and other drugs by people with mental illness is associated with poor treatment outcomes, more severe illness and high service use, presenting a significant challenge for all service providers. Dual diagnosis positions in both MHS and ATODS have been established to enhance capability of services to meet the needs of consumers with dual diagnosis through workforce development and cross-sector collaboration. District dual diagnosis coordinators will hold a key role in the promotion and implementation of these guidelines at the district level.

This document represents the culmination of cross-sector collaboration including policy workers, clinicians, consumers and carers and leads the way for district services to implement collaborative responses to service delivery and workforce development that meets the needs of people with dual diagnosis in Queensland.

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Acknowledgments

The development of the *Queensland Health Dual Diagnosis Clinical Guidelines and Clinician Tool Kit* was a strategy of the Key Recommendation 3 (KR3) project of the Report of the Queensland Review of Fatal Mental Health Sentinel Events – Achieving Balance: A review of systemic issues within Queensland Mental Health Services 2002–2003 (Queensland Government 2005) and the Alcohol, Other Drugs and Mental Health Collaborative (AOD&MHC), a partnership between the Queensland Health Mental Health Alcohol and Other Drugs Directorate (MHAODD), Strategic Policy Unit (SPU) and the Drug and Alcohol Treatment Strategy Unit (DATSU). This document was developed by the SPU and the DATSU.

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Executive summary

The high prevalence of dual diagnosis or co-occurring mental health and alcohol and other drug disorders is a significant issue for clinicians in both service sectors. Dual diagnosis is now commonly acknowledged to be the expectation not the exception in treatment services. Dual diagnosis is often associated with poor treatment outcomes, more severe illness and high service use, presenting a significant challenge for all service providers.

The Queensland Health Dual Diagnosis Policy, Service delivery for people with a dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008), was developed in order to improve treatment outcomes and facilitate collaboration between Queensland Health MHS and ATODS. Integrated care is essential for the delivery of effective treatment for people with a dual diagnosis (Kavanagh 2008; Mueser et al; Queensland Health 2003; Substance Abuse and Mental Health Services Administration (SAMHSA) 1998; Hawkings and Gilbert 2004), and is recognised as the best practice model of treatment for individuals with severe mental illness and co-occurring alcohol and drug problems. In situations where integrated treatment by a single clinician/service cannot be provided, models of care that are coordinated, holistic and collaborative across service sectors are necessary. Collaboration between service sectors requires a proactive response from the primary service provider, which has ongoing responsibility to ensure service provision, review and coordination.

The purpose of the *Queensland Health Dual Diagnosis Clinical Guidelines and Clinician Tool Kit* is to support Queensland Health clinicians in the provision of effective, safe, quality and holistic care to individuals presenting with co-occurring mental health and alcohol and drug problems. These guidelines provide a broad overview of treatment issues, tips for managing clients with dual diagnosis and advice on the implementation of the Queensland Health Dual Diagnosis Policy.

Interventions suggested in these guidelines are based on evidence-based practice, or where the evidence is unclear, on expert consensus. Reviews of the literature on current treatments are available from other sources and have not been repeated here. Integration of substance use and mental health aspects of treatment is well substantiated. However, existing trials typically use multi-component treatments, and at present there is insufficient evidence to recommend any specific treatment component for people with dual diagnosis, with the exception of Motivational Interviewing. Accordingly, the guidelines describe several psychological treatment options without making recommendations for specific treatment. Individuals with dual diagnosis take longer to engage and obtain positive outcomes in treatment. Specific principles for the treatment of this client group are summarised in the following guiding principles.

Dual diagnosis covers a wide range of presentations and conditions; treatment should be tailored to individual needs and consideration given to individual circumstances. The complexity of presentations limits the applicability of standardised guidelines for treatment in all situations. This document should not substitute for careful medical and biopsychosocial assessment. Consideration should be given to the potential benefits and hazards of pharmacotherapy and psychosocial interventions. Treatment decisions should always be made in consultation with the treating team and others (that is, dual diagnosis coordinators (DDC), consultation liaison services and medical practitioners) where appropriate.

A *Clinician Tool Kit* has been developed to support these guidelines. It contains screening tools, worksheets, tables, useful websites and clinical tips. It is recommended that clinicians refer to the relevant sections in the guidelines when applying these tools.

Guidelines at a glance

These guidelines have been developed for clinicians to use within their day to day practice. Clinicians are not required to read the document in its entirety but are encouraged to refer to relevant sections as required. The guidelines will enable clinicians and services to determine the most appropriate service sector response and available treatments. A clear set of guiding principles have been developed to support services in the provision of services for people with a dual diagnosis.

Guiding principles for the management of dual diagnosis

1. Routine, universal screening *(Chapter 5)*

Because of the increased risk, all clients presenting to either Mental Health Services (MHS) or Alcohol, Tobacco and Other Drug Services (ATODS) (including child and youth and older persons' services), should be screened for the presence of a dual diagnosis.

2. Routine comprehensive assessment of individuals who screen positive *(Chapter 5)*

Following the detection of either alcohol or drug use in mental health client populations or a potential co-existing mental health condition in individuals presenting to ATODS, a more comprehensive assessment should be undertaken by the clinician.

If further specialist assessment is required, the assessing clinicians should document this need and arrange for a specialist assessment from the corresponding service or dual diagnosis coordinator where appropriate. Further assessment should be provided in a timely manner. It is the responsibility of the assessing team to ensure that this assessment is conducted.

3. Data recording *(Chapter 5)*

Following the screening and assessment process, it is a requirement of MHS and ATODS that any dual diagnoses are documented and recorded in the appropriate information system, the Consumer Integrated Mental Health Application (CIMHA) or ATODS Information System (ATODS IS).

4. No wrong door system of care *(Chapter 2)*

MHS or ATODS should provide individuals presenting to either service with, or link the individual into, appropriate services regardless of their entry point into care. The presence of either a mental health (MH) or alcohol and other drug (AOD) condition does not constitute criteria for service exclusion or denial. If the individual does not meet service criteria, it is the responsibility of the assessing team to document this and ensure that the individual is linked into the appropriate service and is agreeable to engaging with the service provider. This approach will ensure all services respond to the individual's stated and assessed needs through either direct service provision or linkage to appropriate programs, as opposed to sending a person from one agency to another.

5. Integrated treatment *(Chapters 1, 2, 5, 6, 7, 8, and 9)*

The provision of integrated treatment for dual diagnosis requires the treating clinician and/or service, to coordinate the management of both the mental health and alcohol and other drug use problems and the effects of their associated interaction. Integrated treatment includes:

- care planning, addressing both alcohol and other drug use and mental health problems
- sharing of information between treatment services
- stabilisation of medical problems
- stabilisation of mental state
- management of risk
- pharmacotherapy for both alcohol and other drug use and mental health problems
- psychological interventions for both alcohol and other drug use and mental health problems and the interaction between these problems, including Motivational Interviewing
- stage-wise approach to treatment, where brief interventions are given routinely, and more intensive treatment is restricted to people with more severe problems and to those who do not respond to less intensive interventions
- assertive case management, especially where risks of relapse or serious harm are high
- regular, ongoing monitoring and review of both alcohol and other drug use and mental health problems, and the interaction between these problems.

6. Collaborative care *(Chapter 2)*

Where clinicians/services are unable to meet the needs of the client, then linkage with the corresponding services or with other health services (for example — general practitioners, psychologists, psychiatrists) via agreed district clinical pathways are to be coordinated by the service that the person initially presented to. The coordinating service will remain involved until the new service provider and client (and primary carers if appropriate) agrees that the new service will provide more specialised mental health or alcohol and other drug interventions and coordinate care according to need.

District MHS and ATODS are required by Queensland Health policy to develop local level governance structures and local level policies and protocols guiding the collaboration between service sectors. The coordinating service is responsible for ensuring communication is regularly maintained and all relevant documentation is shared between service providers on a regular basis.

7. Involvement of other care providers *(Chapter 2)*

The involvement of general practitioners, non-government services and private care providers in the care of individuals with dual diagnosis is recommended. Where consumers do not have a general practitioner the treating clinician should ensure linkages to an appropriate primary care provider.

8. Children of parents with a dual diagnosis *(Chapter 10)*

Clinicians are to provide screening, assessment and treatment planning which includes attention to those adult clients who are parents, discussing the reciprocal relationship between their health problems and their capacity to provide care and protection for their child/children. Programs targeting Children of Parents with a Dual Diagnosis (COPDD) are available and clinicians should consult Child and Youth Mental Health Service (CYMHS) on the specialist needs of this client group and the availability of Children of Parents with Mental Illness (COPMI) and COPDD programs in their district.

9. Involvement of carers/significant others in care planning and treatment *(Chapter 9)*

Active participation of the person, primary carers, family or significant others in the treatment and care of people with dual diagnosis should occur wherever possible.

10. Unique needs of diverse populations *(Chapter 10)*

Clinicians are to tailor care in accordance with the unique needs of the consumer. This includes the unique needs of youth and young people, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse populations, women and older people.

When a person has a serious mental disorder or assessed high level of risk, it is imperative that the individual be assertively engaged with the appropriate service provider for initial consultation.

Flowchart for the management of individuals with dual diagnosis within

Mental Health Services

Initial presentation to Mental Health Services (MHS)

All consumers will be screened and assessed for mental health problems, co-occurring alcohol and other drug use problems, and chronic medical conditions

Identified issues included on care plan

Consumers and significant others involved in care planning where possible

Acute medical problems identified and managed

- Intoxication
- Withdrawal management
- Overdose
- Psychostimulant toxicity

Acute psychiatric problems identified and managed

- Stabilisation of mental state including psychoses and distress
- Management of risk
- Management of behavioural disturbance
- Provision of a safe and contained environment
- Monitoring of mental state

Development of care plan and ongoing management

- Pharmacotherapy/withdrawal management
- Psychosocial interventions:
  - Stepped care
  - Brief interventions
  - Motivational Interviewing
  - Evidence-based psychological interventions
  - Relapse prevention
- Assertive case management
  - Active engagement of high risk consumers (strengths based approach)
- Stage-wise approach treatment:
  - Engagement, Persuasion, Active Treatment, Relapse Prevention
- AOD treatment programs and/or counselling
- Linkage with GP
- Residential rehabilitation/self help groups
- Stabilise accommodation e.g. wet, dry, damp housing
- Evidence-based supported employment
- Needs of children of parents with dual diagnosis

Regular monitoring and review

- Reassessment of AOD use at regular intervals and where indicated
- Regular assessment of pharmacological/substance interactions
- Regular monitoring for withdrawals (if reducing AOD use)
- Consultation with MH DD Coordinator/ATODS/ATODS consultation liaison
- Update care plan

Care coordination and collaboration

- Screen and assess for AOD issues
- Identify issues requiring specialist input
- Consumer's and carer's permission to involve other service provider (where possible)
- Linkage with other service
- Sharing of information
- Collaboration on development of care plan
- Co-management where indicated
- Linkage with GP
- Continuous exchange of information
- Involvement of other service in review process
- Documentation of involvement of other service
- Exchange of information documentation e.g. discharge summaries, medication reviews
- Ongoing monitoring and reassessment
- Discharge planning

Flowchart for the management of individuals with dual diagnosis within

Alcohol, Tobacco and Other Drug Services

Initial presentation to Alcohol, Tobacco and Other Drug Services (ATODS)

All consumers will be screened and assessed for alcohol and other drug problems, co-occurring mental health problems, and chronic medical conditions

Identified issues included on care plan

Consumers and significant others involved in care planning where possible

Acute medical problems identified and managed

- Intoxication
- Withdrawal management
- Overdose
- Psychostimulant toxicity

Acute psychiatric problems identified and managed

- Stabilisation of mental state including psychoses and distress
- Management of risk
- Management of behavioural disturbance
- Provision of a safe and contained environment
- Monitoring of mental state

Development of care plan and ongoing management

- Pharmacotherapy/withdrawal management
- Psychosocial interventions for mental health problems
  - Stepped care
  - Brief interventions
  - Motivational Interviewing
  - Evidence-based psychological interventions
  - Relapse Prevention
- Case management
  - Active engagement of high risk consumers (strengths based approach)
- Linkage with GP
- Stage-wise approach to treatment:
  - Engagement, Persuasion, Active Treatment, Relapse prevention
- MH treatment programs and/or counselling for high prevalence disorders
- MH inpatient treatment if indicated
- Residential rehabilitation/self help groups
- Stabilise accommodation e.g. wet, dry, damp housing
- Evidence-based supported employment
- Needs of children of parents with dual diagnosis

Regular monitoring and review

- Reassessment of MH problems at regular intervals and where indicated
- Regular assessment of pharmacological/substance interactions
- Regular monitoring for withdrawals (if reducing AOD use)
- Consultation with MH DD Coordinator/MHS/MHS consultation liaison
- Review with ATODS team
- Update care plan

Care coordination and collaboration

- Screen and assess for MH issues
- Identify issues requiring specialist input
- Consumer's permission to involve other service provider (where possible)
- Linkage with other service
- Sharing of information
- Collaboration on development of care plan
- Co-management where indicated
- Linkage with GP
- Continuous exchange of information
- Involvement of other service in review process
- Documentation of involvement of other service
- Exchange of information documentation e.g. discharge summaries, medication reviews
- Ongoing monitoring and reassessment
- Discharge planning

Preface

Co-morbidity or dual diagnosis is defined as the co-occurrence of two or more disorders in an individual (Teesson and Burns 2001). In this context, it is generally referred to as the co-occurrence of mental illness and alcohol and other drug use problems. 'Dual' suggests the existence of two disorders; however, it more commonly refers to those who have multiple complex needs. The term dual diagnosis does not indicate a secondary condition but instead identifies that a person has concurrent or co-occurring conditions.

In the Queensland context, co-occurring mental health (MH) and alcohol and other drug (AOD) problems are hereafter referred to as dual diagnosis. Other terms in common use include: co-morbidity, co-morbid disorders, complex presentations, concurrent disorders and co-occurring disorders.

This document is designed for clinicians in Mental Health Services (MHS) and Alcohol, Tobacco and Other Drug Services (ATODS) in Queensland. The use of language varies between these two service sectors. The broader alcohol and drug sector in Queensland refers to both government and non-government services. References to the alcohol and drug services/sector will encompass both services, whilst ATODS refers explicitly to government services. The term clinician will be used in reference to workers, practitioners, therapists or primary service providers managing individuals with dual diagnosis.

The term client and consumer refers to individuals receiving a service from either a MHS or ATODS. These terms are used interchangeably in this document according to the context of the treatment setting. The term patient is only used in reference to medical treatment of this client group.

The term alcohol and other drug use is used interchangeably with substance use. The term substance use is widely used internationally and includes the use of any psychoactive substances including alcohol, nicotine and prescription substances. Substance misuse is often used to describe problematic use of substances and incorporates both substance dependence (see Chapter 4) and problematic use.

chapter 1
introduction

dual diagnosis
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key points

- Dual diagnosis is part of the core business of Queensland Health Mental Health Services (MHS) and Alcohol, Tobacco and Other Drug Services (ATODS).
- The provision of integrated care is essential to enable the delivery of effective treatment for people with a dual diagnosis.
- Integrated care is considered best practice for individuals with severe mental illness and co-occurring alcohol and other drug (AOD) problems.
- Collaborative care is crucial to ensure a 'no wrong door' approach to service provision.
- The Quadrant Model can be used as a guide for identifying service sector responsibility.
- All Queensland Health Mental Health (MH) and Alcohol, Tobacco and Other Drug (ATOD) services are required to develop local level dual diagnosis policies and protocols.
- People with dual diagnosis have higher rates of physical, financial, emotional and social problems.
- Effective communication between MH and ATOD services is necessary and authorised by the *Health Services Act 1991* to support holistic, safe care.
- These guidelines are not the only source of guidance for clinicians. MH and ATOD clinicians must engage in consultation, supervision and professional development.

People with dual diagnosis are the core business of MHS and ATODS in Queensland. Effective services for these people, based on their individual needs, rely on the provision of comprehensive, holistic, person-centred interventions and care.

The recent trend both nationally and internationally has been the development of service delivery models and programs focused on the implementation of integrated treatment models and systems to improve collaboration across mental health and alcohol and drug service sectors. It has been well documented that people with dual diagnosis have often been denied care in a single system because of the complexity of managing their co-occurring disorder (Burnam and Watkins 2006). These barriers to treatment at the administrative, funding and service delivery level have been cited to contribute to the incidence of people with dual diagnosis 'falling between the gaps' (Burnam and Watkins 2006; Forster 2005). As dual diagnosis is now considered the expectation not the exception in MHS across Australia, the adoption of more integrated strategies in the treatment and management of people with dual diagnosis is seen as best practice.

Queensland Health has made a commitment to the improvement of care for this client group. These guidelines have been produced to inform and support clinicians to provide holistic, comprehensive care to individuals with co-occurring mental health and alcohol and other drug problems.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 1

Services establish **local level governance** structures that provide leadership in the development, implementation and maintenance of collaborative partnerships and interagency relationships that facilitate the provision of effective screening, assessment, treatment and linkage with services for people with dual diagnosis.

Purpose of the Queensland Health Dual Diagnosis Clinical Guidelines

The purpose of the *Queensland Health Dual Diagnosis Clinical Guidelines* and *Clinician Tool Kit* is to support Queensland Health clinicians (and services) in the provision of effective, safe, quality and holistic care to individuals presenting with co-occurring mental health and alcohol and drug problems. These guidelines provide a broad overview of treatment issues, considerations and tips for managing clients with dual diagnosis. This document is not intended to be the only source of guidance for clinicians or replace local district or Queensland Health policy, protocols or supervision of clinical practice. Clinicians are expected to provide treatment in consultation with their treating team and clinical supervisors that meets relevant district and Queensland Health legislation and requirements.

This document addresses a broad scope of pertinent issues MHS and ATODS clinicians need to be aware of when providing care to this client group. Where possible, other useful resources, protocols and guidelines are referenced for the clinician to source more detailed information. This document can be read in its entirety or the clinician may wish to review relevant sections of this document for specific guidance. All clinicians are required to apply these guidelines in a prudent manner and consult relevant experts when managing clients with dual diagnosis.

There is limited empirical evidence for the management of dual diagnosis. The interventions and principles of management suggested in these guidelines are based on evidence-based practice and expert consensus of treatments available. Numerous reviews of the literature on current treatments are available and have not been replicated in this document.

The Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008), sets out the expectations of district services in service planning and management of individuals with dual diagnosis.

It is a requirement of Queensland Health policy that MHS and ATODS develop local level policies and protocols that guide effective service delivery for people with dual diagnosis, including protocols for engagement, screening and assessment, service linkage, sharing of information, care coordination and treatment. Please check your local district intranet site for local policies, protocols and guidelines or consult with your local mental health dual diagnosis coordinator (MH DDC).

Further information

To access a copy of the Queensland Health Dual Diagnosis Policy, please refer to the Drug and Alcohol Treatment Strategy Unit (DATSU), Mental Health Alcohol and Other Drugs Directorate (MHAODD) and the Patient Safety and Quality Improvement Service (PSQ) intranet sites:

health.qld.gov.au/atod/documents/dual_diagnosis.pdf

health.qld.gov.au/mentalhealth/docs/ddpolicy_final.pdf

health.qld.gov.au/patientsafety/documents/ddpolicy.pdf

Why dual diagnosis?

The prevalence of people presenting with co-occurring alcohol and other drug and mental health problems is high in both MH and AOD treatment sectors. The prevalence of dual diagnosis ranges from 50–70 per cent in mental health settings, and 40–80 per cent in alcohol and other drug treatment settings (as high as 80 per cent in dependent drug users) (Queensland Health 2003). The increased incidence of poor clinical outcomes, including a significant number of fatal sentinel events in the mental health population, highlights the need to improve services for this group.

It is now common practice for both service sectors to engage in screening for co-occurring mental health and alcohol and other drug problems. The introduction of a suite of standardised mental health assessment forms in the Consumer Integrated Mental Health Application system (CIMHA) has included screening of alcohol and drug problems as a mandatory component of mental health assessments. Screening for dual diagnosis is seen as an indicator for a more in-depth assessment of co-morbid conditions. In ATODS, screening and assessment of mental health problems is included in the ATODS Information System (ATODS IS). The National Minimum Data Set for Alcohol and Other Drug Treatment Services Working Group is considering enhancing mental health data collection as a mandatory standardised procedure.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Principle 2

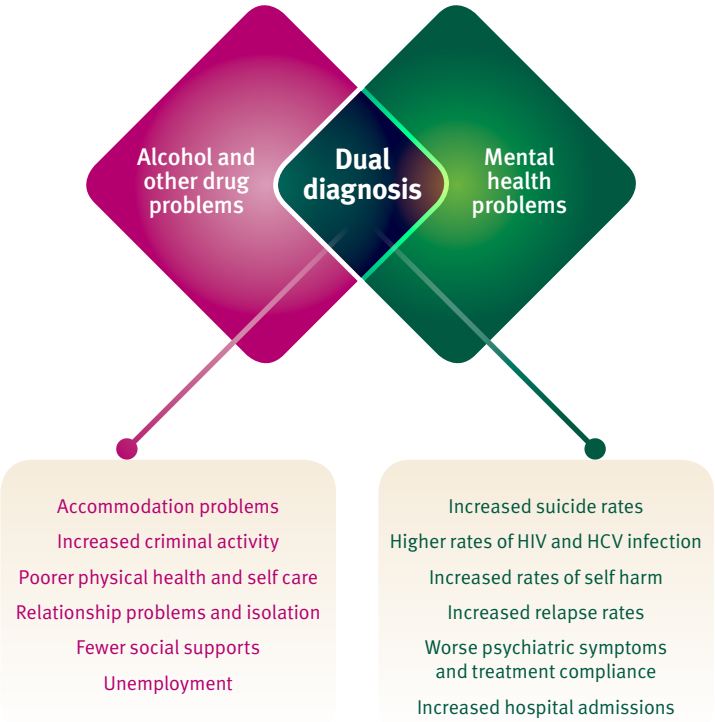
Individuals with dual diagnosis are the **expectation not the exception**.

The impact of dual diagnosis

The prevalence of co-occurring problems is a significant treatment issue for clinicians in both service sectors. Dual diagnosis is often associated with poor treatment outcomes, severe illness and high service use, presenting a significant challenge for service providers across both service sectors. Relapse of one disorder often triggers a relapse in the other among people with psychotic disorders (Mueser et al. 1990). The high prevalence of alcohol and drug use in mental health populations and specifically people with severe mental illness, contributes to the cost of treatment with alcohol and drug use exacerbating symptoms, contributing to functional deficits and triggering impulsive behaviours (Kavanagh 2007). In comparison to people experiencing a single disorder, people with dual diagnosis have higher rates of physical problems, homelessness, financial difficulties, involvement in criminal behaviour and subsequent incarceration, admissions to acute mental health units, self harm and suicide (Department of Human Services 2007; Queensland Health 2003). The impact of dual diagnosis is not limited to financial cost of high intensity services (including emergency and crisis care, high support

community housing and inpatient admissions), but also includes the broader emotional, psychological and relational impacts on the consumer and their family's quality of life (Kavanagh 2007; Kavanagh and Mueser 2007; Minkoff and Cline 2004).

Figure 1 Impact of dual diagnosis
(extract from Queensland Health Strategic Plan for People with Dual Diagnosis, 2003)



Key concepts

These guidelines promote five key concepts to ensure effective care for this client group. These concepts have been developed in response to external reviews, coronial inquiries, best practice treatment models and expert consensus. Key concepts underlying this document include:

- Mandatory screening, detection, assessment and care of individuals presenting to either mental health or alcohol and drug services. The identification of co-occurring mental health and alcohol and drug problems should be accompanied by appropriate documentation in the clinical and data reporting systems of the service sector.
- Integrated care refers to the provision of treatment for both mental health and alcohol and drug problems by a single clinician or treating team wherever possible and where not possible, the provision of treatment by two or more clinicians working within a network of services. Integrated services must appear seamless to the person participating in services.
- Integration is defined as the coordination of interactions and relationships within and across ATODS and MHS in order to secure the best possible service system response for a person with dual diagnosis, and does not imply the structural realignment of service systems. Integration with the non-government and private service sectors is essential to increase access to a wider range of services that can meet the varied needs of individuals with co-occurring conditions.
- The severity and complexity of mental health and alcohol and drug problems is determined by the range and impact of an individual's presenting symptoms on their level of functioning, rather than diagnosis alone.
- Statewide policy guiding service provision for individuals with complex needs has been developed to address these key concepts to ensure effective, safe, holistic treatment responses for this client group.

Evidence for practice

Comprehensive literature reviews are available elsewhere and have not been replicated in this document. The principles and interventions suggested in this document are based on evidence-based practice and expert consensus of the treatments available.

The provision of integrated care enables the delivery of effective treatment for people with a dual diagnosis and is recognised as the best practice model of treatment for this client group (Queensland Health 2003). In situations where integrated treatment is not able to be provided, integrated models of care that focus on coordinating holistic, collaborative care across service sectors is promoted. Collaboration between service sectors requires a proactive response from the primary service provider with ongoing responsibility, review and coordination by this service.

Principles of care

Principles of care for individuals with a dual diagnosis provide the foundation for service planning, delivery and evaluation of systems of care. They also provide guidance for the design of service systems and service integration (Centre for Alcohol and Other Drug Use Treatment 2006). The articulation of care principles will assist clinicians and service systems to improve their response to these individuals with complex needs.

The principles outlined below have been developed, and articulated in the Queensland Health Dual Diagnosis Policy. These principles of care are based on evidence- and consensus-based research and clinical practices for people with dual diagnosis, and have been validated across the MH and AOD treatment fields (Centre for Alcohol and Other Drug Use Treatment 2006, Minkoff 2001).

The principles include:

1. Effective **collaborative partnerships** between MH and ATODS, and with professionals in primary care, social services, housing, criminal justice, education and related fields are required to meet the complex needs of people with dual diagnosis and to sustain recovery. This includes service providers across government, non-government and private sectors.
2. Recognition that individuals with dual diagnosis are the **expectation not the exception**. Systems planning, service operations and the delivery of treatment and care must address the need to provide services for people with co-occurring mental health and alcohol and other drug problems.
3. An **integrated care approach** that ensures continuity and quality between MH and ATODS, and across other service sectors, is used in the provision of treatment for individuals with dual diagnosis. Services must facilitate the seamless delivery of MH and substance use treatment services through a variety of agencies across all health and welfare settings.
4. A **no wrong door approach** is used that provides people with, or links them to, appropriate services regardless of where they enter the system of care. Services must be accessible from multiple points of entry and be perceived as caring and accepting by the consumer. This principle commits all services to respond to the individual's stated and assessed needs through either direct service or linkage to appropriate programs, as opposed to sending a person from one agency to another.
5. The development and maintenance of a **therapeutic alliance**, or quality treatment relationship based on mutual respect, is an essential component of effective treatment for individuals with dual diagnosis. Empathy, respect and belief in the individual's capacity for recovery are fundamental service provider attitudes and values.
6. Integrated service provision involves a **biopsychosocial approach** comprising an array of physical, psychological and social service interventions in the provision of engagement, assessment, treatment and care. These interventions are outlined in an integrated and comprehensive treatment plan based on an assessment of individual needs and preferences, matched to appropriate levels of care, and coordinated within a broad range of provider networks and social services.
7. A **harm minimisation approach** is used and promoted in the treatment of people with dual diagnosis. This approach recognises that people with substance use problems have a wide range of treatment goals that range from the reduction of harms related to use through to abstinence, and that interventions need to be realistic and achievable.
8. A holistic, **recovery-based approach** is used in the provision of assessment, treatment and care, involving direct service provision for MH and AOD problems and effective linkage with the broader social service network to meet the range of complex needs experienced by people with dual diagnosis.
9. Within the treatment context, both MH and AOD problems are considered of **primary importance to the clinical presentation**. As MH symptoms and AOD use can vary over time and strongly interact, both MH symptoms and AOD use needs to be given equal priority in treatment. Both issues need to be continually assessed and treatment plans adjusted accordingly. The complexity of the interdependence of MH and AOD problems must be reflected in the treatment plan.
10. The needs of **special populations** are acknowledged in the provision of integrated care, including youth and young people, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse populations, women and older people.
11. The active participation of the **person, primary carers, family or significant others** in the treatment and care of people with dual diagnosis occurs wherever possible.
12. The **contribution of the community** to the course of recovery for people with dual diagnosis and the contribution of people with dual diagnosis to the community must be explicitly recognised and supported in treatment planning and consumer advocacy.

Further information

Further information regarding service and clinical responsibilities toward individuals with a dual diagnosis, can be found in the Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008) at:

health.qld.gov.au/atod/documents/dual_diagnosis.pdf

health.qld.gov.au/mentalhealth/docs/ddpolicy_final.pdf

health.qld.gov.au/patientsafety/documents/ddpolicy.pdf

The principles and responsibilities outlined in the Queensland Health Dual Diagnosis Policy underpin the content provided in these guidelines. The implementation of this policy at the service delivery level can be achieved by addressing the needs of this client group as outlined in these guidelines.

Models of care

Historically, mental health and alcohol and other drug treatment services operate from different philosophies and treatment models. ATODS operate from a harm minimisation philosophy/model where therapeutic engagement is based on the assumption that the client has both the right and capacity to make an informed decision about their drug use. MHS work from a medical model where abstinence is the preferred option and therapeutic engagement is more direct and often involuntary.

This variation in care models has resulted in services operating in silos where the person's mental health or substance use problem is dealt with in isolation. This approach to care has contributed to fragmented treatment, often with the result of the person being denied a service due to the presence of the other disorder or problem.

Treatment for co-occurring disorders can be provided by three different treatment models: sequential, parallel or integrated treatment. A growing body of evidence advocates that individuals with severe mental illness do not do well under serial or parallel approaches and an integrated treatment model is the most effective mode of treatment (Kavanagh, Mueser and Baker 2008 cited in Teesson and Proudfoot 2003; Kavanagh and Mueser 2007).

1. Sequential treatment

The individual receives treatment for one disorder or problem first and is not eligible for referral to receive treatment for the other disorder until the first problem has been resolved or stabilised. This model is often used in acute settings where the most urgent need is dealt with first, or in community settings where one service may advise the client to approach the other service (Teesson and Proudfoot 2003). This model of treatment has historically led to consumers being excluded from treatment. It also relies on the premise that one disorder is primary and the secondary problem will resolve with the effective treatment of the primary disorder.

2. Parallel treatment

Under a parallel approach both disorders are treated concurrently by two separate treatment services. This means the person has to attend separate services which may be independent of each other.

3. Integrated treatment

Integrated treatment refers to the provision of holistic care, addressing both mental health and alcohol and other drug use by the same service provider or treatment team (Mueser et al. 2003). Under this model both the person's mental illness and substance use are treated at the same time in a coordinated approach either by the one clinician or in collaboration with the other service in a seamless coordinated approach. Both issues are recognised and the interdependence of the disorders addressed in the care plan.

A mapping exercise of MHS and ATODS in Queensland, undertaken in 2007 by the Key Recommendation 3 (KR3) project of the Report of the Queensland Review of Fatal Mental Health Sentinel Events – Achieving Balance: A review of systemic issues within Queensland Mental Health Service 2002–2003 (2005), indicated that integrated service provision in Health Service Districts is limited. Queensland Health services are operating under a parallel model of service delivery with limited collaboration across the service sectors.

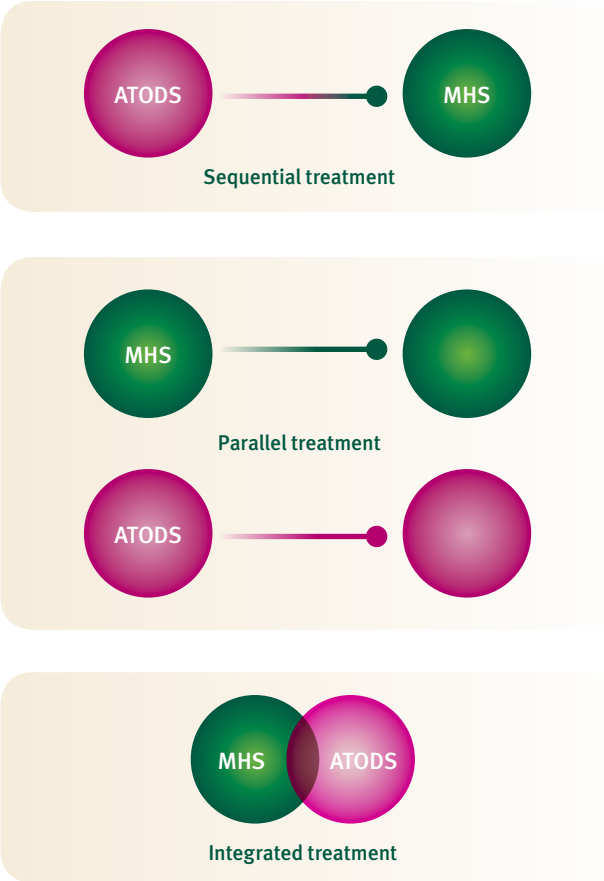
Retaining such a model of service provision increases the risks of clients falling through the gaps due to fragmentation of services, poor communication, ineffective referral pathways, conflicting treatment philosophies and service eligibility criteria.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Principle 3

An **integrated care approach** that ensures continuity and quality between mental health and alcohol and other drug services, and across other service sectors, is used in the provision of treatment for individuals with a dual diagnosis.

Figure 2 Models of care for people with dual diagnosis



The Quadrant Model

The increased international focus on the need for collaboration between service sectors has seen the application of a conceptual framework known as the Quadrant Model (Minkoff 2003), across both international and Australian health service sectors. Queensland Health is promoting the application of this model to facilitate improvements in coordinated care across the mental health and alcohol and other drug treatment sectors.

Effective service delivery across both service sectors requires a commitment to improving working relationships, the revision of current protocols and practices, and the development of more effective processes to support the provision of a seamless integrated care approach. The Quadrant Model provides guidance for the level of service coordination (defined as consultation, collaboration, or integration) needed to improve consumer outcomes and is commonly used to inform the identification of treatment sector responsibility.

The Quadrant Model comprises of four domains which describe co-occurring disorders in terms of symptom severity rather than specific diagnoses and is shown in Figure 3. Clinicians should be mindful that quadrants-domains are somewhat arbitrary and clients do not always fit readily into a particular quadrant. Boundaries may be blurred and all pertinent clinical and psychosocial factors need to be taken into consideration when negotiating service sector responsibility.

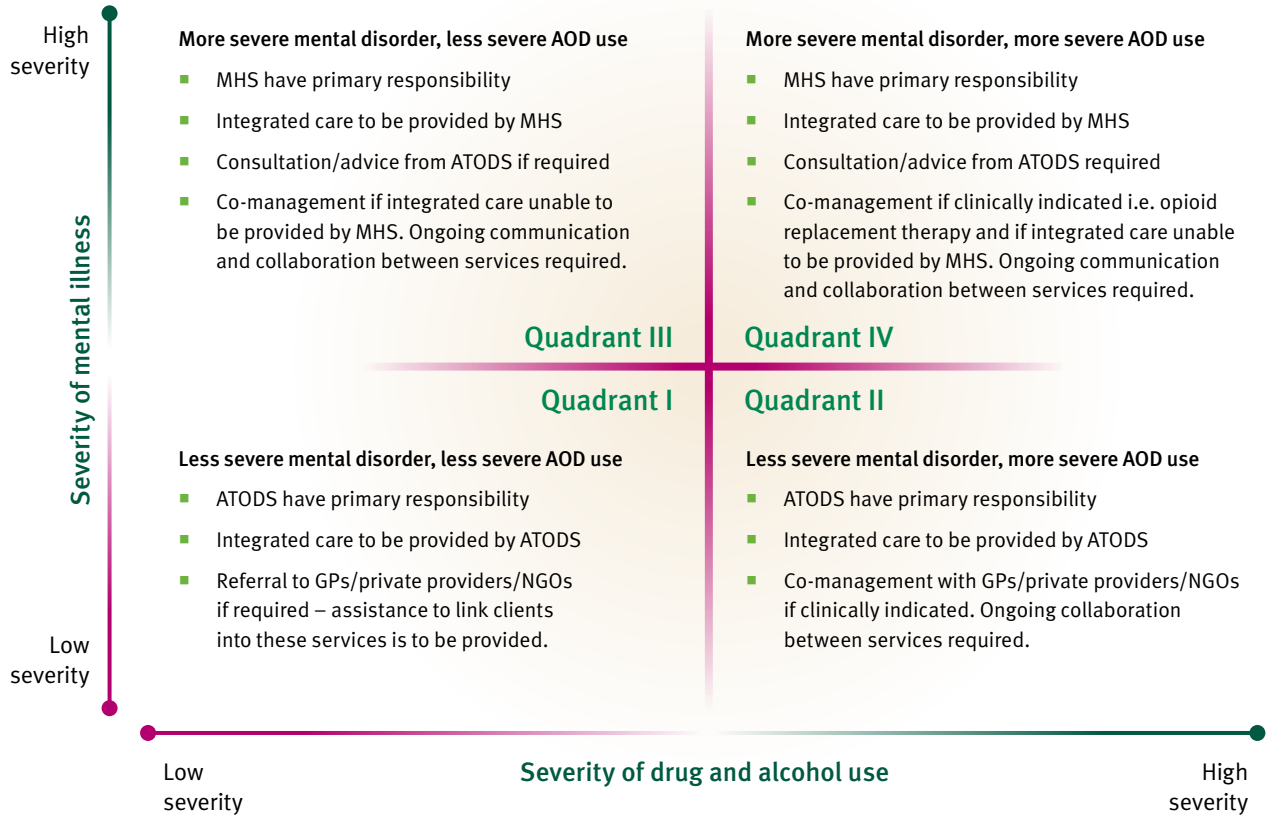
Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 6

Where MH or AOD problems or disorders of mild-moderate severity are detected, MH and AOD services provide AOD and MH brief interventions, respectively. Reassessment of MH and AOD problems and disorders is to occur on an ongoing basis.

It is critical that the application of this framework is flexible and adaptable to individual circumstances and not applied to exclude consumers from services.

Figure 3
The Quadrant Model for understanding co-occurring mental health and alcohol and other drug use disorders (dual diagnosis)



Quadrant I

Less severe mental disorder, less severe alcohol and other drug use

This domain is consistent with the needs of people whose problems are generally not severe enough to fulfil the eligibility criteria for public health sector services provided by MHS and ATODS. This group may also include people at risk of harm and/or developing more severe alcohol and drug or mental health disorders. This group may include children and young people.

Individuals falling into this domain are most appropriately serviced by the primary health care system, the non-government sector and in some cases local alcohol and other drug services. Individuals presenting to public health care services with this profile should be assisted to access an appropriate primary health care provider. A brief intervention prior to referral and linkage to the appropriate services is to be provided to all individuals and follow-up care should be provided until effective engagement with the identified service is achieved.

Quadrant II

Less severe mental disorder, more severe alcohol and other drug use

People whose needs are consistent with this quadrant include those with a more severe alcohol and drug use and a less severe mental health problem. This includes people who may be unstable and actively using substances. These individuals are most appropriately cared for in the alcohol and drug treatment sector.

Less severe mental health problems can be managed under an integrated treatment framework with the alcohol and drug service providing treatment for their mental health symptoms. Alternatively, if mental health expertise is not available in the alcohol and drug service, collaboration, consultation and support by the local MHS or by the non-government, primary care or private health sector can assist in the management of this client group.

The alcohol and drug sector will hold primary responsibility for the care of these clients and is required to coordinate ongoing treatment across both services. The alcohol and drug sector will take responsibility for inter-service consultation, and care planning and review, until the new service provider and consumer (and primary carers if appropriate) agrees that the new service will provide more specialised mental health or alcohol and other drug interventions and coordinate care according to need.

Quadrant III

More severe mental disorder, less severe alcohol and other drug use

Individuals whose needs meet the profile of this domain include those with more severe mental health problems and less severe alcohol and drug problems. People falling into this domain may include those not currently misusing alcohol or drugs or those using infrequently, with minimal to moderate impact upon their mental health. MHS are generally the most appropriate service to be managing individuals described in this domain.

MHS must screen and assess all individuals presenting to their service for alcohol and drug problems and provide treatment appropriately matched to their client's needs. In this situation, MHS should provide brief interventions, harm minimisation, Motivational Interviewing, Cognitive Behavioural Therapy (and/or other evidence-based psychosocial interventions) and relapse prevention to their clients.

Consultation with ATODS to inform care and, if necessary, specialist input from ATODS can be accessed if integrated treatment by MHS is unable to be provided.

Specialist consultation may include: joint assessments, joint case conferencing, supervision, joint training, and consultation and liaison. Specialist consultation from a MH DDC is available to many Queensland Health district MHS to enhance their capability to respond holistically to the needs of their clients. MHS will hold primary responsibility for the care of these clients. The MHS is required to coordinate ongoing treatment across both services (if relevant) and take responsibility for inter-service consultation, care planning and review.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 6

Where either the MH or AOD problem or disorder is of moderate-high level severity or complexity, and the other (MH or AOD) problem or disorder is of mild-moderate severity or complexity, it is expected that both a comprehensive assessment and specialised MH and AOD intervention is provided by the MH or AOD service that the person presented at, wherever possible. If this is not possible due to the requirement for more specialised expertise (e.g. eating disorders, prodromal psychotic symptoms, chroming, psychedelics), then linkage with MHS, ATODS or with other health services (e.g. general practitioners , psychologists, psychiatrists) via agreed clinical pathways is coordinated by the service that the person initially presented to. The coordinating service will remain involved until the new service provider and consumer (and primary carers if appropriate) agrees that the new service will provide more specialised MH or AOD interventions and coordinate care according to need.

Quadrant IV

More severe mental disorder, more severe alcohol and other drug use

This domain includes people with more severe mental health disorders and more severe alcohol and drug problems. This domain will reflect those individuals with severe and persistent mental health problems. Those individuals described by this domain may include individuals with drug induced psychoses, severe personality disorders, severe mood disorders or psychotic disorders and concurrent alcohol and drug problems and/or dependence. These individuals may present to either MHS or ATODS.

The best practice recommendation for the treatment of this client group is for MHS to take primary responsibility and provide integrated treatment to this client group. Specialist input from ATODS may be required for specific issues such as opiate substitution programs, withdrawal management programs, specialist consultation, specialist assessments and co-management of particularly complex clients.

MHS are to retain primary responsibility for this client group and to coordinate treatment planning, management and review, and specialist consultation across both services.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 8

Where MH and AOD disorders are both of moderate-high level severity or complexity, MHS are to take primary responsibility for the care of these clients. It is expected that a more comprehensive assessment, more specialised AOD interventions and ongoing reviews are coordinated by MH services. Linkage with ATODS is to occur via agreed clinical pathways. Co-case management or shared care with respective service providers is to be provided via regular communication and clinical review meetings to ensure a consistent and integrated treatment approach is adopted and maintained. The MH service will continue to hold primary clinical responsibility for the ongoing management and review of these individuals. The participation of providers of other health and social services involved in the person's care is actively encouraged.

Special considerations

One of the challenges in applying this framework is the movement of clients across services, as is commonly found in traditional models of service. Services must consider the implications of fluctuations in severity of symptoms that influence a client's profile within a particular domain and the importance of continuity of service provision.

Individuals who initially present with severe symptoms that settle with a clinical intervention, may be best served by remaining within this treatment sector to reduce future presentations and the provision of ineffective care.

This is particularly the case for individuals presenting with a personality disorder who are frequent presenters at services and who may settle following the provision of crisis intervention. MHS may best meet the needs of these individuals by providing brief interventions or retaining continuity of care in pursuit of the long-term goal of reducing mental health presentations and fluctuations in severity of mental health symptomatology.

In addition, individuals presenting with drug induced psychoses may also experience a reduction in severity of symptoms but re-present frequently if not adequately cared for by MHS. In these cases, it is the MHS that should adopt the primary responsibility for service provision.

In rural and remote areas where limited service capacity exists or limited tertiary services are available, these issues need to be reflected in the local district health service protocols. In the absence of alcohol and drug treatment services, the service sector with greater resource capacity may end up managing individuals representing all four domains described in the Quadrant Model. District health services need to identify intersectoral support and processes for referral and ongoing collaboration between general practitioners, local non-government providers, ATODS and MHS.

Dual Diagnosis Clinician Capability Framework

Queensland Health ATODS and MHS have identified dual diagnosis workforce development as a key objective to improve workforce capability in meeting the needs of clients with co-occurring problems. It is recommended that dual diagnosis content be a mandatory component of workforce development programs for all Queensland Health ATODS and MHS.

The purpose of the Dual Diagnosis Clinician Capability Framework is to inform safe and effective clinical practice and to provide requisites for the development of dual diagnosis training modules, programs, professional development and other sustainable training — for example, orientation and clinical placement programs. The framework can also be used to inform the development of role descriptions, performance appraisal and development plans, and clinical supervision.

Dual diagnosis clinical capabilities are applicable within all Queensland Health ATODS and MHS. They are divided into essential and advanced categories. Essential capabilities provide a framework for practice and include core knowledge, skills and attitudes that **all clinicians are expected to have** to deliver safe and effective clinical services. Advanced capabilities represent **expertise in the field** and include knowledge and skills that clinicians develop beyond an essential level which can be acquired on the job or through further education, professional development, and/or clinical supervision.

The Dual Diagnosis Clinician Capability Framework is included in the accompanying *Clinician Tool Kit*. Educators and supervisors are encouraged to utilise this resource in the development of local training programs and skills development strategies.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 15

Staff are provided with education and skills in AOD and MH screening and brief interventions respectively, and treatment plan development and care coordination services to enable the delivery of fundamental services for people with dual diagnosis in all phases of their recovery.

Legislation

Sharing client information

People with dual diagnosis have the right, along with other health service recipients, to expect information held about them to remain confidential. However, in terms of the complex nature of co-occurring disorders, information will often need to be shared across service providers.

The release of confidential information by Queensland Health employees, officers and agents is regulated and specified in Part 7 of the *Health Services Act 1991*:

> 'Queensland Health staff are authorised under the Health Services Act to share information across relevant health services.'

This specification allows for the sharing of relevant clinical information between health service providers without the client's consent. It is a requirement of safe, holistic treatment that the treating clinical team obtain all relevant clinical information in order to manage the client.

The preferable mechanism for sharing client information is with the consent of the person concerned. However, if there is significant suicide risk or risk of harm to others, clinicians can seek collateral from family or significant others without consent. There may be circumstances where the consent of a person cannot be obtained — for example, due to incapacity. In this instance, consent is not required when information shared is related to treatment and care, and is between health professionals within and outside of Queensland Health — for example, general practitioners or non-government organisation professionals.

It is considered best practice to discuss disclosure with the person to ensure that they are fully informed. Information shared should only be information which is relevant to the treatment episode and documented in the client record. All decisions to share or obtain information about a client should be made in consultation with the treating team and documented in the client's file.

Practice tip

Contact with other service providers is recommended (and often necessary) for safe, quality and holistic treatment even if consent is not granted by the client.

Information can be provided without consent to the Department of Child Safety but this information is specifically in relation to the protection of a child's safety (s159N and s159Q of the *Child Protection Act 1999*), however prior consultation with the treating team is recommended.

If the disclosure of information is to prevent a serious risk to the life, health or safety of an individual, or to public safety, then disclosure can be made to a Commonwealth or state government entity — for example, Queensland Police Service (*Health Services Act 1991*, s62N and s62I). The Queensland Health Director General has delegated this disclosure to senior positions within district health services.

Further information

For more information please refer to the following web sites:

- *Queensland Health Services Act 1991* legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealthServA91.pdf
- Queensland Health, Health Services Act Part 7 Confidentiality Guidelines health.qld.gov.au/foi/docs/conf_guidelines.pdf
- Queensland Health, Protecting Queensland Children: Policy Statement and Guidelines on the Management of Abuse and Neglect in Children and Young People (0–18 years) qheps.health.qld.gov.au/csu/policy.htm

The Mental Health Act 2000

The *Mental Health Act 2000* (the Act) provides for the involuntary assessment, treatment and the protection of persons with mental illness. At the same time, the Act aims to safeguard and balance the rights and freedoms of people who have a mental illness and those of others.

The Act contains provisions for patient's rights by:

- providing safeguards for the use of involuntary provisions
- involving patients in decisions affecting them
- ensuring regular independent reviews of a patient's involuntary treatment.

All clinicians involved in the involuntary treatment of a client should work in collaboration with other services involved in the care of the client. As the *primary service provider,* it is the responsibility of the mental health case manager of an involuntary client to ensure that corresponding services involved in the client's care (for example — ATODS) are involved in treatment planning, reviews and discharge planning, and are engaged in regular communications regarding treatment progress.

Further information

Further information on the *Mental Health Act 2000* including multilingual fact sheets, processes for obtaining involuntary assessment and patients' rights and responsibilities can be found at health.qld.gov.au/mha2000/default.asp

chapter 2

collaborative care

dual diagnosis
clinical guidelines

key points

- A 'no wrong door' approach describes a service system that provides people with, or assertively engages them in, appropriate services regardless of where they enter the system of care.
- Collaborative care can include consultation, liaison, joint assessment and care planning, as well as co-case management of consumers between services.
- Only a relatively small percentage of clients will require input from Mental Health Services (MHS) and Alcohol, Tobacco and Other Drug Services (ATODS) due to the differing severity of problems seen by each sector.
- Working collaboratively requires clear protocols, guidelines and good communication between services.
- Collaboration between services is based on professional respect, delegation and effective working relationships and systems.
- Working collaboratively with the non-government sector can supplement capacity limitations within both mental health (MH) and alcohol and other drug (AOD) services.

The provision of integrated care is essential to enable the delivery of effective treatment for people with a dual diagnosis (Queensland Health 2003). At the systems level, integrated care entails a focus on the provision of holistic and coordinated care, liaison and advice, and the development of clinical pathways between and across a range of agencies. As such, a prerequisite for the delivery of effective treatment for people with dual diagnosis is strong collaboration and cooperation and effective working relationships between the MH and AOD service sectors and the broader network of social welfare services (Queensland Health 2003).

There will only be a relatively small percentage of clients who will require input from both MHS and ATODS due to the differing severity of problems seen by each sector. In most cases, care will be provided in an integrated fashion by the primary service provider and there may be some level of expert consultation/ input from the other service sector. However, clients with both severe mental health and alcohol and drug problems may require clinical input from both service sectors. This co-management requires active clinical collaboration between MHS and ATODS.

The development of processes to support effective working relationships across services is a priority of Queensland Health. Working collaboratively requires clear protocols, guidelines, good communication between services and the opportunity to address systemic problems encountered on the ground. It is a requirement under the Queensland Health Dual Diagnosis Policy for district MHS and ATODS to convene a local dual diagnosis steering committee to facilitate the development of policies, protocols and referral pathways, problem solve issues and progress local initiatives.

Care coordination necessitates the identification of service sector responsibility for the management and care of individuals with a dual diagnosis. Working collaboratively across services requires that one service adopt primary responsibility for the care of the individual. Primary responsibility includes the provision of a comprehensive assessment of both mental health and alcohol and drug problems, the facilitation of further in depth assessment where screening indicates the presence of a co-occurring problem, and the identification of care needs in the integrated treatment plan. It also entails the responsibility for clinical review and treatment planning involving all care contributors, and the dissemination of documentation on all treatment provided. A case manager or primary service provider, allocated from either MHS or ATODS, is responsible for this coordination role.

The identification of primary responsibility for the care of this client group has been a complex and greatly debated issue. The Queensland Health Dual Diagnosis Policy provides guidance on this issue by clearly articulating service responsibilities in regard to the assessment and management of people with co-occurring problems (see the Queensland Health Dual Diagnosis Policy for further information).

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 2

Services develop **local level policies and protocols** that guide effective service delivery for people with dual diagnosis, including protocols for engagement, screening and assessment, service linkage, sharing of information, care coordination and treatment management.

Where co-case management is undertaken between the two service sectors, the primary service provider will ensure:

- clear referral pathways are utilised and feedback is provided to referring parties
- all parties are informed and involved in significant treatment decisions
- all parties are informed of the client's progress in treatment
- dissemination of assessments/case notes/reports/reviews/discharge plans to all services involved in care
- involvement of all care providers in clinical reviews and treatment planning
- regular communication (and documentation of this communication) between all care providers.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 14

In instances where a person is linked with a more specialised service for treatment of MH or AOD use problems, **co-case management or shared care arrangements** are provided. The initial service provider is to retain active involvement in treatment and care coordination to ensure the person's needs are met and to facilitate a positive outcome.

Practice tip

Check with your local service for district protocols and policies relevant to collaborative care.

The service with primary responsibility is to ensure that integrated care is provided by all services involved in care of the individual, the engagement of the corresponding service in the exchange of clinical information and input in the treatment planning, review and discharge processes.

Collaboration between services is based on professional respect, delegation and effective working relationships and systems. The defining characteristics of the collaborative practice relationship are:

- mutual respect and acknowledgement of each profession's role, scope of practice and unique contribution to health outcomes
- clearly stated protocols and guidelines for clinical decision-making which comply with relevant legislation and Queensland Health and district health service policy and protocols
- clearly defined levels of accountability with an acceptance that joint clinical decision-making is an integral component of collaborative practice
- a belief that the best health outcomes are achieved when services work in collaboration and partnership in both service sectors.

No wrong door

A 'no wrong door' approach describes a service system that provides people with, or assertively engages them in, appropriate services regardless of where they enter the system of care. Services must be accessible from multiple points of entry and be perceived as caring and accepting by the consumer.

This approach requires MHS and ATODS to adequately assess and respond to an individual's needs through either direct service provision or linkage to appropriate programs, as opposed to sending a person from one agency to another. Services are required to facilitate linkage to other service providers by assertively engaging consumers with these services.

Services must follow-up referrals and ensure that the client is linked into the most appropriate service provider before the referring service provider withdraws from care, rather than merely provide referral contact details. In the case of alcohol and drug services linking a client in with MHS due to an assessed high level of risk, it is imperative that ATODS engage the client assertively and facilitate linkage with MHS prior to handing over primary clinical responsibility.

This more comprehensive linkage process will decrease the possibility of clients 'falling through the gaps' due to ineffective referral processes and reluctance of individual clients to contact services independently. These improvements to linkages between services will ensure appropriate and safe care is provided to the individual.

When a person has a serious mental disorder it is important that the individual be assertively engaged with the appropriate service provider for initial consultation.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 3

Services implement a **no wrong door approach** for people who present with co-occurring MH and AOD conditions; all are eligible recipients of triage, assessment, inpatient admission and care coordination services. The presence of either a MH or AOD condition does not constitute criteria for service exclusion or denial.

The assessment of symptom severity and complexity of a mental health or alcohol and drug problem has historically posed difficulties for services attempting to clarify service sector responsibility. The Quadrant Model (refer to Chapter 1), provides guidance with negotiating service sector responsibility to support linkages into appropriate treatment.

The individual's social support networks, acuity, recidivism and impact of illness must also be considered when deciding which service is to adopt primary responsibility for the care of the client. This decision should be made in collaboration between the two services with potential problems or limitations in the provision of integrated care addressed by district management.

Case scenario

Collaborative care

Bill is a 27 year old man with a history of Schizophrenia that was diagnosed in prison five years ago. He has few social supports and has moved frequently. His compliance with medication has been poor. He has voluntarily engaged with a community mental health service and has been allocated a case manager.

Unfortunately, Bill's condition has been complicated by substance use which has included the regular injection of opioids in the form of Buprenorphine which he gets off a friend. He explains that if he can't get any he hangs out and goes into withdrawal.

Bill's mental health case manager diagnoses Bill with co-morbid polysubstance abuse, as well as opiate dependence and identifies the need to work in collaboration with a specialised alcohol and drug service to assess Bill for treatment in a maintenance opioid program.

In this case Bill has a severe mental illness that requires case management but he also requires specialised alcohol and drug treatment. The two case managers work in collaboration on Bill's care, with the mental health case manager taking primary responsibility to ensure ongoing communication and care planning.

Inter-agency collaboration

The increasing focus in Australian health care delivery on the development of partnerships and improved intersectoral working relationships with non-government organisations provides another avenue for addressing the complex needs of these individuals. Often government services are unable to provide the full spectrum of care to this client group. This is particularly the case in regional and rural areas in Queensland with limited or no clinical alcohol and drug treatment services available. In these circumstances it is imperative that non-government organisations, community organisations and the primary care sector be engaged to support the care of people with dual diagnosis.

Working collaboratively with the non-government sector can support capacity limitations within both mental health and alcohol and drug services. The recent Commonwealth focus on improved services for co-morbidity has seen the Council of Australian Governments (COAG) provide significant funding enhancements for non-government services across Australia to improve their capacity to provide services to people with a dual diagnosis. MHS and ATODS are encouraged to work collaboratively with these services, other local non-government organisations and the private sector in their district.

The Quadrant Model can help guide negotiation of service sector responsibility. It can be applied to individuals with mild to moderate mental health or alcohol and drug problems who may not meet service level criteria to receive a service from the government sector.

Services can work collaboratively with non-government organisations in order to support these individuals and provide early intervention services before problems increase in severity.

An example of intersectoral collaboration in this circumstance may be a client with moderate to severe alcohol and drug problems and mild depression and anxiety. If the mental health issues are unable to be addressed by the ATOD service, the individual can receive treatment in the private sector or by local non-government organisations in collaboration with the ATOD service.

Intersectoral collaboration is also based on effective working relationships, clear referral pathways and communication between services. It is advised that services utilise the same principles of inter-service collaboration that are outlined between MHS and ATODS. The primary service of responsibility is required to fulfil the same obligations and involve the non-government organisations and/or community service providers in treatment and disseminate information to all care providers.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Principle 1

Effective **collaborative partnerships** between mental health and alcohol and other drug services, and with professionals in primary care, social services, housing, criminal justice, education and related fields are required to meet the complex needs of people with dual diagnosis and to sustain recovery. This includes service providers across the government, non-government and private sectors.

chapter 3
mental health

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key points

- Mental Health Services (MHS) and Alcohol, Tobacco and Other Drug Services (ATODS) share a philosophy of recovery which is defined as a personal journey that includes hope, personal responsibility, connectedness, discovery and an active sense of self.
- One in five Australians will suffer a mental illness.
- People can and do recover from mental illness.
- The spectrum of mental illness ranges from high prevalence disorders, such as anxiety and depression, to low prevalence disorders, such as psychosis and eating disorders.
- Clinicians should be alert to a number of common co-morbidities when working with people with a suspected dual diagnosis, including nicotine dependence.

Mental illness – wellness continuum

It is useful to think of mental health on a continuum ranging from wellness to illness, with different degrees in between. In this context mental health is seen as a process, not a static state. Mental health is the state of emotional and social wellbeing that is more than the absence of illness. It influences how an individual copes with the normal stressors of life and whether they achieve their potential. Characteristics of mental health include:

- resilience
- balance
- flexibility
- self actualisation
- ability to enjoy life.

In this way, while someone may not meet the criteria for the diagnosis of a mental illness, they may not necessarily be considered mentally healthy if they have poor work-life balance, few social supports, engage in substance misuse and so on. Conversely, someone diagnosed with a mental illness can still have good mental health if their illness is well-managed.

The presence of a diagnosis or label may not reflect an accurate picture of what is happening for the individual at a particular point in time, but may lead to stigma and preconceptions (Hawkings and Gilburt 2004). It is of grave concern that mental health problems and mental illness are among the greatest causes of disability, diminished quality of life and reduced productivity in the community. According to the 2007 National Survey of Mental Health and Wellbeing: Summary of Results (ABS 2007) one in five (20 per cent) Australians had a mental disorder including anxiety, affective and/or substance use disorders in a 12 month period. Young people under 26 years experience higher rates of disorder (26 per cent) in a 12 month period compared with 5.9 per cent of those aged 75–85 years old.

Mental illness covers a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities (Australian Health Ministers, 2003) and day to day functioning. Mental disorders range from anxiety, behavioural, personality, mood, substance use and other psychotic disorders including drug induced psychosis. These are described in more detail later in the chapter.

It is important to note that given the size of the problem, treatment alone is not sufficient to reduce the burden of new cases. Research and government policy is thus increasingly advocating the need for promotion, prevention and early intervention as a means of enhancing wellbeing, as well as helping to reduce the need for people to require standard or long-term treatment.

Further information

Further information on the commitment from Queensland Health to mental health promotion, prevention and early intervention can be accessed at health.qld.gov.au/mentalhealth/abt_us/qpfmh/pfmhfsheet2.pdf

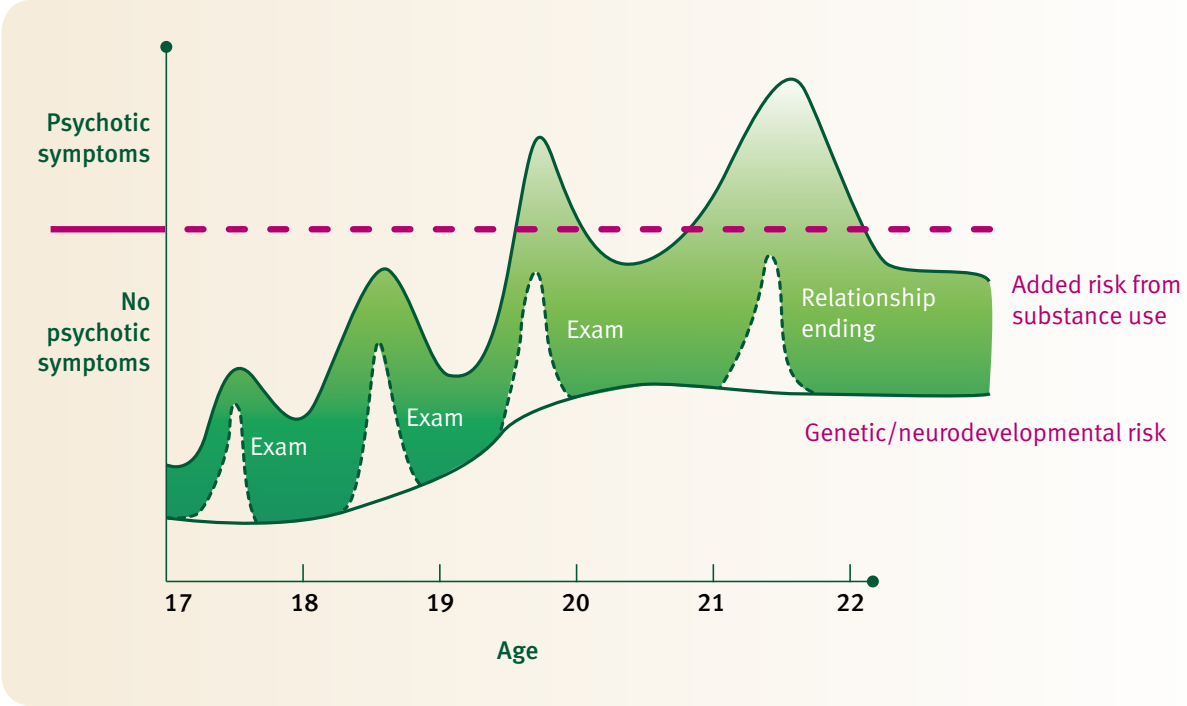
Stress Vulnerability Model

The Stress Vulnerability Model (Mental Illness Fellowship Victoria 2005) proposes factors which can contribute to the occurrence of mental disorders. Such factors include:

- biological (that is, family genetic history)
- personal (that is, self-esteem, ineffective coping skills, traumatic experiences)
- social/environmental (that is, family, stressful events, substance misuse).

The above factors can trigger mental health problems in vulnerable individuals. For example, an increase in environmental stress (substance use), can trigger mental health problems or relapse in predisposed individuals.

Figure 4 Stress Vulnerability Model
Adapted from Zubin and Spring (1977)



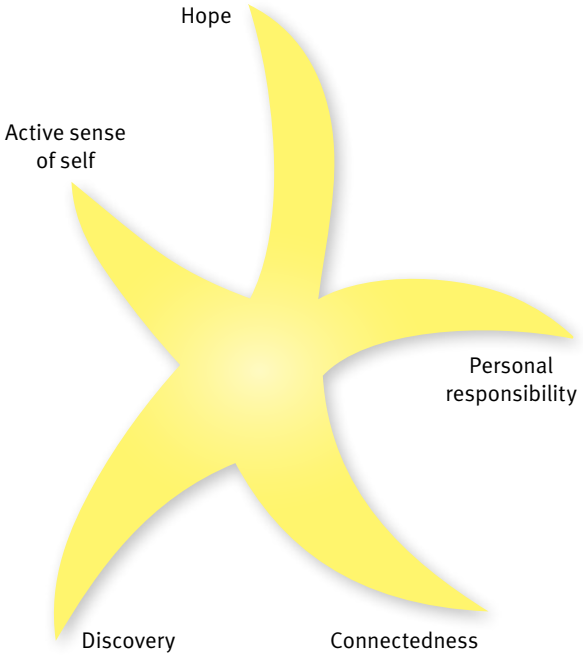
Recovery Model

The Recovery Model has now been adopted as the guiding principle of the mental health system in Queensland Health.

> *'The concept of recovery is an emerging paradigm that has significant implications for people with a mental illness, carers, families and service providers. It marks a substantial shift in philosophy from more traditional models of service provision and represents a change in beliefs, services, practices, anticipated outcomes and power relationships' (Queensland Health 2005).*

It has gained momentum due to an increasing recognition that people severely affected by mental illness can recover and live productive lives. The Recovery Model emphasises and supports an individual's potential for recovery. Recovery can be conceptualised as a personal journey and requires the provision of: hope, a secure base, supportive relationships, empowerment, social inclusion, coping skills, and finding meaning in one's experiences. This model also emphasises both the individual's personal journey to recovery and the connectedness of the individual to the community and wider society. Five elements have been identified as necessary in supporting each individual during their recovery journey. These elements include: hope, personal responsibility, connectedness, discovery and an active sense of self. The standardised suite of mental health assessment forms available on the Consumer Integrated Mental Health Application (CIMHA) includes a recovery plan to assist clinicians to focus assessment and treatment toward these recovery principles.

Figure 5 The Recovery Model
(Sharing Responsibility for Recovery: creating and sustaining recovery orientated systems of care for mental health, 2005)



The application of the recovery model for people with dual diagnosis requires the adoption of a stage wise approach. It is common for these individuals to experience relapse (of either or both disorders) and progress toward clinical outcomes may take a number of years, especially for individuals with severe mental illness (Mueser et al. 2003). Clinicians should familiarise themselves with the Stages of Change Model and stage appropriate interventions (refer to Chapter 8) to address the broad range of issues impacting on the functioning of these clients. Longitudinal studies in the United States have demonstrated support for positive long-term treatment outcomes and optimism for these clients (Munro and Edward 2008). Improvement in recovery oriented domains have been demonstrated in: controlling symptoms of Schizophrenia, remission from substance use, improved independent living, employment, social contacts with non-substance using peers and overall life satisfaction (Drake et al. 2006 cited in Munro and Edward 2008). Clinicians should retain a hopeful, recovery oriented perspective when dealing with these clients and seek support from peers and supervisors when experiencing difficulty in the provision of recovery oriented care.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Principle 8

A holistic, **recovery-based approach** is used in the provision of assessment, treatment and care, involving direct service provision for mental health and alcohol and other drug problems and effective linkage with the broader social service network to meet the range of complex needs experienced by people with dual diagnosis.

Responsibility 10

Assessment of co-occurring conditions includes a **holistic, recovery-oriented approach** to a person's general health and social welfare needs.

Further information

Further information on the Recovery Model can be found at health.qld.gov.au/mentalhealth/docs/Recovery_Paper_2005.pdf

Mental health disorders

Anxiety disorders

The Australian Bureau of Statistics (2007) identified anxiety disorders as the most common mental disorder. In total 14.4 per cent of Australians aged 16–85 years had a 12 month anxiety disorder. That is, persons with a lifetime disorder who experienced symptoms in the 12 months prior to the survey interview, with females experiencing rates at 22 per cent compared to males at 18 per cent.

Anxiety is a term used to describe a normal feeling people experience in response to a threat, danger or when stressed. However, some people experience these responses at extreme levels, which can significantly disrupt daily functioning. Although anxiety disorders are common, many people do not seek treatment, and try to cope by themselves. Sometimes, they use alcohol or other drugs as a coping strategy, although this can compound their problems.

A person may experience a range of anxiety disorders including:

- Panic Disorder with or without Agoraphobia
- specific phobias
- Social Anxiety Disorder
- Generalised Anxiety Disorder
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder
- Acute Stress Disorder
- Separation Anxiety Disorder
- Substance Induced Anxiety Disorder due to intoxication or withdrawal.

Practice tip

Clinicians should be mindful that in clients with alcohol dependence, some symptoms of alcohol withdrawal resemble generalised anxiety disorder.

Mood disorders

Mood disorders have been identified by the World Health Organization (WHO) as contributing to the major burden of disease in the developing world by 2020 (Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1999). In Australia 6.2 per cent of the population surveyed had a 12 month affective disorder, that is, persons with a lifetime disorder who experienced symptoms in the 12 months prior to the survey interview, with females experiencing rates at 7.1 per cent compared to males at 5.3 per cent (ABS 2007). On average, one in five people will experience depression in their lives; one in four females and one in six males (beyondblue.org.au).

Depression is more than just a low mood — it is a serious illness which can affect physical and mental health. A person may be considered depressed if for more than two weeks they have felt sad, down or miserable most of the time or lost interest or pleasure (anhedonia) in most of their usual activities. People with severe depression may also neglect eating or drinking, or engage in overeating, or experience delusions and/or hallucinations. Thoughts of self harm and suicide are also common in depression demonstrating an increased risk that should be monitored regularly.

Sometimes depression may be masked by alcohol and/or drug use. The incidence of co-occurring substance use with a depressive disorder is very high. Individuals withdrawing from substances may also experience lower mood and the clinician should be alert to the overlap between withdrawal effects and depressed mood.

Mood disorders include:

- Adjustment Disorder with depressed mood
- Major Depressive Disorder
- Dysthymic Disorder
- Bipolar Disorder
- Substance Induced Mood Disorder
- Postnatal Depression.

Bipolar Affective Mood Disorder

In Australia, 2.9 per cent of the population surveyed had a life time prevalence of bipolar disorder (formerly known as manic depression) with 1.8 per cent experiencing symptoms in the previous 12 months (ABS 2007). Bipolar Disorder is characterised by extreme mood swings ranging from depression and sadness to elation and excitement. Such episodes are of a recurring nature which can have a significant impact on the person's ability to function. Some people with this disorder do not experience depressive episodes — only the episodes of elation and excitement.

People with bipolar disorder are more likely to use substances – particularly alcohol, cannabis and benzodiazepines. When experiencing mania, an individual may find that the reinforcing effects of their 'high' mood masks the negative consequences of substance use. Poor insight into their mental state may impact upon the individual's compliance with medication and treatment interventions as well as reduce their insight and commitment into the need to address their substance use.

Psychosis

Psychosis is a condition which can be triggered by any number of factors including physical and psychological factors. Psychosis affects the brain's ability to evaluate reality. The individual can have trouble interpreting what is going on around them, which may lead them to become extremely frightened.

Psychosis can lead to significant disturbance in thinking, emotions and behaviours. Psychosis is generally characterised by positive symptoms including hallucinations, delusions and thought disorder and negative symptoms which may include blunted expression of emotions, low energy and avolition. The use of cannabis and amphetamines has been associated with an increase in positive symptoms of psychosis.

Disorders characterised by psychosis include:

- Schizophrenia
- Schizophreniform Disorder — for example, first episode psychosis or early psychosis
- Schizoaffective Disorder
- Brief Psychotic Disorder
- Substance Induced Psychotic Disorder
- Alcoholic Hallucinosis.

Personality disorders

Personality disorders are persistent, maladaptive patterns of behaviour and inner experiences that deviate from a person's cultural expectations and affect at least two of the following areas:

- thinking
- mood
- personal relationships
- control of impulses.

Personality disorders affect a person's life and have a negative impact on work, family and social life. Onset is in adolescence/early adulthood and remains stable over time. Most people with mild personality disorders may generally function well but during times of increased stress or external pressures (such as work, family or a new relationship) there may be an exacerbation of dysfunctional coping mechanisms and behaviours seriously interfering with emotional and psychological functioning. People may demonstrate a pattern of these personality traits without meeting the full diagnostic criteria for a personality disorder. The presence of persistent, significant distress, maladaptive coping or impairment must be present for a formal diagnosis to be given.

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR®)* (American Psychiatric Association 2000) and *International Classification of Disease 10 (ICD-10)* (World Health Organization 2007) have classified personality disorders into three clusters. People with Cluster A personality disorders demonstrate traits ranging from aloof to odd to eccentric. People with Cluster B personality types are more likely to be dramatic, erratic and impulsive. Cluster B personality types are the most likely to seek help from services. Cluster C personality types tend to be anxious, inhibited and fearful.

People with a personality disorder often experience co-occurring depression, anxiety and substance use problems and are likely to present to health services. Personality disorders which remain challenging for clinicians can include the dramatic impulsive styles — for example, antisocial and borderline types which are outlined in more detail below.

Antisocial Personality Disorder

The DSM-IV-TR® criteria for Antisocial Personality Disorder (ASPD) include a history of conduct disorder in adolescence and a pervasive pattern of disregard for, and violation of, the rights of others. Antisocial Personality Disorder may be characterised by participation in unlawful activities, lying, impulsivity, aggressiveness, a disregard for the safety of oneself and others, irresponsibility at work and at home, and a lack of remorse. People with Antisocial Personality Disorder are at risk of depression and substance use, and are over represented in the criminal justice system.

Borderline Personality Disorder

People experiencing Borderline Personality Disorder (BPD) frequently present to health services. People meeting criteria for Borderline Personality Disorder are well represented in mental health facilities with estimates of 11 per cent in community clinics and 20 per cent in inpatients units (Swartz et al. 1990 cited in Krawitz and Watson 2000). The majority (75 per cent) are female and many authors believe males are under diagnosed and under reported in MHS, and are more likely to be found (but not diagnosed) in alcohol and other drug treatment settings (Krawitz and Watson 2000). As a group, people with Borderline Personality Disorder are complex and often difficult to treat. Individuals with Borderline Personality Disorder are at heightened risk of dual diagnosis with the presence of a history of substance use often contributing to the attainment of a Borderline Personality Disorder diagnosis.

The disorder is characterised by marked instability in interpersonal relationships, emotional dysregulation, impulsivity and self harming behaviours. Of people with Borderline Personality Disorder, 75 per cent have a history of self harm on at least one occasion (Krawitz and Watson 2000).

Factors contributing to the development of Borderline Personality Disorder include:

- chaotic childhood
- parental neglect or abuse
- disrupted education
- legal difficulties
- substance use and/or dependence
- sexual abuse, early onset sexual activity or promiscuity
- fears of abandonment and maintenance of self destructive relationships
- failure to achieve potential or long-term goals
- poor ego boundaries and being unduly influenced by those around them.

Eating disorders

Eating disorders are a cluster of illnesses that are characterised by severe disturbances in eating behaviour and include Anorexia Nervosa, Bulimia Nervosa and eating disorders not otherwise specified. A disturbance in perception of body shape and weight is an essential feature of both Anorexia Nervosa and Bulimia Nervosa. The incidence of co-occurring substance use with this population is high though limited Australian statistics are available. In the United States (US) up to 50 per cent of people with eating disorders use alcohol or illicit drugs (National Centre on Addiction and Substance Abuse, 2003). Drugs misused can include caffeine, tobacco, alcohol, diuretics, laxatives, emetics, amphetamines, cocaine and heroin, which may suppress appetite, increase metabolism, purge unwanted calories and self medicate negative emotions. It is therefore vital for clinicians who have detected eating disorders to assess for substance use and offer standard substance use treatment interventions.

Common co-morbidities

Prevalence rates of dual diagnoses or co-morbidities are difficult to ascertain due to low rates of detection and recording of co-occurring problems. However, several mental health and alcohol and/or other drug problems are commonly found to co-exist. Clinicians should be alert to these most common co-occurring problems and engage in adequate screening for both disorders if one disorder is detected. The most common co-morbidities include:

- nicotine dependence and psychosis
- amphetamines and psychosis
- cannabis and psychosis
- alcohol and depression
- opioid dependence and Antisocial Personality Disorder
- eating disorders and substance use disorders.

The US Epidemiological Catchment Area (ECA) Study (Regier et al. 1990) is a seminal study on the prevalence of co-morbidities and identified co-occurring substance use disorders in several mental health populations. These figures are listed below. The co-occurrence of substance use disorders is the most prevalent in bipolar disorder. It is also interesting to note that nicotine is not included in statistics assessing the prevalence of dual diagnosis in this study. Nicotine dependence in people with dual diagnosis has been found to be the most prevalent of all substance use disorders with rates of co-morbidity up to 90 per cent (Access Economics, 2007). The assessment and intervention to address mental illness and co-occurring nicotine dependence is routinely low by Queensland Health MHS clinicians (Kavanagh et al. 2009) and should be a priority area to be addressed by clinicians in both service sectors.

Table 1
Lifetime prevalence of alcohol and other drug disorders among persons with mental disorders

Bipolar disorder	56%
Schizophrenia	47%
Panic Disorder	36%
Obsessive Compulsive Disorder	33%
Major depression	27%
General population	17%
Antisocial Personality Disorder	84%

Table 2
Lifetime prevalence of mental disorders among persons with any alcohol abuse diagnoses

Any mental disorder	37%
Schizophrenia	4%
Any affective disorder	13%
Any anxiety disorder	19%
Antisocial Personality Disorder	14%

(The US ECA Study 1990)

Practice tip

All clinicians should consider the likelihood of dual disorders following detection of one disorder.

Screening and assessment for co-occurring substance use disorders should always be undertaken once one disorder is identified.

All problems detected should be recorded in the clinical chart and relevant information systems.

In the Australian context there are also limitations on reported rates of co-morbidity. However, the prevalence of substance use in clients with a severe mental illness is particularly high (Munro and Edward 2008). In addition, substance use has been found to be almost double that of the general population in individuals experiencing first episode psychosis (Barnett et al. 2007; Munro and Edward 2008). Australian research from the Early Psychosis Prevention and Intervention Centre (EPPIC) has identified 74.1 per cent of young people admitted to a mental health facility with a lifetime prevalence of a substance use disorder and 61.1 per cent of this population meeting criteria for a current substance use disorder (Hinton et al. 2008, in Allsop 2008). These high rates of co-morbidity highlight the need for rigorous screening, assessment, and management for dual diagnoses.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Principle 9

Within the treatment context, both mental health and alcohol and other drug problems are **considered of primary importance to the clinical presentation.**

chapter 4

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key points

- Diagnostic criteria for substance use problems outlined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR®)* (American Psychiatric Association 2000) and *International Classification of Disease 10 (ICD-10)* (World Health Organization 2007) describe a range of conditions including intoxication, withdrawal, abuse, harmful use and dependence.
- Alcohol, Tobacco and Other Drug Services (ATODS) and Mental Health Services (MHS) operate on the principle of harm minimisation and recognise that the effects of alcohol and drug use depend on a range of individual, drug and environmental factors.
- Substances (alcohol and other drugs) and their effects can be categorised according to central nervous system depressants; central nervous system stimulants; and hallucinogens.
- The spectrum of alcohol and drug use includes non use, experimental, recreational, regular and dependent use, and also includes patterns of polysubstance and binge usage.
- The intravenous route preferred by some substance users is associated with significant health risks such as hepatitis. Clinicians should adequately assess, document and provide advice and education on safe injecting practices, and alternatives including non injecting routes. Clinicians should always provide information and linkage with their local ATODS needle and syringe program (NSP).
- Clinicians should have knowledge and understanding of a range of special considerations in the assessment of individuals including those presenting with intoxication, overdose and level of mental health risk.
- Other considerations include level of tobacco use, pregnancy, individuals with opioid dependence, those with chronic pain and HIV as well as marginalised groups such as prisoners, lesbian, gay, bisexual and transgender individuals and those who are homeless.

Types of drugs and their effects

Drugs have been described as any substance that affects the way the mind works or how we think, feel or act. This is obviously a very broad definition that takes in a wide range of substances including those that are socially acceptable such as coffee, tea and alcohol, through to those that are not, such as cannabis and heroin.

The effects of alcohol and drug use depend on the following:

1. individual factors – age, weight, gender, general health, tolerance and previous experience of the substance including intoxication and withdrawal, current mood and psychological health
2. drug factors – purity, route of administration, drug/medication interactions and type of use — for example, binge use
3. environmental factors – social settings and company and cultural context including ritual.

Drugs can be classified according to the following three categories:

- central nervous system depressants
- central nervous system stimulants
- hallucinogens.

(NCETA 2004)

Depressants

Moderate doses of central nervous system depressants can cause relaxation, euphoria and a sense of wellbeing. Often depressants are used to 'wind down' or to reduce stress, anxiety and/or inhibitions. They don't necessarily make a person feel depressed, but feelings of depressed mood are often a consequence of taking these substances. They also reduce coordination and impair concentration and judgment. A person may also become sluggish or uncoordinated, have slurred speech, and experience nausea and vomiting. In higher doses depressants can slow breathing and heart rate, and can result in overdose and death.

Stimulants

These types of drugs stimulate or increase the functioning of the central nervous system and speed up the messages going to and from the brain to the body. Stimulants include tobacco/nicotine, caffeine, amphetamines/methamphetamines and cocaine. Short-term effects of stimulants can include a heightened alertness, increased energy, confidence and decreased need for sleep. Stimulants also increase heart and breathing rate, elevate blood pressure, suppress appetite, dilate pupils and cause agitation and insomnia. Stimulants can induce extreme agitation and irrational, impulsive and paranoid behaviour which may result in aggression. Stimulants can also trigger psychoses and, in prediposed individuals, severe and enduring psychotic illness.

Further information

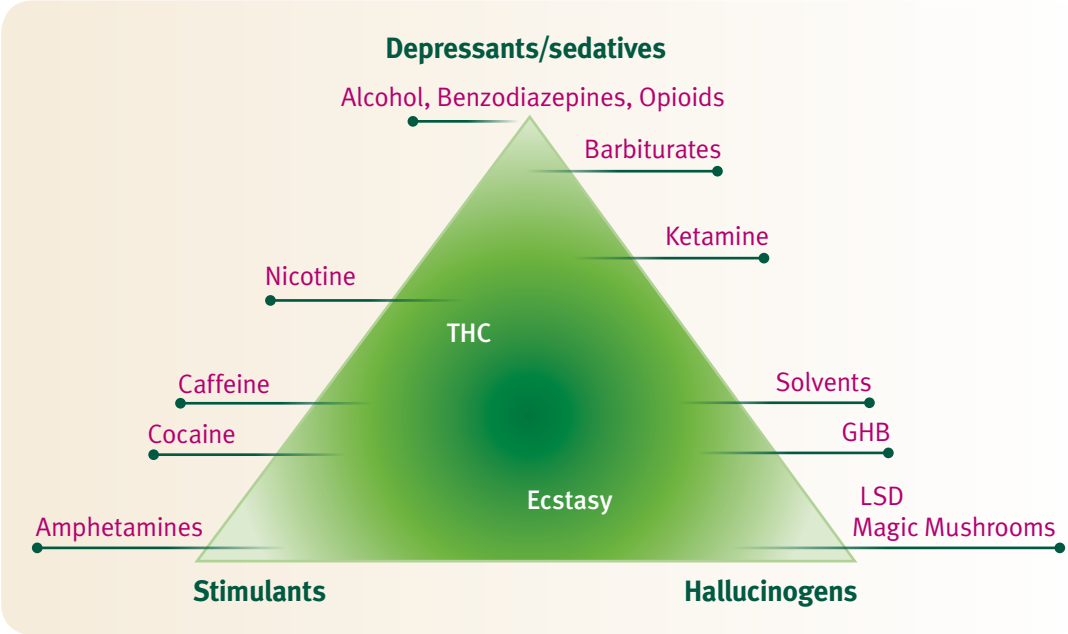
Further information on *The Management of Patients with Psychostimulant Toxicity: Protocols for Emergency Department* (2008) is available on QHEPS at health.qld.gov.au/atod/documents/psychostimulant_toxic.pdf

Hallucinogens

Hallucinogenic drugs are also known as psychedelics and affect all the senses, altering a person's thinking, sense of time and emotions. The sought after effects of these substances include increased energy, relaxation, detachment from the world, visual hallucinations, distortions of reality and sensory experience. The effects of hallucinogens are difficult to predict, and are greatly affected by the mood of the person and the context of use. Negative effects can include panic, anxiety, paranoia, feelings of persecution and a loss of contact with reality.

Combining substances can lead to unanticipated consequences. Substances of the same class can have an enhanced effect. Clinicians should be alert to the combination effects of substances especially if the two substances are both depressants. This increases the risk of medical complications including overdose and even death. Combination effects can occur with any class of substance. However, combining depressants puts the individual at heightened risk of respiratory failure. Other substances like cannabis and ecstasy can also have combination effects increasing the risk of overdose and adverse reactions. Clinicians should also be mindful of the interactive effects of substances with psychotropic medications. Clinicians are encouraged to document all concerns and seek medical advice.

Figure 6 Triangle of drugs and their effects
Adapted from Sim M. (2001), Triangle Theory, cited in (Khong 2004)



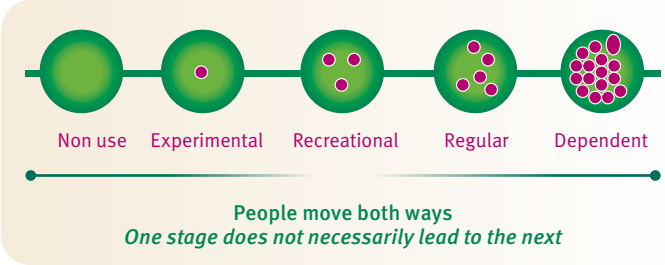
Patterns of substance use

Substance use is often categorised by describing behavioural patterns of use. These categories are not rigid definitions and substance use can be problematic at any stage. There are risks associated with all levels of use. Clinicians should consider opportunities for early intervention and the provision of brief interventions whenever any substance use is detected.

When considering patterns of use the key factor is the amount taken and the effect on the person. A person can have different patterns of use with different drugs — for example, regular use of cannabis yet experimental use of ecstasy. Alcohol and drug use ranges from safe levels to hazardous consumption characterised by dependence. The Spectrum of Use (Victorian Health 2000) describes the five categories of alcohol and drug use:

- non use
- experimental
- recreational
- regular
- dependent.

Figure 7 Drug use spectrum



Experimental use

Experimental use implies the person is trying out the drug to ascertain the effects. Young people will often experiment with drugs out of curiosity, to fit in with a peer group or to challenge authority. For example, a young person may use alcohol or tobacco for the first time with friends. Experimental use could also apply to a person who tried ecstasy once six months ago and wants to try it again, or a person who has grown up with no drug or alcohol use but gets drunk with friends to see how it feels. The number of individuals experimenting is steadily increasing and the age of initiation of use is decreasing. However, experimental use tends to be random and is usually social. It is important to note that it does not necessarily lead to dependency — the slippery slope theory is not supported by research (Hawkings and Gilburt 2004).

Clinicians should always assess and manage all alcohol and drug use in clients with severe mental illness.

Recreational use

Recreational use usually occurs at specific events when the user is aware of the substance effect, and makes a conscious decision to seek out that effect to enhance an event. The person using alcohol and/or drugs recreationally may be able to control their use and stop for long periods of time. Recreational use applies to both licit and illicit substances and is usually a social experience. An example could be a person uses ecstasy infrequently at dance parties.

Regular use

Regular use of alcohol and/or drugs describes a pattern of use where an individual is consuming a substance on a regular predictable basis (for example — daily, weekly, every other weekend or monthly). Regular use may lead to dependent use if high quantities are consumed at regular intervals. Regular use can also be associated with activities, social triggers (for example — having beers on a Friday night) or specific triggers (for example — pay day). This pattern of use is associated with psychological triggers and habitual patterns of behaviour and may be a risk factor for developing dependent use.

Dependent use

Dependent use of alcohol and/or other drugs refers to a syndrome which involves a cluster of cognitive, behavioural and physiological changes which exist in various degrees and develops after repeated use over months or years. In this context, use of the drug is given a much higher priority than other behaviours which once had value; life becomes more and more focused on alcohol and drug use. Neuroadaptation is a term often used to describe the ability of the body to adapt and yet still function despite being under the influence of alcohol or other drugs. It is important to recognise that individual biological, psychological and social factors strongly influence development of substance dependence. The importance of these factors varies from person to person and for some may be of greater importance than the simple biological drug effects in maintaining dependence or in contributing to relapse. For further information on dependent use refer to the *DSM-IV-TR®* evidence of dependence.

Practice tip

Any substance use by people with severe mental illness is considered clinically significant and should be addressed by the clinician.

Special considerations

Individuals with severe mental illness may consume far smaller quantities of alcohol and other drugs than other substance users. However, the impact of their use may be severe due to the interaction between their mental illness and the alcohol and drug use. Clinicians should always assess and manage *all* alcohol and drug use in clients with severe mental illness.

Early intervention is a key aim of treatment and even low levels and irregular use of substances should prompt feedback, brief interventions, psychoeducation or more intensive substance use interventions.

Other patterns of use

Polysubstance use

Polysubstance use describes the use of more than one type of substance by the same individual and is considered the norm for people with dual diagnosis. Polysubstance use may be related to the accessibility of certain types of substances or the deliberate combining of different types of drugs in order to enhance the drug effect. Polysubstance use can indicate the use of multiple types of drugs at one time either in a drug cocktail or one after the other. Taking a combination of substances can produce more unpredictable and dangerous outcomes. Clinicians should be alert to the interactive and possible adverse effects of polysubstance use especially when substances of the same class are consumed. Clinicians should assess substance use thoroughly and address the use of each substance in the management of the individual. Clinicians should also be aware of common language used by consumers such as the terms grass, weed, spin (mixing tobacco with cannabis), cone, foil, quarter (in those who use cannabis).

Binge use

Binge use describes a pattern which involves episodic use of a substance in large amounts over a condensed period of time (which may be a period of hours, days or weeks) followed by little or no use. Often the period between binges becomes shorter and substance use becomes heavier and more problematic. An example of binge use includes a drinker who once a month consumes large amounts of alcohol all weekend and who may have physical complaints, such as liver damage, alcohol poisoning or social consequences such as regularly getting into fights whilst intoxicated. Binge use would also describe an Ice/amphetamine user who spends large amounts of money on the substance and then doesn't use for some time.

Practice tip

When combining drugs with the same type of action (for example — central nervous system depressants such as heroin and alcohol) the effects are intensified, increasing the risk of intoxication and overdose.

Clinicians should pay extra attention to the use of multiple drugs of the same class (including interactions with medications) and routinely assess risk.

Diagnosis and classification of substance use disorders

The recording of an appropriate diagnosis is imperative for the development of a management plan. Broadly, diagnoses list the substance and the related disorder. Examples of these include intoxication, withdrawal, abuse, harmful use and dependence. As well as these groups there are also disorders which are 'induced' by the substance. These do not simply occur in the context of intoxication or withdrawal and can include psychotic or mood symptoms.

There are two main systems for the classification of substance use disorders. The *DSM-IV-TR*® is published by the American Psychiatric Association (2000) and the *ICD-10* is published by the World Health Organization (2007).

Each provides diagnostic criteria for substance use disorders. The *ICD-10* has been widely utilised in coding and administration but *DSM-IV-TR*® has gained more popularity amongst clinicians. Although the systems are quite similar there are differences that can cause confusion. One of these is the use of the category 'substance abuse' in the *DSM-IV-TR*® as opposed to 'harmful use' as defined by *ICD-10*. The two definitions are similar and virtually interchangeable in a clinical setting. The term 'harmful use' may be considered preferable and clinically more useful, as the term 'abuse' has negative associations. Clinicians are recommended to use the diagnostic classification that is used within their service.

Harm minimisation

Harm Minimisation is the primary principle underpinning the National Drug Strategy 2004–2009 and Queensland Drug Strategy 2006–2010. Harm minimisation has been defined either as 'policies and programs aimed primarily at reducing the health, social and economic costs of psychotropic drugs without necessarily reducing drug consumption' (Van Beek 2009) or 'an overall aim to minimise or limit the damage arising from the use of alcohol and other drugs to both individuals and the community' (Ministerial Council on Drug Strategy 2004).

The adoption of a harm minimisation goal means the wellbeing of the individual and their community is central. This does not imply that clinicians ignore the client's needs to reduce or cease substance use. When the assessment identifies that substance use is excessive or is causing harm, feedback or evidence is to be provided in a non-judgmental way, concern is expressed and brief advice is given. However, many clients will continue to use alcohol and other drugs, no matter what risks are involved. Harm minimisation works with, and respects, the decision making of individuals. Where a person elects to continue substance use, the intervention focuses on maintaining safety and reducing other negative impacts on the person, their family and community. The success of an intervention does not depend on changes in consumption, as important as that may be. Successful interventions provide conditions that maximise the chance that harms are reduced and wellbeing is enhanced.

Where people have co-occurring mental health and substance use disorders, cognitive impairments may limit their ability to make these choices. Interventions compensate for these deficits by minimising the information these clients need to hold in memory — for example, using visual aids, more repetition and summaries, and shorter sessions. However, when there is serious cognitive impairment, clients may be unable to make an informed decision about their substance use. When such a person is at imminent and serious risk, harm minimisation is consistent with actions to ensure the protection of themselves and those around them.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Principle 7

A **harm minimisation approach** is used and promoted in the treatment of people with dual diagnosis.

Examples of harm minimisation strategies that can be used when a client is pre-contemplative or ambivalent about changing their substance use include:

- providing access to clean injecting equipment and related education
- strategies to prevent or rapidly address overdoses
- drink driving interventions
- interventions that reduce the risk of self harm when intoxicated
- brief interventions
- withdrawal management/detoxification programs
- relapse prevention
- opioid treatment programs
- encouraging safer means of drug ingestion — for example, ingesting rather than injecting
- vein care
- skill development activities
- 12 step programs.

Harm minimisation practice tips

Some examples of harm minimisation tips are listed below. This list is not exhaustive and a range of other strategies can be engaged by clinicians:

- do no harm
- respect the rights of individuals with drug related problems
- focus on the harms caused by the substance rather than substance use itself
- maximise treatment intervention options
- attempt to negotiate realistic goals.

Early intervention is a crucial component of harm minimisation and the provision of treatment services. Early intervention aims to reduce further harm and the possible development of more severe, chronic substance use problems and/or associated health problems. All clinicians should be aiming for early intervention in clients with dual diagnosis. Once any substance use is detected in this population, intervening early is crucial in minimising the development of more complex and chronic problems.

Early intervention includes:

- provision of accurate information about drug use and associated risks — for example, education on standard drinks, recommended levels of alcohol use and drink driving campaigns
- developing skills and providing resources that promote safer use of drugs — for example, safe injecting techniques, needle and syringe programs, and training health and welfare workers in the early detection and prevention of alcohol and drug use problems
- targeting minimal or moderate substance use in order to facilitate a reduction of use and arrest the development of a more severe or chronic substance use disorder.

Intravenous substance use

Many individuals who use substances choose to inject drugs as their preferred route of administration. A variety of drugs are commonly injected. Injecting drug use is associated with significant risks and health complications. Various drugs are also associated with drug-specific risks caused by this method of administration.

Some of the harms related to injecting include:

- overdose especially if polysubstance use
- blood borne viruses (BBV): HIV, HCV or HBV
- trauma and/or infections of injecting sites such as scarring, thrombosis or thrombophlebitis cellulitis
- Staphylococcal and other systemic bacterial and fungal infections causing septicaemia, infective endocarditis, pneumonia, osteomyelitis or renal complication (glomerulonephritis)
- Tetanus and Anthrax.

It is important for the clinician to be alert to the possibility that their client may be using substances intravenously even if the client withholds information. If the clinician suspects intravenous drug use, this can be raised hypothetically with the client and an appropriate brief intervention provided. Suspicions of intravenous drug use should always be documented in the client's chart. The aim of the interaction with the suspected intravenous drug using client is to build rapport and promote engagement whereby pertinent personal information will be disclosed freely and addressed in the context of the therapeutic relationship.

There is no 100 per cent safe way to inject substances, especially illicit substances, which are non sterile and of unknown quality and quantity. The clinician should always seek advice from the local ATODS and ensure appropriate referral of the client to their local NSP.

If a client admits to intravenous drug use it is important that the clinician:

- assesses the risks and provides objective information regarding ongoing risks and offers practice strategies to decrease risks
- documents in the client's file that the individual is injecting, the drug used, quantities and other drugs used (combining of drugs and/or medication). In addition, their history of sharing of injecting equipment and paraphernalia including tourniquets, spoons, water and swabs should be documented. Consumers may not identify the sharing of injecting equipment with their partner or close friends as 'real' sharing and therefore not identify themselves at risk. Clients should be offered testing for blood borne viruses (HIV, HCV and Hepatitis B) and receive vaccination or treatment as appropriate
- documents the advice and details of the educational material provided by the clinician to minimise the risk of harm to the client via safer injecting practices with the alternatives to non injecting routes being emphasised.

In the case of children or adolescents injecting substances other considerations apply in regard to the Gillick Competency (Department of Communities and Disability Services Queensland 2007) which refers to the child's/young person's ability to make informed consent about a medical procedure, informing parents of high risk behaviours and involving parents/caregivers in treatment.

If the child/young person passes the Gillick Competency test, the clinician requests/offers the client the opportunity to discuss their concerns and their at risk behaviours with the parent/guardian. If the client declines, this needs to be documented. Special consideration needs to be given to the potential increase in risk to the client if they state their intention not to attend further sessions if confidentiality is compromised. It is recommended that the team undertake discussion regarding the merits of disclosing or not disclosing confidential information given consideration to the complexity of the issues involved. The rationale for any decision should be documented giving reasons why it was decided to disclose information or not to the parents/guardians. Specific reference needs to be made to the perceived risk of disengagement and the potential loss of counselling interventions and that any decision was agreed to by the treating team.

Practice tip

All brief interventions provided and risks identified need to be documented by the clinician in order to support their care of this client and enact their duty of care in managing an individual engaged in high risk behaviours.

Safe injecting practices: an application of a harm minimisation approach

An underlying principle of a harm minimisation philosophy is that an individual has the right and capacity to make an informed decision about the continued use of their drug of choice. Harm minimisation is the philosophy that underpins the provision of information regarding safe injecting practices and the availability of needle and syringe programs (NSP) throughout Queensland. If an individual declines to cease injecting substances, it is considered the clinician's duty of care to ensure information on risk and strategies to minimise risk are provided to the client. In cases where the individual lacks insight into the level of risk of their behaviour, treatment strategies, including harm minimisation strategies, need to be agreed by the treating team and support provided to enhance the safety of the individual. Clinicians are encouraged to request further information and seek advice from the Mental Health Dual Diagnosis Coordinator (MH DDC) and ATODS to support the care of clients who are injecting drug users. Comprehensive information on safe injecting practices and the contact details for local NSPs can be obtained from local ATODS.

Further information

Client and clinician educational material can be obtained from the Alcohol and Drug Information Service (ADIS) on: 1800 177 833 (freecall) or see health.qld.gov.au/northside/documents/ads_insert1.pdf

This service is provided by Metro North Health Service District and offers a comprehensive information and referral service 24 hours a day to the public and health services of Queensland.

The Clean Needle Helpline: 1800 633 353

Queensland Health, ATODS, Queensland Needle and Syringe Program, see health.qld.gov.au/atod/qnsp.asp

Practice tip

Any individual disclosing the use of substances intravenously should be given information about their local needle and syringe program (NSP) provided through ATODS. This information should be documented on the client's file.

Hepatitis

Hepatitis C is most commonly found in injecting drug users. The sharing or re-using of contaminated injecting equipment is the most common form of transmission and injecting drug users should never share any injecting equipment; they should utilise other safe injecting practices. Approximately 83 per cent of Hepatitis C infections in Australia (Hepatitis Australia 2008) (hepatitisaustralia.com) have resulted from unsafe injecting drug use. It is crucial for clinicians to highlight these risks with clients engaging in injecting drug use.

Medical treatments are available for chronic Hepatitis C infections and those infected with this virus are also advised to engage in modifications to their lifestyle to manage their symptoms and minimise the risk of progression to more severe illness. Ongoing alcohol use can increase the risk of liver disease and people with Hepatitis C are advised to limit or cease alcohol use. Alcohol use is also likely to affect the response to treatment, making treatment less effective. Tobacco and cannabis use may also accelerate the progression of Hepatitis C.

Side effects of pharmacological treatments are significant and can include: irritability, depression, suicide and psychosis. Individuals with a dual diagnosis considering treatment for Hepatitis C, should discuss treatment options with their doctor. The mental health of those undertaking treatment should be closely monitored throughout the duration of treatment. It is important for mental health clinicians involved in the person's care to make contact with the liver specialist and for a partnership approach to treatment to be engaged, with regular liaison between the treating teams.

Clinicians should offer their clients vaccinations for Hepatitis B and Hepatitis A.

Practice tip

Clinicians working with an individual with Hepatitis C should regularly monitor their client's alcohol consumption. Educational information regarding alcohol use and Hepatitis should be provided and abstinence from alcohol recommended.

Clinicians should ensure that clients undergoing medical treatment for Hepatitis C are regularly assessed by a mental health professional.

The liver specialist, ATODS and MHS should all be involved in the integrated care of the individual as outlined in the Queensland Health Dual Diagnosis Policy.

Further information

Further information on managing consumers with co-occurring mental health problems and Hepatitis C, clinicians should refer to Queensland Health Protocols Hepatitis C and Mental Health Protocols (2004), available at health.qld.gov.au/mentalhealth/docs/23007.pdf

Further information and support for those with Hepatitis can be obtained from the:

- Hepatitis Council of Queensland – hepqld.asn.au/
- Hepatitis Australia – hepatitisaustralia.com
- Queensland Injectors Health Network (QuIHN) – quihn.org/

Special considerations

Wernicke's Encephalopathy and Korsakoff's Syndrome

These syndromes are caused by thiamine deficiency among other things and can be related to the long-term, heavy use of alcohol. Therefore these syndromes are more likely to be seen in adults or older persons. Wernicke's Encephalopathy is an acute medical emergency that classically presents with the triad of ataxia, nystagmus (eye movement disturbance), and a confusional state. It can be reversed to a large extent by expedient administration of thiamine parentally. For this reason, thiamine supplementation should be offered routinely to all clients who present with an alcohol related disorder or if there are any symptoms suggestive of Wernicke's Encephalopathy.

Korsakoff's Syndrome is often a chronic or end stage condition, characterised by profound short-term memory loss with relative preservation of other intellectual abilities. The gaps in short-term memory may be filled in by confabulation or the formation of false memories, perceptions or beliefs. Its resolution is less predictable and long-term care may be needed.

Intoxication and overdose

The acutely intoxicated client provides special challenges to the clinician. The nature of the intoxication relates directly to the pharmacological effects of the substance and generally resolves with time. The intoxicated state is accompanied by behavioural, cognitive and physical disturbances. An overdose occurs when the person's physical state becomes compromised as a result of an excessive dose of the drug(s). This can be life threatening requiring urgent medical intervention.

The intoxicated client may pose considerable difficulties in assessment. Behavioural disturbance can be severe and include refusal of care. The client may be misinterpreting their environment or may behave aggressively because of the situation. Intoxicated clients may pose a risk of violence and should be carefully observed. An overdose may be intentional and the risk of further suicidal behaviour should also be considered.

The symptoms of intoxication may also mask a co-morbid problem. For example, the client intoxicated on alcohol and experiencing ataxia may also have Wernicke's Encephalopathy or a head injury. Similarly intoxicated clients who voice unusual beliefs may have an underlying psychotic illness.

Intoxication management

If a person presents intoxicated to a health service, clinical staff should manage this behaviour in the same way they would assess and manage any other complex, crisis presentation. All clinical staff are required to treat the intoxicated individual in a professional manner.

Tips for interacting with an intoxicated consumer include:

- non-judgmental and non-confrontational approach
- reality orientation (time, place, person)
- simple, clear and short communication (that is, uncomplicated, brief sentences)
- unambiguous statements
- repeated explanations
- provision of a low stimulus environment
- calming verbal communication
- de-escalation techniques if required
- provision of emergency care if the consumer becomes agitated, aggressive or displays signs of medical complications.

Established hospital protocols for **assessing intoxication** should be applied. The clinician should attempt to establish the type and level of intoxication. A variety of methods can be utilised to assess levels of intoxication and include:

- self reports of substance use
- collateral information
- laboratory tests
- urine tests – rapid urine tests (if available)
- breath analysis.

Physical assessment and observations should be performed to assess the level of any compromise, and as a baseline to monitor for deterioration. It is also important to screen for any possible physical cause of their symptoms. Early consideration should be given to specific treatments such as naloxone in the case of opioid overdose and thiamine in the alcohol affected individual.

The level and type of intoxication will determine the management of the consumer. If the client is mildly intoxicated with minimal risks then supportive friends or relatives may be able to provide a safe environment for recovery. In some communities sobering-up centres may be an option.

If the consumer is a ***dependent substance user***, it is likely that they will enter a withdrawal state following the resolution of acute intoxication. Clinicians should be alert to signs and symptoms of substance withdrawal and utilise the clinical protocols for detoxification in hospitals and detoxification facilities (Saunders and Yang 2002).

Polydrug users are at greater risk of complicated intoxication. Clinicians should explore the possibility of polydrug use as combining substances increases the risk of interactive or compounding effects of substances (that is, heightened effects of drugs of the same class or interactive effectives between classes of drugs).

*If the consumer is a **dependent substance user**, it is likely that they will enter a withdrawal state following the resolution of acute intoxication.*

Overdose

Possible indicators/symptoms of overdose include:

- suspicion or confirmation that an excessive quantity of drug has been taken
- reduced level of consciousness
- impaired breathing
- abnormal pulse rate (racing, slowed or irregular pulse)
- extreme drowsiness
- extreme pallor or weakness
- excessive vomiting
- marked changes in behaviour or personality
- hallucinations, extreme anxiety or depressed mood
- self report of substance use, quantity or mix of drugs.

During an overdose, it is advisable that the person is closely observed, monitored, and referred for acute emergency treatment. If possible try to obtain the client's name, quantity and type of substance taken and provide all information to the medical team.

Practice tip

A mental state examination may be conducted on anyone who is conscious, including those who are intoxicated. The state of intoxication is likely to influence the outcomes of the exam and should be noted. The clinician should be alert to the fact that the outcomes of the assessment may change when it is repeated at a time when the client is not intoxicated (NSW Department of Health, 2009).

The client should be given a place of safety until they become sober and then a thorough mental state examination and risk assessment conducted.

Ongoing observation of risk is essential to maintain safety throughout the sobering up period.

Assessment of risk

All intoxicated people require a mental health risk assessment and risk management plan. The use of established district protocols on the provision of risk assessment should be applied.

If the person is voicing suicidal ideation or has a history of mental illness they must be provided with a safe environment until a thorough mental state and risk assessment can be conducted upon the resolution of acute intoxication. It is also important to note that the results of a mental state examination may differ when a person is intoxicated to an examination when they are sober. However, the principle remains that a mental state examination may be conducted on anyone who is conscious, including those who are intoxicated.

Clients considered high risk, whether this is in their mental or physical state, require specialised assessment and treatment. If the client requires assistance with transport to facilitate this level of care, careful consideration should be given to the provision of adequate containment and safety.

Special precautions are to be taken for the following high risk groups:

- pregnant women
- children
- adolescents
- Aboriginal and Torres Strait Islander peoples
- people from culturally and linguistically diverse backgrounds.

The **clinical notes** should record an assessment, diagnosis and management plan. This should include a specific mental health risk assessment. Collateral history and response to treatment also need to be documented. If the patient is discharged, documentation of their discharge mental state, as well as the presence of a safe discharge environment and responsible carers, should be noted. A follow-up plan should be negotiated with the client/s and referral to appropriate services facilitated.

If the intoxicated individual discharges themselves against medical advice and leaves suddenly by themselves, the clinician should try and inform significant others, if possible, or the police/security if necessary. The clinician should ensure documentation of these events and implement a follow-up plan.

Involuntary assessment

A MHS consumer presenting with substance intoxication may be subject to involuntary assessment. The *Mental Health Act 2000* allows for detainment for up to 24 hours for assessment when it appears the consumer suffers mental illness but cannot, or refuses, to be assessed. Two forms need to be completed: the recommendation for assessment and the request for assessment. Further details can be obtained in the Act.

Further information

Further information on the *Mental Health Act 2000,* including multilingual fact sheets, processes for obtaining involuntary assessment and patients' rights and responsibilities can be found at health.qld.gov.au/mha2000/default.asp

For further information on the management of intoxication, clinicians should familiarise themselves with district protocols and work unit guidelines. Protocols governing the assessment of risk are paramount in the management of intoxication and the provision of a comprehensive risk assessment should underpin clinical decisions in the management of these consumers.

Tobacco use

People with mental illness smoke at around twice the rate of other Australians. In particular, people with Schizophrenia have a smoking prevalence rate of around 90 per cent (Access Economics 2007). Such high prevalence of smoking rates raises health and public policy concerns. The relationship between smoking and mental illness, including anxiety, depression and substance use disorders is complex, as mental illness is not only a risk factor for smoking; but smokers are two to four times more likely to develop a mental illness (Access Economics 2007). The assessment and intervention to address mental illness and co-occurring nicotine dependence is routinely low by Queensland Health MHS clinicians (Kavanagh et al. 2009) and should be a priority area to be addressed by clinicians in both MHS and ATODS.

Queensland Health has a smoking policy to manage smoking at all public health care facilities. Clinical staff are required to provide brief interventions including advice about quitting smoking and referral to Quitline for more information and counselling.

People with dual diagnosis who smoke need to have access to smoking cessation programs based on relapse management techniques and be encouraged to attempt to quit. Royal Brisbane Women's Hospital (RBWH) Division of Mental Health has designed, implemented and evaluated one such quit smoking program. For further information regarding this program please contact the Team Manager or the Quit Smoking Program Coordinator, Resource Team, Inner North Brisbane Mental Health Service, RBWH, Metro North Health Service District.

Further information

Further information can be obtained at qheps.health.qld.gov.au/qhsmp.quitnow.info.au/

Pregnancy

Alcohol and/or drug use during pregnancy is known to have adverse effects on foetal development. Early detection and provision of evidence-based interventions for tobacco, drug and/or alcohol using women who are pregnant or likely to become pregnant is an effective way of improving pregnancy outcomes. Women of child bearing age who are seeking assistance for alcohol and other drug problems should be asked about contraception and provided with education about the harmful effects of alcohol and other drug use during pregnancy.

All pregnant women should be screened for mental health and substance use problems. It is important for pregnant substance using women to receive appropriate specialist care including pre and post natal care. This may include birth planning for special circumstances (for example — avoidance of blood borne virus transmission, early admission in labour, anaesthesia management, management of labouring women on a opiate replacement treatment program), and post natal care to address a range of risk factors including the management of Neonatal Abstinence Syndrome, timing of discharge, contraception advice, sudden unexpected deaths in infancy, prevention advice, support and advice regarding breastfeeding and the coordination of assertive follow up. Clinicians should liaise with their local obstetric department regarding pregnant consumers of their service.

Clinicians should also be aware of the risk of Postnatal Depression which may be complicated by psychosis. This may further complicate the presentation and management of this condition.

Further information

Clinicians requiring further information should refer to the *National clinical guidelines for the management of drug use during pregnancy, birth and the early developmental years of the newborn* (NSW Department of Health) at health.nsw.gov.au/pubs/2006/pdf/ncg_druguse.pdf and *Best for me and my baby* booklet available at copmi.net.au to assist with managing mental health during pregnancy and early parenthood.

Opioid dependent individuals

Further specialist alcohol and other drug assessment is required to respond to opioid dependence. The treating clinician should consult with a MH DDC or Opioid Treatment Program (OTP) clinic, to refer the client to the local OTP for further assessment. The treating clinician should comply with responsibilities as outlined in the Queensland Health Dual Diagnosis Policy. They are to retain full clinical responsibility until a treatment plan is developed and the two services identify who is to retain primary case management responsibility for the patient. Both services are to remain involved in treatment and share information as prescribed by the policy.

Registered opioid dependent individuals

If an individual is currently registered with a public Queensland OTP, this service should work collaboratively with the local MHS in the management of the client with a mental illness and co-occurring opiate dependence. It is important to verify the dose and regime of persons being prescribed Methadone, Biodone, Subutex or Suboxone through an OTP (either through public clinics or general practitioners). The treating clinician either contacts the Drugs of Dependency Unit to determine who is the prescriber, or contacts the prescriber directly to determine when the last dose was, the dosing regime and to establish links with the OTP prescriber. The opioid replacement regime is to be documented by MHS. Both services are required to work in collaboration with clinical input into treatment planning, review, and management of the client. The two services are to establish which service will hold primary responsibility for case management and the exchange of information across services.

Further information

Information regarding the Drugs of Dependency Unit can be obtained at health.qld.gov.au/atod/ddu.asp

Clinicians can also access information regarding opiate prescribers at the Prescription Shopping Information service, phone 1800 631 181.

Practice tip

Opioid withdrawal management should be considered a starting point for ongoing treatment rather than as a complete treatment in its own right.

Following withdrawal management, clients should be linked in with post-withdrawal services with access to drug treatment services such as: opioid maintenance treatment with Methadone or Buprenorphine, drug free counselling, residential therapeutic communities or self help groups.

Further information

Clinicians requiring further information should review the Queensland Opioid Treatment Program Clinical Guidelines October 2009, at qheps.health.qld.gov.au/TPCH/adscl/ads_opioid_program.pdf

Further reading

Intergovernmental Committee on Drugs, 2007, *National pharmacotherapy policy for people dependent on opioids*, Australian Government, Canberra.

Pain

The International Association for the Study of Pain (IASP) defines pain as, '...an unpleasant sensory and emotional experience, associated with actual or potential tissue damage, or described in terms of such damage'. Chronic pain (daily pain for more than three months) affects one in five Australians, 80 per cent of whom may receive suboptimal treatment; it is Australia's third most costly health problem (draft National Pain Strategy 2009). Ideally patients with chronic pain should undergo a multi-disciplinary assessment including mental health assessment before major treatment decisions are made — that is, commencement of opioids.

Rapid growth in the prescription of long acting opioids is reflected in an increasing number of chronic pain patients developing problem opioid use, now estimated at 250,000 compared to ~80,000 people in Australia with heroin dependence (Lintzeris 2008). While this is a relatively poorly understood area, escalating opioid doses may reflect increasing tolerance, opioid-induced hyperalgaesia or dose diversion. One recent study of patients with disabling back pain after injury showed those with opioid dependence had significantly worse long-term outcomes across a range of measures (Dresh et al. 2008). Patients on long-term opioids risk overdose death and a range of other adverse effects.

Mental health problems may also complicate the management of patients with chronic pain and problematic opioid use. Factors may include unresolved issues of blame or grief surrounding the cause of the pain, as well as pre-existing personality vulnerabilities that may reduce the patient's ability to cope. There may also be a diagnosis related to the cause of pain or secondary to it, such as Post Traumatic Stress Disorder, Anxiety Disorder or a mood disorder.

Such complex co-morbidity may make care of these patients a challenge, requiring collaboration between multiple disciplines and involving close communication and considerable planning.

Human Immunodeficiency Virus (HIV)

Human Immunodeficiency Virus (HIV) infection may impact on people with dual diagnosis (Queensland Health 2003). Clinicians need to be aware of strategies to prevent the contraction of HIV infection and impart this information to clients. Infection with HIV remains uncommon in injecting drug users in Australia, resulting in part from effective needle and syringe programs (Dolan et al. 2005; Vlahow and Junge 1998; World Health Organization 2004). However, if a positive test result is obtained, advice should be sought from a specialist clinician. Treatment is available for post exposure prophylaxis, for acute infection, for chronic HIV infection and for those who present with an AIDS defining illness. Clinicians should contact a local hospital to identify the availability of services in the local area.

Further information

Further information can be found in the Queensland Health HIV/AIDS Mental Health Protocols and Glossary of Terms Used in Mental Health and HIV/AIDS and Sexual Health 2002 available at health.qld.gov.au/ph/documents/cdb/17101.pdf

Homeless individuals

It is important for the clinician to be aware of lifestyle issues and difficulties the homeless individual with co-occurring problems may be experiencing. Social and environmental difficulties may affect the individual's ability to change problematic behaviours, and the likely success of the intervention. Where possible, interventions should take place at locations convenient to the individual which may include parks, homeless shelters or homeless drop in centres. Services should be delivered using a collaborative approach in conjunction with other agencies that may be involved in the individual's care. Due to the often highly complex nature of the homeless client, it is essential for the clinician to be aware of, and treat, all relevant health factors impacting upon the individual and their problematic behaviours. Homeless Health Outreach Teams (HHOT) have been implemented in several health service districts around Queensland in order to respond to the needs of homeless individuals in these districts.

Further information

Further information on the HHOTs in Queensland please contact the MHAODD qheps.health.qld.gov.au/mentalhealth/default.htm

Recently released prisoners

The risk of death for individuals in the first two weeks post release from prison has been found to be up to 17 times higher than in the general population (Stewart et al. 2004; White, Chant and Whiteford 2006). The risk of death from substance abuse, suicide or accident is highest in the days and weeks immediately following release (Biles, Harding and Walker 1999; Kariminia et al. 2007; Sattar 2001) and up to one year post-release, regardless of whether they have an identified mental illness. This trend appears to begin at an early age with juvenile offenders and continue into the adult offender population (Hobbs et al. 2006; Kariminia et al. 2007; Pratt et al. 2004). It has been suggested that the risk of post release death increases with the number of incarcerations, however this relationship does not appear to be well understood (Graham, 2003).

Little is known about the reasons for the high rates of suicide in the immediate post-release period. The high prevalence rates of mental illness and substance use, combined with socioeconomic deprivation in released prisoners, are likely to increase the risk factors (Bland, Thompson and Dyck 1998; Fazel and Danesh 2002). Other reasons may include: community exclusion, stigma, homelessness, lack of paid employment and a lack of appropriate care and attention to suicidal ideation in released prisoners (Pratt et al. 2006).

The question is how best to deliver comprehensive and effective health services to this marginalised group of people who, even without mental illness, have a very high risk of death on release. While there are no easy solutions, it would seem that many of these deaths are potentially preventable and given that many of the deaths occur in the weeks and months following release, this period provides a key opportunity for intervention.

Lesbian, gay, bisexual and transgender individuals

Research increasingly indicates that social pressures linked to sexuality and gender identity can have negative impacts upon health outcomes with the lesbian, gay, bisexual and transgender (LGBT) community at heightened risk due to the impact of social stigma and isolation. These adverse health outcomes commonly include mental health problems, drug and alcohol use and limited uptake of health care services due to attitudes within the LGBT community regarding help seeking. The risk of suicide is highest in individuals at the time of disclosure of their sexual identity, described as 'coming out'. However, unlike other characteristics, sexuality and gender identity are not physical attributes and cannot be easily identified. As a result many LGBT clients are not visible within health services. Clinicians should be alert to the high prevalence of substance use and mental health problems in this population and consider screening and appropriate interventions.

Further information

Further information and support for clinicians working with LGBT clients can be accessed from the Queensland Association of Health Communities qahc.org.au/ or Open Doors supporting LGBT young people at opendoors.net.au/

Behavioural addictions

Behavioural addictions appear to be related to substance use disorders and include work, gambling, overeating, internet and sex addictions. The mechanisms involved in these addictions are complex and not fully understood. To date, there is no consistent concept for diagnosis and treatment of excessive reward-seeking behaviour. However, a range of individual biological, psychological and social factors are also involved, including evidence of effects in brain reward pathways similar to those activated in individuals with substance use disorders (Hawkings and Gilburt 2004).

chapter 5

dual diagnosis assessment

dual diagnosis
clinical guidelines

key points

- Alcohol, Tobacco and Other Drug Services (ATODS) and Mental Health Services (MHS) clinicians are required to use the standardised assessment processes of their service.
- Clinicians of each service should be aware of a range of assessment considerations and undertake a thorough bio-psychosocial assessment including current and past alcohol and other drug use and the client's mental state.
- A range of screening tools are available to assist clinicians to identify any co-occurring mental health, alcohol and drug problems, and determine if more detailed assessment is required.
- Conducting physiological and biological investigations may also be useful in the assessment of suspected dual diagnosis.
- It is imperative that the assessing clinician records all assessment and treatment information including additional diagnoses within the relevant database to ensure vital information is available after hours or in an emergency. This will also facilitate the accurate recording of prevalence data and assist service planning.
- The primary service provider has responsibility to develop a single care plan that addresses the consumer's needs and management of co-occurring problems.
- If collaborative care between MHS and ATODS is provided, the responsibilities of each service in the provision of treatment, crisis planning and relapse prevention strategies for an individual with a dual diagnosis should be documented on the care plan.

All alcohol and other drug and mental health assessment processes will adhere to the standardised assessment and screening documentation developed and promoted by the respective MHS and ATODS.

Within MHS the statewide assessment package is the Queensland Health, MHS Statewide Standardised Suite of Clinical Documentation with accompanying User Guide (2010). The mental health suite of assessment forms can be obtained from qheps.health.qld.gov.au/patientsafety/mh/mhform.htm

Within ATODS the statewide assessment package is the Queensland Health, ATODS – Comprehensive Assessment suite of forms with accompanying screens and outcome measures (2004).

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 9

Assessment of dual diagnosis involves examination of symptom multiplicity and severity using a **biopsychosocial approach**, involving focus on the impact of symptoms on level of functioning, rather than specific diagnoses.

Dual diagnosis assessment principles:

- All people receiving mental health and alcohol and other drug treatment should be screened and/or assessed for a co-occurring disorder.
- Always conduct a thorough medical screening to exclude organic causes of the presentation, such as head injuries, fever, infection and sepsis.
- Screening and/or assessment for a co-occurring disorder should take place at or near a person's first contact.
- Screening and/or assessment needs to be adapted according to the client's mental state and/or physical condition — for example, acute psychosis, in pain or intoxicated.
- Younger people should receive some level of screening for a co-occurring disorder at each contact.
- All people with co-occurring disorders should be actively and meaningfully assisted to obtain appropriate treatment from within the service system by the service to which they present, even if they don't meet that service's criteria for treatment (the no wrong door service system approach).
- Clients should receive integrated treatment for co-occurring mental health and substance use problems.
- Clinicians are to display an awareness of culture and the specific consideration of cultural issues within the assessment.

Practice tip

Clinicians should undertake a thorough assessment of current and past alcohol and drug use.

Clients may be reluctant to disclose this information at the first meeting with a clinician and further assessment should occur at a later date including obtaining collateral information to support the client's self report.

A bio-psychosocial assessment is a time intensive process that collects information to establish a case formulation which will:

- inform the diagnosis/problem
- reveal any potential life threatening medical and or psychiatric emergency
- predict the possibility of alcohol and other drug withdrawal
- alert the possibility of interactions with medications and substance use
- indicate the selection of appropriate bio-psychosocial interventions
- provide feedback on assessment outcomes
- provide an opportunity for a brief intervention around high risk behaviours (for example — injecting drug use or unsafe sex)
- provide opportunities for education
- engage the person with the service
- inform the development of a treatment/care plan.

Assessment information is obtained from various sources including:

- observation of the client in formal and informal settings
- direct questioning during semi-structured interviews
- history taking
- screening tools
- pathology testing
- collateral (family, friends and other health care providers).

During the bio-psychosocial assessment process the clinician needs to observe and document the client's mental state, signs or evidence of injecting drug use, and overall level of physical health.

Assessment considerations

People presenting to health services who may be in a distressed state need to be treated with respect and in a manner which will contain their anxieties. Therefore, care and attention must be taken with the environment and context in which they are seen. A containing environment includes:

- positive staff attitudes
- a calm atmosphere
- staff displaying a friendly, courteous manner
- privacy and respect for confidentiality
- comfortable surroundings
- engaging strategies to establish rapport and trust.

During the interview it is important for the clinician to display:

- interest and attention
- empathy
- warmth
- active listening skills
- thoughtfulness
- reflective responses
- a calm demeanour
- a non-judgmental stance that does not blur into collusion
- a style of questioning that enquires in an open, non-judgmental way about issues of relevance to the client's presentation
- consideration of the cultural background and appropriateness of the assessment process, tools and environment.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 4

Services treat people with dual diagnosis with a **welcoming attitude and professional, non-judgemental approach**. Staff are proactive in engaging and retaining people in treatment and work towards the development and maintenance of a therapeutic alliance based on dignity and mutual respect.

Practice tip

Individuals with a history of heavy use of substances may demonstrate difficulty recalling information regarding their alcohol and drug use due to cognitive deficits, chaotic patterns of use and lengthy periods of intoxication.

Clinicians should be mindful of the limitations of self reported information and seek collateral information to support clinical formulations and treatment planning.

Principles to consider when raising the issue of alcohol, tobacco and other drug use include:

- Be inquisitive but non-confrontational.
- Be friendly and factual, while avoiding subjective statements.
- Wherever possible, seek collateral information on the client's substance use. Collateral information can be obtained from friends, family, and medical tests.
- Self reported alcohol and drug use may be understated. Some ways to encourage more accurate reporting include overstating the average — such as 'some people drink up to 18 drinks per session; how much do you drink?'
- If the clinician is concerned about the accuracy of the client's self reported use, an emphasis should be placed on establishing an effective therapeutic rapport in order to enhance accuracy of client disclosure. Provided the client's memory is intact and questions are asked in a suitable way, clients will often answer truthfully — for example, 'Lots of people use substances while they're in jail as a way to cope with being in such a bad place. How did you get through it?'
- It may be difficult to raise the issue with a psychotic or intoxicated person and the assessing clinician may need to return to these issues at a later date. The clinician should ensure the need for further assessment is documented and occurs as soon as possible.
- Be spontaneous and opportunistic:
  - 'You mentioned before that you like a drink; can you tell me how many drinks you'd have in an average week?'
  - Lots of people like a drink to relax, how about you? What do you like to use?'
- Raise the issue as part of an overall health assessment which can be included in questions about diet, exercise and general lifestyle.

A few further suggestions regarding lines of questioning about alcohol and other drug use include:

- When did you start using?
- Have you stopped before and if so for how long?
- What do you like about using drugs?
- In what ways does drug use help you to...?
- What things are not so good about your drug use?
- What do others think is not so good about your drug use?

Assessment criteria

To undertake routine standardised bio-psychosocial assessment, informed consent should be gained from the client with an explanation of the purpose of the assessment; an overview of the line of questioning and time involved and benefits in relation to screening and the use of evaluation tools to measure outcomes.

The assessment takes the form of a semi-structured interview and should cover the following.

Presenting issues

Elicit what the client perceives to be the major problem and reason for presentation which may include broader issues — such as family disharmony, financial problems, homelessness or legal problems. Presenting issues should also cover:

- source of referral
- time course and precipitants
- other symptoms
- level of disability/problem — for example, ask 'How are you coping at work or with relationships?'; 'How do you spend your time?'
- social context
- effectiveness of previous coping strategies and treatments.

Alcohol and other drug use

It is important to gain an understanding of the range of licit and illicit substances used including quantity and frequency of use, duration of use, and mode of administration. It can be useful to gather this information by asking the client to describe a typical day when he/she is using alcohol and/or other drugs and how these substances enhance or interfere with daily activities. Therefore information collected will include:

- type of substances used
- amount consumed and pattern of use (such information will indicate tolerance)
- presence and type of withdrawal symptoms
- past successful and/or unsuccessful attempts to cut down
- activities given up or reduced (will indicate salience)
- readiness for change.

Further information

Further information regarding the impact and prevalence of potential substance misuse, and recommendations for responsive service provision. Please refer to the landmark report on drug use in the family (Dawe et al. 2007), commissioned by the Australian National Council on Drugs and available at ancd.org.au/images/PDF/Researchpapers/rp13_drug_use_in_family.pdf

Further alcohol and other drug questions that need to be asked include:

- How do these substances affect you? (physically, emotionally, mentally and or cognitively)
- Have you had any attempts at abstaining or controlling use?
- What are your thoughts and feelings about substance use?
- How do you view your substance use?
- How do others view your substance use?
- When did you first start using substances? Ask about the context of the substance use, details of type of substances used, patterns of use and psychosocial factors impacting on the person at that particular time in their life.

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR®)* (American Psychiatric Association 2000) evidence of dependence instrument is useful to assess alcohol and drug dependence according to diagnostic criteria. This instrument is a mainstay of alcohol and drug assessment and is available in the Alcohol, Tobacco and Other Drug Information System (ATODS IS) assessment package.

Clinicians should also be mindful of the potential impact of substance use on an individual's parenting role. Alcohol and other drug use in a family does not, in itself, indicate child neglect or abuse. However, the risk of child abuse and neglect is higher in families where parents or caregivers have significant problems with alcohol or other drugs. All health professionals working with parents and guardians who have drug and alcohol problems need to be aware that the safety, welfare and wellbeing of any children within their care is paramount. This includes an assessment of the client to ascertain the existence of any dependent children, and the nature and extent of their contact with them (Drug Treatment Services Program 2000).

A recent amendment to Section 20: Issues for Specific Areas of the Queensland Health Protecting Queensland Children Policy Statement and Guidelines for the Management of Child Abuse and Neglect in Children and Young People (0–18 years) outlines that staff who are involved in counselling or treating people with alcohol or other drug use issues need to be proactive in making routine enquiries about their capacity to cope with the care of their children. All assessments should include questions to ascertain whether the client has any children in their care and if there are any concerns about the care of these children. Additional tips are included in Chapter 10 on parental dual diagnosis.

Assessing readiness to change substance using behaviour

It is necessary to assess a client's readiness to change their substance use behaviour as this information will inform the type of intervention offered. Assessing readiness takes into account the Stages of Change Model (Prochaska and DiClemente 1986). Refer to Chapter 8 for a more detailed discussion of this model. However, the clinician should be mindful to apply the model in a flexible manner and not as a rigid method of classification to inform treatment interventions. The model provides a broad framework for conceptualisation of the client's readiness to address their substance abuse concerns and the appropriateness of particular interventions. Interventions from various stages may still be applicable depending on the client's individual circumstances and clinicians should consider a range of interventions and match them appropriately to the client's needs.

The assessing clinician should take into consideration that:

- not all people are ready to change their substance use
- clients, family members and carers can be at different stages of change
- a person's readiness to change will determine the type of intervention offered.

Practice tip

The clinician can assess readiness and confidence to change by asking the person 'How ready are you to change your substance use now?' or 'How confident are you in being able to change your substance use?'

Assessing readiness for treatment

An expansion of the Stages of Change Model has included readiness to accept psychiatric treatment.

This transtheoretical model has been developed by Osher and Kofoed (1989) and includes adapting treatment interventions according to not only the client's readiness to address their substance use but also readiness to accept treatment for their mental health problem (Mueser et. al. 2003). Addressing both issues at the one time is the foundation of managing dual diagnosis. Clinicians should ensure treatment is integrated and addresses both problems.

A regular substance user may be at risk of withdrawal and may require urgent medical input to manage withdrawal symptoms.

Assessing for dependence and withdrawal

Withdrawal occurs when a person has consumed significant quantities of a psychoactive substance regularly, has recently decreased or stopped use, and has symptoms and signs which are broadly opposite to the acute effects of the substance(s). A person in withdrawal may be at risk of physical harm, psychological harm and occasionally even death (for example — from delirium tremens in alcohol withdrawal) if their condition is not recognised.

Symptoms of withdrawal may exacerbate mental health problems; they include anxiety, depression and psychosis. Substance use and withdrawal may mimic presentations more commonly seen with personality disorders. Consumers with mental illness in withdrawal may require additional care to effectively manage the withdrawal and their mental health symptoms and to minimise risk.

Clinicians of both ATODS and MHS should use screening tools to help identify dependence and withdrawal. Refer to the following section on screening tools in this chapter. The severity of dependence scale is included in the mental health standardised suite of assessment forms and should be used as a core component of the assessment process with every client presenting at services to assess levels of dependence and potential withdrawal states. Detection of withdrawal requires medical and controlled withdrawal management. Refer to the section on withdrawal management in Chapter 7 for further information.

If a young person is in withdrawal, clinicians should immediately involve a medical practitioner and consider referring the young person to the Adolescent Drug and Withdrawal Service (ADAWS). ADAWS is a residential withdrawal management service based at South Brisbane for young people aged 13–18 years from across Queensland. The program comprises an intake each fortnight for an 11 day program with a daily relapse prevention focus, as well as a range of recreational activities.

Further information

Further information on withdrawal can be found in Clinical Protocols for Detoxification in Hospitals and Detoxification Facilities at health.qld.gov.au/atod/documents/24904.pdf

For information on services available to assist with withdrawal management, contact the Alcohol and Drug Information Service (ADIS), freecall 1800 177 833 (available 24 hours).

For more information on youth withdrawal management services, contact Adolescent Drug and Withdrawal Service (ADAWS), phone (07) 3163 8400 or visit kidsinmind.org.au

Mental health

It is important that a client's mental state is assessed not only at initial presentation but at every clinical presentation. The mental state examination (Sadock and Sadock 2007) is a clinical assessment by a clinician at the time of interview. Many aspects of a client's mental functioning can be picked up by observation examination, with the formal outline of a mental state examination providing a structure for the purposes of recording and measuring changes over time. The mental state examination provides a structure for documentation in clinical case notes. The components of the mental state examination need to be written up in a professional and objective manner using terminology which is non-prejudicial.

Initially this practice may be unfamiliar for ATODS clinicians. However, if the mental state examination structure is followed, this practice will become routine. The Queensland Centre for Mental Health Learning (QCMHL) provides regular training on the mental state examination. Interested clinicians should seek further information from QCMHL on the availability of training programs.

During the process of conducting a mental state examination, clinicians should enquire about a client's psychological functioning in a sensitive, respectful and non-judgmental manner.

Within alcohol and other drug treatment settings, responses to two questions have been found to be significantly correlated with the presence of an anxiety and or affective disorder in the past month (Lee et al. 2007). These questions include:

- Have you ever seen a doctor or psychiatrist for emotional problems or problems with your 'nerves'/anxieties/ worries?
- Have you ever been given medication for emotional problems or problems with your 'nerves'/anxieties/ worries?

It is important that these questions are included in the assessment of clients presenting to ATODS.

Practice tip

Clinicians in ATODS undertaking assessment of an individual's mental health, should ask the client if they have ever seen a doctor or psychiatrist for an emotional problem and if they have ever been given medication for an emotional problem (see information above).

If the client answers yes to the above questions, indicating they have experienced mental health symptoms (anxiety or depressed mood) or have been diagnosed with a mental health disorder, the clinician should ask the following questions:

- When did the mental health symptoms start (pre or post substance use)?
- Do the symptoms occur when intoxicated or withdrawing from the substance?
- Have the symptoms continued even after a period of abstinence (for example — one month)?
- Do the symptoms change when substances are stopped? (for example — get better, worse or stay the same)?
- Is there a family history of mental health problems?

(Mills et al. 2008)

If the mental health symptoms subside when the intoxicating effects of alcohol/and or drugs wear off or after a period of one month, the mental health symptoms are more likely to be alcohol and/or drug induced. If the mental health symptoms continue after this period of time, they were prominent prior to substance use and/or there is a family history of a mental health problem, perhaps a mental disorder exists. In both situations, the symptoms will need to be monitored and if indicated, treated.

It is important that the sequence of symptoms not exclude a client from accessing treatment by either service. The no wrong door approach outlined in Queensland Health policy, requires that the client should be provided with treatment or linked into appropriate services wherever they enter the service system of care.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Principle 4

A **'no wrong door' approach** is used that provides people with, or links them to, appropriate services regardless of where they enter the system of care.

Assessing psychotic symptoms

The presence of psychotic symptoms, especially acute symptoms, suggests a psychiatric emergency which warrants an assessment of risk and safety with referral for specialised psychiatric intervention as necessary. Such symptoms can include:

- paranoia — suspicions about friends and acquaintances as people plotting to harm them
- delusions — extreme beliefs that are unsupported by evidence — such as, the client is invincible or can receive messages from television, radio or computer
- hallucinations — seeing, hearing, smelling or feeling things that other people cannot — for example, hearing people commenting on their actions in a derogatory way.

Clients presenting to ATODS may not always display obvious symptoms, so the structured mental state examination is often the best way to ascertain such abnormalities.

Other lines of psychological questioning need to address the following:

- current life situation/circumstances
- trauma history (particularly prevalent with this population) — the presence of a trauma history will indicate the need for further trauma screening for possible Post Traumatic Stress Disorder
- recent or past losses — for example, loved ones
- past and current treatment and the effectiveness — including hospital admissions and prescribed medications
- names of current/previous clinicians/doctors
- mood symptoms including neurovegetative symptoms — for example, sleep, energy or libido
- suicide/aggression risk (refer to Chapter 6 on assessing risk).

Conducting an integrated assessment of alcohol and drug use and mental health problems is a central component of assessment. During the assessment process, clinicians should identify the relationship between the level of consumption of alcohol and drug use and mental health symptoms by routinely asking about the effect of alcohol and drug use on mental health symptoms, and the client's attributions of their symptoms.

Many clients may not perceive that they have an issue with either alcohol or drug use or their mental health and not offer information on these factors. Eliciting information regarding the interactions between alcohol and drug use and mental health can assist the clinician to understand the client's perspective and rationale for their problems, as well as inform the treatment plan, by identifying the need for education on the effects of alcohol and drug use on mental health or other appropriate interventions.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Principle 9

Within the treatment context, both mental health and alcohol and other drug problems are **considered of primary importance to the clinical presentation**.

Assessing physical health

Clients presenting with dual diagnosis commonly have co-occurring physical complaints and conditions particularly: if they smoke; use intravenous drugs; have a sedentary lifestyle and poor diet; are prescribed psychotropic medication; or have a family history of physical ailments. It is therefore imperative that an assessment of physical health be carried out. It is necessary to ask information pertaining to:

- allergies/alerts
- time since last medical examination review
- pregnancy
- Hepatitis B, C or HIV status
- major medical conditions (for example — diabetes or hypertension)
- current/past prescribed medications
- current general practitioner
- at risk health behaviours (for example — intravenous drug use, unsafe sex practices, binge drinking or poly-substance use)
- history of falls, accidents, motor vehicle incidents, fights (any trauma)
- recent illness symptoms such as flu, headache or nausea.

Assessing psychosocial domains

It is often psychosocial issues that trigger clients to present for treatment. Clinicians can use this opportunity to engage clients by attentively taking their concerns seriously, subtly making the link with co-occurring mental health and substance use problems and drawing up a plan of action or treatment plan. It is imperative to collect information pertaining to:

- relationships with family, friends or social supports
- responsibilities for children and/or contact with children
- education (highest level and experience)
- employment (current and/or past)
- living circumstances (stability and affordability)
- legal issues (pending and/or history)
- finances (legal sources of income)
- involvement with other agencies
- strengths including interests, hobbies and leisure activities.

Practice tip

A comprehensive assessment underpins accurate clinical formulation and effective treatment planning.

The assessing clinician should enquire about both current and past alcohol and drug use which may influence the presence of presenting MH symptoms.

All information should be documented and communicated to the treating team in order to inform the treatment plan.

Screening tools

The semi-structured bio-psychosocial assessment can be aided by the use of standardised screening tools and interview schedules which can provide an objective (reliable and valid) record of a clients' presenting issues and can be used to compare against population norms and/or measure outcomes. Screening indicates if a particular problem may be present, with a positive screen result prompting further detailed assessment. Where possible, clinicians should use measures that are culturally and developmentally appropriate to the client and their current needs. Clinicians should seek advice from dual diagnosis coordinators, Aboriginal and Torres Strait Islander health workers and transcultural coordinators regarding the use of appropriate screening tools.

Practice tip

The detection of either a mental health problem or alcohol and drug problem requires the clinician to engage in screening for co-occurring problems.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 5

Mental Health and ATOD services **screen all people on their initial presentation** to each service for AOD and MH problems respectively, and the detection of AOD and MH problems is recorded and addressed in the person's treatment plan and other relevant information systems.

Screens for mental health symptoms and disorders

A brief description of the available screens for mental health problems is listed below. Please refer to the *Clinician Tool Kit* for these screening tools.

Mini Mental State Examination

The Mini Mental State Examination (MMSE) (Folstein et al. 1975) is generally a reliable, valid measure of cognitive impairment including memory, concentration and other cognitive skills. The MMSE is a set of questions that provide an indication about a person's general level of impairment. It takes five minutes to administer and covers such areas as the ability to recall facts, write and calculate numbers. The test provides a quick way to determine if more in-depth neurological testing is needed.

Psychosis Screener

The Psychosis Screener (PS) is an interview style questionnaire which asks about the presence of psychotic symptoms including delusions of control, thought interference and passivity, delusions of reference or persecution and delusions of grandeur (Deganhardt et al. 2005). This screen is useful for ATODS clinicians who have limited experience in working with clients exhibiting psychotic symptoms and will assist in the clarification of presenting psychotic ideation.

PsyCheck

PsyCheck: Responding to mental health issues within alcohol and drug treatment (Lee et al. 2007) is an evidence-based screening tool which comprises:

- a general mental health screen (self reporting questionnaire that assesses current symptoms of depression and anxiety)
- a suicide risk assessment
- a brief mental health history
- mental health probes.

Further information

PsyCheck is linked with a cognitive behavioural intervention which can be used upon identification of a positive result from the mental health screens. Further information can be obtained from the PsyCheck website at psycheck.org.au

Kessler Psychological Distress Scale

The Kessler Psychological Distress Scale (K10) (Kessler et al. 2002) is a screening/rating tool for the indication of psychological distress which can be used to identify those in need of further assessment. It has primarily been designed for high prevalence disorders — for example, anxiety and depression. The K10 can also be used as an outcome measure to capture change in psychological distress. This tool is available in the ATODS IS assessment package.

Depression and Anxiety Stress Scale 21

The Depression and Anxiety Stress Scale 21 (DASS 21) (Lovibond and Lovibond 1975) has been shown to be a valid and reliable screening tool (Brown et al. 1997) to measure depression, anxiety and stress and can be used to measure such states over time (outcomes). This tool is available in the ATODS IS assessment package.

Primary Care Post Traumatic Stress Disorder Screen

The Primary Care Post Traumatic Stress Disorder Screen (PC-PTSD) (Prins et al. 1999) is a brief screen which has been validated for PTSD in people with alcohol and other drug problems (Kimberling et al. 2006).

Risk screens

Risk screens are included in the ATODS IS assessment package and include a suicide/self harm screen; homicide/aggression screen; and domestic violence screen. Risk screening is a mandatory component of an ATODS assessment. PsyCheck contains a risk screen component which may be useful for alcohol and other drug clinicians (Lee et al. 2007).

The MHS standardised suite of clinical documentation incorporates the assessment of risk into all aspects of the assessment, providing risk factors as cues for further questioning and elaboration. This information along with clinical judgement will inform the clinician's assessment of risk and the development of a risk management plan. A stand alone risk assessment form is also included in this package for ongoing and ad hoc assessment to support clinical documentation.

Clinicians should be guided by district policies and protocols on the identification and management of risk.

Indigenous Risk Impact Screen

The Indigenous Risk Impact Screen (IRIS) (Schlesinger et al. 2007) is a statistically validated tool effective in the early identification of alcohol misuse and mental health risks for Aboriginal and Torres Strait Islander people. The use of this tool requires training in administration and scoring.

Further information

Clinicians with clients from an Aboriginal and Torres Strait Islander background who are interested in obtaining further information regarding this tool should seek information from the Queensland Health ATODS intranet site at health.qld.gov.au/atod/default.asp

World Health Organization Quality of Life Questionnaire

The World Health Organization Quality of Life Questionnaire (WHOQoL BREF) is a useful screen to measure subjective quality of life according to physical and psychological health, social relationships and environment. This screen is also useful to monitor changes in quality of life over time. The tool is available in the ATODS IS assessment package.

Further information

Further information can be obtained from the WHOQOL BREF 2004, Geneva, WHO at who.int/substance_abuse/research_tools/en/english_whoqol.pdf

Practice tip

All clinicians should use the screening tools available to them through the Queensland Health comprehensive assessment package utilised by their service.

Screens for substance use behaviours and disorders

A brief description of the available screens for alcohol and other drug problems are listed below. Refer to the *Clinician Tool Kit* of resources for these screening tools.

Alcohol Use Disorders Identification Test

The Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al. 1993) was developed by the World Health Organization (WHO) to identify people who are drinking alcohol at harmful levels for their health. The screen has been described as useful for younger persons though its use for elderly populations is questionable (Dawe et al. 2002). The screen is available in the ATODS IS assessment package and is included in the MHS statewide standardised suite of clinical documentation. Assessing clinicians are encouraged to use this tool where screening indicates the use of alcohol.

Severity of Dependence Scale

The Severity of Dependence Scale (SDS) (Gossop et al. 1995) is a brief five item scale designed to measure psychological aspects of dependence for such drugs as heroin, methadone, cocaine, amphetamines, cannabis and benzodiazepines. This screen is available in the MHS statewide standardised suite of clinical documentation.

DrugCheck problem list

The DrugCheck problem list can be used as a screening instrument, or as part of a motivational interview (Kavanagh et al. 2010 in submission) to indicate problematic use and areas requiring further investigation.

This screen is available in the MHS statewide standardised suite of clinical documentation as the Drug Assessment Problem List. Clinicians are recommended to complete this screen for all substances identified, to indicate problem areas related to substance use.

Blood Borne Virus Transmission Risk Assessment Questionnaire

The Blood Borne Virus Transmission Risk Assessment Questionnaire (BBV-TRAQ) (Fry et al. 1998) is a useful tool designed to measure blood borne virus risk in terms of injecting, sexual intercourse and skin penetration. This tool can also be used to measure changes in risky behaviours over time (outcomes) and is available in the ATODS IS assessment package.

Fagerstrom Test for Nicotine Dependence

The Fagerstrom Test for Nicotine Dependence (FTND) (Heatherton et al. 1991) is designed as a screen to measure nicotine dependence in terms of 'heaviness of smoking'. It identifies those individuals who because of smoking dependence have compromised immune systems and are therefore prone to contracting disease.

A rapid and practical alternative to this screen is the Nicotine Dependence Test which identifies:

1. Minutes after waking to first cigarette.
2. Number of cigarettes per day.
3. Cravings and withdrawal symptoms during previous quit attempts.

Both the FTND and the Nicotine Dependence Test are available in the ATODS IS assessment package.

Further information

Further information on screening for nicotine dependence can be found in the Smoking Cessation Guidelines for Australian General Practice: Practice Handbook 2004
http://www.quitsa.org.au/cms_resources/documents/AustralianGeneralPracticeGuidelineHandbook.pdf

Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES – 8A and D)

The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES – 8A and D) (Miller and Tonigan 1996) measures motivation in relation to changing alcohol and other drug using behaviour. Such components include recognition of the problem, taking steps to address the problem, and ambivalence about making change. This screen is available in the ATODS IS assessment package.

Practice tip

The detection of an alcohol or drug problem identifies the need for a more comprehensive assessment.

If the assessing clinician is unable to undertake a more comprehensive assessment, they are required to document the need for further assessment and ensure the client receives it in a timely manner.

Investigations

Investigations can be useful to detect evidence of substance use as well as for monitoring purposes, although they are not always reliable. Some medications also have side effects that need to be monitored. The use of investigations may be necessary for treatment under involuntary conditions (such as limited community treatment orders, forensic treatment orders or parole), but also may inform and support the treatment of voluntary clients. The use of investigations should be discussed with the treating doctor and client.

Following is a brief description of common tests that may be useful.

Blood alcohol level: can be reliably measured via a breathalyser machine which needs to be regularly calibrated and is an indicator of recent alcohol consumption and tolerance.

Urine drug screen: detects the presence or absence of specific drugs or drug metabolite. However, it cannot be used to determine dosage, time of administration and or drug effects.

Hair analysis: will detect drug use for the duration of the hair growth.

Blood testing

Biochemistry

Electrolytes can become disturbed during alcohol detoxification and should be monitored.

Liver function tests including gamma glutamyl transferase, aspartate aminotransferases and alanine transaminase provide useful indicators of possible liver pathology as a result of excessive alcohol use or Hepatitis C.

Thyroid function tests are indicated with Lithium use as thyroid function can become compromised.

Drug levels may also be appropriate to monitor — for example, Lithium and Sodium Valproate.

Aspartate transaminase and alanine transaminase, and some medications can cause metabolic syndrome. This can result from the newer atypical antipsychotics and results in lipid changes and glucose intolerance. Blood glucose and triglyceride measurement may be indicated.

Haematology

A full blood count can be useful as some substances affect blood cells — for example, excessive alcohol use may result in a raised mean corpuscular volume and suppressed platelets. Medications may also affect blood cells — for example, sodium valproate can suppress platelets and Clozapine, can severely depress white cells.

Coagulation studies can help assess the level of liver impairment associated with alcohol abuse.

Other investigations

Specialised studies like EEG or CT head scans may also be useful if an organic lesion or epilepsy is suspected.

Data recording

Although prevalence rates of dual diagnosis in both MHS and ATODS client populations is known to be significant, the recording of problems in the relevant information systems is undertaken inconsistently by clinicians of both services. The detection and assessment of co-occurring problems is the first step to the provision of holistic care addressing all of the individuals needs. Once a problem has been detected it is imperative it is recorded in both the consumer's clinical chart and the relevant information system. Without a record of mental health and alcohol and other drug problems, it is unlikely that these problems will be addressed in the care plan, that interventions will be provided, or the problems monitored for future intervention.

The risks of inadequate and unsafe care are significant if recording of an additional diagnosis or problem is only undertaken in the clinical chart. In circumstances where the clinical chart is unavailable, the client may be at risk of receiving inappropriate and/or inadequate care.

The use of secondary diagnostic fields in the mental health application system Consumer Integrated Mental Health Application (CIMHA), allows for the recording of co-occurring issues. However, it is important that clinicians do not become focused on which disorder is considered primary. As mental health symptoms and alcohol and other drug use can vary over time and strongly interact, both need to be given equal priority in treatment. Reassessment of the interactions between disorders is imperative to ongoing care, and treatment plans should be adjusted accordingly.

The recording of dual diagnoses should not focus on primary versus secondary disorders, but instead on both disorders requiring intervention.

It is a requirement of the Queensland Health Dual Diagnosis Policy that co-occurring problems and disorders are recorded in the relevant information system in use by the service. It is the responsibility of the assessing clinician to record the dual diagnosis in both the clinical chart and the associated information system.

Practice tip

If co-occurring mental health and alcohol and other drug problems are detected both problems are required to be recorded in both the consumer's clinical chart and relevant information system by the assessing clinician.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 5

The detection of alcohol and drug and MH problems is recorded and addressed in the person's treatment plan and **other relevant information systems**.

Care planning

An individual care plan, as defined by the National Standards for Mental Health Services (MHS), is 'a documented set of goals, collaboratively developed by the consumer and the treating service (usually the case manager). The care plan sets the direction for treatment and support, identifies necessary resources and specifies outcomes for the consumer. It is recorded in the consumer's individual clinical record' (Queensland Health 2004).

Care planning is a fundamental component of providing a service to any individual accessing health services and is particularly important for people with dual diagnosis. Given the frequent complexity of the health and social problems experienced by people with a dual diagnosis, careful and accurate care planning addressing the full range of presenting issues is necessary to guide and measure the care and treatment provided.

Care plans developed for people with a dual diagnosis need to address both the mental health and substance use problems in an integrated manner. The complexity of the interdependence of mental health and alcohol and other drug problems must be reflected in the treatment plan. It is not sufficient to simply identify an issue and document the need for referral to another service. Carefully planned strategies addressing the issues are to be identified and recorded and the process for achieving these outcomes documented in the care plan.

Practice tip

If co-occurring mental health and alcohol and other drug problems are detected, further assessment and management of these problems should be identified on the care plan.

The care plan should address the interactive effects of substance use on mental health.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Principle 9

Within the treatment context, both mental health and AOD problems are **considered of primary importance** to the clinical presentation. As MH symptoms and AOD use can vary over time and strongly interact, both MH symptoms and AOD use needs to be given equal priority in treatment.

Who is responsible for coordination of the care plan?

Within the delivery of an integrated system of care for dual diagnoses, it is important for the primary treatment service (ATODS or MHS) to coordinate the development of a single care plan that encompasses regular reviews and involvement of the consumer, carers and each of the services involved.

The primary treatment service is also responsible for ensuring the consumer, carers and appropriate health and social care providers have convenient access to an updated copy of the care plan.

To guide determination of the most suitable service to provide primary treatment responsibility, refer to the Quadrant Model outlined in Chapter 1 of this document.

Key principles of the care planning process

- The care needs of the consumer are the focus of all planning processes.
- Consumer and carer involvement in the planning process is essential (including an advocate, if required).
- The extent of planning relates to the complexity of need. More comprehensive care planning and coordination is required for consumers with chronic or complex needs.
- Integrated care planning may require the active participation of the partnering service, or the provision of specialist advice and consultation by this service, to inform the development of the care plan even if they are not actively involved in direct client care.
- Planning for discharge starts once the consumer has been accepted for care by MHS or ATODS.
- Care planning is multi-disciplinary.
- Care planning needs to be delivered in a culturally sensitive manner for people from diverse linguistic and cultural backgrounds including Aboriginal and Torres Strait Islander peoples.
- Timely ongoing communication, information transfer and coordination between hospital and community based services is essential.
- Health care providers must comply with consumer confidentiality and privacy obligations when using or disclosing information about their consumers. Information on the sharing of information within Queensland Health is addressed in Chapter 1 of these guidelines.

Key components of the care plan

- **Problem/issues/strengths:** these are identified from the biopsychosocial assessment process and address both the substance use and mental health problems in one care plan.
- **Objectives/goals:** these need to be SMART (specific, measurable, achievable, realistic and timely).
- **Intervention:** this describes and outlines the proposed care and treatment strategies that are to be provided to, and with, the consumer. Interventions should match the client's stage of change and level of motivation (refer to Chapter 8 Stages of change and Stage-wise case management). Also included should be the person/agency responsible for implementation of specific interventions and planned frequency of contact between the care team, health professionals and the consumer.
- **Review date:** this is the planned date of the next care plan review.
- **Review and reassessment:** regular review of the consumer's care is required including the reassessment of both mental health and alcohol and other drug problems. Established protocols for review should be engaged and evaluation measures undertaken (that is, MHS outcome systems such as Health of the Nation Outcomes Scales (HoNOS) and ATODS case reviews) at required intervals (90 day review cycle, changes to status of care or new service episode). This includes a reassessment of substance use. A client's substance use may fluctuate over time and well documented patterns of use will assist with care planning and crisis management and will also serve as an indicator of client progress. Regular reassessments can also be used to provide feedback to the client on their level of use and a motivational intervention to facilitate the decision to change their substance use.
- **Review outcome:** the progress and/or outcome of clinical interventions should be documented at each clinical review and plans for further intervention and/or monitoring outlined if required.
- **End date:** the completion date of the intervention should be documented clearly outlining if the intervention has ceased.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 12

The development of a **comprehensive treatment plan**, including regular review of the treatment plan, involves the person's active participation whenever possible.

Relapse prevention plans

The consumer's care plan needs to address relapse prevention and strategies to manage crises of mental health or substance use problems. The standardised suite of mental health assessment forms includes a relapse prevention plan, which outlines further details on the factors influencing a consumer's risk of relapse as well as strategies identified by the consumer to manage these situations. Clinicians should develop relapse prevention plans for all consumers and address dual diagnosis issues within this plan. All agencies involved in the consumer's care should be involved in the development of the care plan. Sharing of information between all agencies involved in care of the consumer is imperative and required under the *Health Services Act 1990* (see Chapter 1). The consumer, carer and relevant agencies should be provided with a copy of the relapse prevention plan.

The plan may include:

- strategies to maintain mental health (for example — reduce stress or engage in exercise)
- strategies to maintain abstinence/reduced use of drugs (for example — drug refusal skills or craving management)
- relapse triggers for mental health/substance use problems (for example — stopping medication or losing a job)
- early warning signs for relapse (for example — re-visiting the pub or a return of hallucinations)
- strategies/actions to manage early warning signs (for example — contact case manager or visit an Alcoholics Anonymous (AA) meeting)
- role of other professionals (for example — Department of Emergency Medicine staff or acute care crisis staff).

chapter 6
risk assessment

dual diagnosis
clinical guidelines

key points

- Comprehensive risk assessments are essential at every stage of service provision.
- People with dual diagnosis may have a higher level of risk for suicide, self harm, aggression and violence.
- Clinicians should undertake a thorough and ongoing assessment of an individual's static and dynamic risk factors and identify protective factors.
- Strategies/interventions to manage risk should be provided and documented in the care plan.
- Vulnerability factors also influence risk and should be considered within comprehensive assessment procedures.
- Mandatory reporting of child protection issues is the responsibility of every clinician.

A fundamental part of the assessment process is the assessment and management of risk in all clients presenting to Mental Health Services (MHS) or Alcohol, Tobacco and Other Drug Services (ATODS). Conducting an adequate risk assessment is an essential strategy in the protection of the client, clinicians and the wider community and can promote engagement enabling a more effective working relationship between the client and the treatment team (Hawkings and Gilburt 2004). Mental health problems and the use of alcohol and other drugs can contribute significantly to the level of risk (Hawkings and Gilburt 2004). In addition, these risk factors may be exacerbated by poor compliance with medication and/or treatment. Therefore, risk should always be addressed when working with individuals with dual diagnosis.

The assessment of risk is an ongoing process and should be integrated into all facets of assessment and ongoing management. Once risk is identified it should be documented and response strategies recorded on the treatment plan. Strategies to manage this risk are required to be actioned by the treating team. This may require a collaborative approach between MHS and ATODS, carers/significant others and other service providers.

Risk assessment has been built by MHS into various points of the required documentation (for example — intake, comprehensive assessment, care planning, case review and discharge plans) rather than only being recorded on a stand alone form (Patient Safety Centre 2007). The most important information should be included in additional comments to provide context and the clinician's rationale for their assessment of risk.

Risk-screening tools are also included by ATODS in its suite of assessment forms. Clinicians are encouraged to use these tools. It is important that the information gathered during this screening process is included in the client's formulation and treatment plan.

The assessment of risk should include both static and dynamic factors. Static risk factors are historical factors which often cannot be changed, whereas dynamic risk factors are the current precipitating factors and may be amenable to change (Patient Safety Centre 2007).

Practice tip

Risk assessment is an ongoing process of assessment, and adjusting a client's management in accord with changes in their presentation/circumstances, may increase or decrease imminent risk.

Ongoing assessment is a more reliable basis for practice than a one-off prediction of risk.

Further information

Further information on the recording of risk in a MHS setting, refer to the Queensland Health Mental Health Adult Services Statewide Standardised Suite of Clinical Documentation User Guide at
qheps.health.qld.gov.au/patientsafety/mh/mhform.htm

Suicide/self harm

Contact with public health services provides an opportunity to identify people at risk of suicide/self harm and to undertake early intervention (Queensland Health 2004).

Clinicians may fear that asking about suicidal feelings could encourage the person to engage in them when in fact, this is unlikely. Instead, by acknowledging people's thoughts, clinicians can work with them using various interventions — for example, reinforcing protective factors or mobilising support networks.

Distinguishing between self harm with or without suicidal intent can at times be difficult. Regardless of motivation or intention, both are dangerous behaviours associated with a heightened risk of dying. Self harm is a maladaptive behaviour that reflects severe internal distress (which may not always be evident in the external demeanour) and a limited ability to develop effective coping strategies to deal with difficulties.

Historical items that often cannot be changed constitute static factors. These may include:

- history of self harm
- previous suicide attempts
- gender
- sexual orientation
- cultural background.

Dynamic factors are current precipitating factors and may be amenable to change. These can include:

- personal risk factors especially involving loss or humiliation (for example — court cases, adverse publicity)
- at risk mental states especially hopelessness, depressed mood, despair, agitation, shame, guilt, anger or psychosis
- alcohol and other drug use/intoxication
- recent loss
- interpersonal problems
- acute mental and physical illnesses
- personality/vulnerability (for example — impulsivity or dramatic behaviour)
- recent major life events (for example — separation, divorce, redundancy or death of a loved one).

Hazards are external factors which increase the likelihood of danger occurring. They are not necessarily predictors of suicide but may indirectly influence a person's level of distress and can include:

- lack of access to general practitioners or public health services
- environmental conditions
- changes in service contacts
- low socioeconomic communities
- rural and remote communities
- subcultures (for example — 'emos').

Protective factors are positive aspects of a person's life that may reduce the risk of self harm/suicide. These include:

- strong perceived social supports
- family cohesion
- peer group affiliation
- good coping and problem solving skills
- positive values and beliefs
- ability to seek and access help.

Suicide risk assessment involves consideration of past historical factors, dynamic factors, hazards and protective factors. Special consideration has to be given to whether the circumstances that led to the crisis are now resolved. A person who no longer reports self harm ideation may still require psychosocial support to reduce their level of vulnerability.

Practice tip

The first 28 days following discharge from a mental health inpatient unit or correctional facility is a period of increased risk for suicide. Regular monitoring and support for the client is required during this period.

Aggression/violence

Research shows that people who have a dual diagnosis are more likely to have a history of violence than people with mental health problems alone. The link between alcohol and other drug use and violence is unclear. The environment in which alcohol and other drug use occurs could also play a part since the legality of many substances and associated crime can be linked to violent behaviour (Hawkings and Gilburt 2004).

The assessment of risk includes an evaluation of the person's emotional state at the time of the interview with close attention paid to the individual's affect. Individuals who are angry and lack empathy for others are at increased risk for violent behaviours. The clinician should observe the person for physical signs and symptoms of changes indicating incipient violence.

As risk is a dynamic process, monitoring changes is essential. Changes of interest include the presence or increase of a risk factor (for example — anger, intoxication or acute psychosis). Where there is a previous history of violence there may be triggers or factors that risk is conditional upon (for example – a return to amphetamine use or an anti-social peer group). Such factors should be documented in the treatment and relapse plan as targets for both monitoring and intervention.

While more risk factors generally mean increased risk, it is important to note that certain factors alone may increase risk (for example — carrying a weapon in relation to a perceived threat). It is also important to note the presence of protective or mitigating factors (for example — supportive family sensitive to a person's risk). Risk can be formulated in terms of a balance sheet of increasing and decreasing factors. A more sophisticated scheme is to think of risk in terms of predisposing (static or historical), precipitating (acute dynamic), perpetuating (stable dynamic), protective and prognostic factors that contribute to a person's risk. This information can be used to develop a risk management plan that addresses the factors that contribute to an individual's risk of violence. Once a risk assessment is completed the clinician should have developed a model of the pathways to the person's risk — for example, why might they cause harm, to whom and under what circumstances.

As previous behaviour remains a strong, though imperfect, predictor of future behaviour, it is necessary to have an understanding of a person's behaviour pattern. Information about the frequency of previous harm, who was harmed and methods employed for causing harm, provides a useful guide regarding the likelihood and seriousness of future harm. Historical information also needs to be considered in relation to current dynamic and contextual factors.

In addition to identifying relevant risk factors, it is important to consider the **seriousness** of possible harm (often based on the person's past behaviour or current threatened behaviour), the **likelihood** of this harm occurring and the **imminence** (is it anticipated to happen now or in 10 days).

Practice tip

A past history of violence and the pattern of a person's behaviour are the strongest indicators of future risk behaviour.

Special considerations

Psychiatric symptoms

Specific psychiatric symptoms and diagnoses should be carefully reviewed when conducting a violence risk assessment. Issues for consideration when assessing the risk of violence include:

- The presence of active psychotic symptoms is of particular concern when evaluating a person's risk of future violence.
- Among MHS clients, a co-existing diagnosis of substance misuse is predictive of an increased risk of violence.
- Personality traits associated with violence include impulsivity, low frustration tolerance, callousness, lack of empathy, a sense of entitlement, and superficiality.
- It is important to assess for the presence of antisocial personality disorders in individuals, as Antisocial Personality Disorder in combination with mental disorder, increases the risk of future violence.
- The concept of psychopathy is important because the presence of psychopathy is a strong predictor of criminal behaviour and violence among adults.
- Depression is the most common diagnosis in murder-suicides.
- Clients with mania show a high percentage of aggressive or threatening behaviour (especially when being restrained or having limits set on their behaviour), but serious violence itself is less common.
- Brain injury or illness and/or lower intelligence can increase the risk of aggressive behaviour.
- Situational factors that increase the risk of future violence include associations with a criminally offending peer group, lack of financial resources and housing, being a victim of violence, easy access to weapons, and exposure to alcohol or illicit drugs.

Practice tip

Always document identified risks in the clinical chart. Strategies/interventions for the management of risk also need to be documented in the treatment plan or a separate risk management/crisis management plan.

Violence often involves others so the clinician should be alert to such behaviour. Examples include psychotic ideas regarding children, delusional or substance induced jealousy, delusional misidentification, command hallucinations, paranoia and threat from others which is delusion-based.

The clinician should treat all threats seriously and clearly document the content and nature of any threats that are made.

The clinician should assess the suicide risk in any client making a homicidal threat.

Intoxication, withdrawal and delirium can increase violence risk.

Vulnerability

The assessment of vulnerability should include information regarding financial, physical, sexual and emotional abuse, as well as risk for self neglect, and should include details as appropriate. Status regarding cognitive/intellectual impairment, which may increase a person's risk for vulnerability, should also be included.

Social vulnerability and at risk behaviours should be recorded. At risk behaviours could include injecting drug use, binge drinking, unsafe sexual practices, health risks, legal risks and dangerous behaviours engaged whilst under the influence of substances.

Where identified, it is important that strategies are documented and put in place to address risk factors.

Child protection issues

Clinicians should be mindful of the potential impact of co-occurring disorders on an individual's parenting role. Alcohol and other drug use and/or mental health problems in a family does not in itself, indicate child neglect or abuse. However, the risk of child abuse and neglect is higher in families where parents or caregivers have significant problems. All health professionals working with parents and guardians who have drug and alcohol and/or mental health problems need to be aware that the safety, welfare and wellbeing of any children within the client's care is paramount. This includes an assessment of the client to ascertain the existence of any dependent children, and the nature and extent of their contact with them (Drug Treatment Services Program 2000).

Further information

The interested clinician should refer to the landmark report on drug use in the family (Dawe et al. 2007), commissioned by the Australian National Council on Drugs, regarding the impact and prevalence of parental substance misuse, and recommendations for responsive service provision, see ancd.org.au/images/PDF/Researchpapers/rp13_drug_use_in_family.pdf

A recent amendment to Section 20: Issues for Specific Areas of the Queensland Health Protecting Queensland Children Policy Statement and Guidelines for the Management of Child Abuse and Neglect in Children and Young People (0–18 years), outlines that staff who are involved in counselling or treating people with alcohol or other drug use issues need to be proactive in making routine enquiries about their capacity to cope with the care of their children. Additional tips are included in Chapter 10 on parental dual diagnosis.

Queensland Health has instigated mandatory reporting requirements for all relevant health professionals in relation to notifying suspicions of abuse or neglect of children and young people. Expert advice regarding the risk to children with whom the consumer lives, or has close contact with, can be sought from the child protection advisors and dedicated child protection liaison officers within each health service district. Children Of Parents with a Mental Illness (COPMI) have been identified as a priority group at both the national and state levels. District COPMI positions have been developed to enhance systemic responses to support these children (Queensland Health 2005).

Further information

Refer to the Mental Health Alcohol and Other Drugs Directorate website for details on current programs at qheps.health.qld.gov.au/mentalhealth/default.htm

chapter 7
medical interventions

dual diagnosis
clinical guidelines

key points

- Complex pharmacotherapy issues exist in the treatment of people with a dual diagnosis.
- A comprehensive drug and alcohol assessment is vital to ensure safe and effective prescription and administration of the range of psychotropic medications.
- Mental health (MH) clinicians should be aware of the range of medications used in the management of substance misuse and their impact on the positive and negative symptoms of mental illness.
- Alcohol, Tobacco and Other Drug Service (ATODS) clinicians should be aware of the range of medications used in the management of mental illness and their potential for abuse.
- The assessment and impact of withdrawal and management of withdrawal symptoms in a person with a dual diagnosis should be considered within all stages of treatment and care planning.
- People with a dual diagnosis have a heightened risk of a range of physical health concerns, including oral health issues, and require active monitoring of their general health.

Pharmacology

As people with dual diagnosis frequently present with complex issues, medication used in their treatment needs to be carefully considered as interactions between medications and illicit substances can occur. For example, the combination of antidepressants and psychostimulants can result in toxicity. Some antidepressants (for example — fluvoxamine) can reduce the metabolism of methadone, while some anticonvulsants/mood stabilisers (for example — carbamazepine) will increase it. Hence it is not easy to make simple guidelines for the use of medications in this population (Boyer and Shannon 2005).

This section broadly outlines the classes of commonly used psychotropic medication and provides general information about their use.

This document should not substitute careful medical assessment and consideration of potential benefits and hazards.

Prescribed psychotropic medications that affect mood, perception and/or behaviour have been prevalent in the field of psychiatry for the last 60 years (Usher et al. 2009). These medications target biochemical processes which restore an excess or deficiency of neurotransmitters or their receptors in various parts of the brain and prove more effective when accompanied by supportive psychosocial interventions. Psychotropic medications will be prescribed by a medical officer or, if available, a psychiatrist. When being prescribed the following should be considered:

- potential interactions between prescribed and non-prescribed substances
- the presence of co-occurring medical problems (for example — liver dysfunction related to long-term alcohol and other drug use or hepatitis)
- the abuse potential of the medication being prescribed.

A comprehensive alcohol and drug assessment is integral to safe, effective and appropriate pharmacotherapy treatment. All clinicians are responsible for undertaking a holistic assessment to inform clinical formulation and treatment planning. Plans for long-term pharmacotherapy treatment should occur after an adequate alcohol and drug assessment, including history, has been undertaken.

Further information

For an overview of the brain and pharmacological principles refer to an appropriate text such as *Psychopharmacology for Health Professionals* (Usher et al. 2009).

Medications used for disturbance in cognition and perception

Antipsychotic agents

There are two main groups of antipsychotics: typical and atypical. These are also called neuroleptics or major tranquillisers. Their main action is to decrease dopaminergic activity in the brain.

Table 3 Antipsychotic agents

Typical antipsychotics	Atypical antipsychotics
Chlorpromazine	Amisulpride
Droperidol	Aripiprazole
Flupenthixol	Clozapine
Fluphenazine	Olanzapine
Haloperidol	Paliperidone
Pericyazine	Quetiapine
Trifluoperazine	Risperidone
Zuclopenthixol	Ziprasidone

Antipsychotic medications are principally used to reduce positive psychotic symptoms. These include auditory hallucinations and delusions. Many of these medications have the side effect of sedation, which can be used therapeutically to reduce agitation or assist in rapid tranquillisation. Recently, many antipsychotic agents have been shown to have mood stabilising effects and so can be used in Bipolar Affective Disorder as well as augmenting antidepressant agents in the treatment of depression. Other uses include treatment in tic disorders and as an antiemetic.

Typical antipsychotic medications are generally more sedating than the newer, atypical antipsychotic medications. The atypical medications are better tolerated with fewer side effects than the typical agents. However, antipsychotic medications still have substantial side effects and their use needs to be carefully considered. Some common side effects include: sedation, weight gain, movement problems and hormonal disturbances.

Some antipsychotic medications are available as solutions (depot) for injection. Depot injections can have effects which can last for more than two weeks which can be useful where there are issues of non-adherence.

All atypical antipsychotic medications are restricted to authority prescriptions under the pharmaceutical benefits scheme. The specified conditions are generally restricted to major mental illness which limits their use for drug related conditions. Clozapine is a restricted antipsychotic medication due to the adverse side effect agranulocytosis, which requires monitoring via regular blood testing.

Practice tip

As a general rule, oral administration is the preferred first line treatment of psychosis. The use of depot injection may be considered following a period of assessment and monitoring as to its appropriateness.

Neuroleptic Malignant Syndrome

A significant and potentially fatal adverse effect of antipsychotics is Neuroleptic Malignant Syndrome (NMS). NMS is less common with atypical antipsychotics with an incidence of between 0.01 per cent and 2.5 per cent. The mortality rate of those diagnosed with the disorder is between 10–30 per cent (Usher et al. 2009). An essential feature of NMS is the development of severe muscle rigidity and elevated temperature in individuals using neuroleptics (antipsychotics). Urgent medical assistance should be sought for anyone displaying NMS symptoms.

Further information

For a further description of signs and symptoms of NMS, refer to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR®)* (American Psychiatric Association 2000) at https://online-statref-com.cknservices.dotsec.com/Document/Document.aspx?FxId=37&DocId=1&SessionId=F43F96GPTKQPRIVL

Prescribing and administration issues for antipsychotics

The prescription of antipsychotic medication should take into account a comprehensive assessment and exclusion of other organic causes of psychotic phenomenon — for example, inhalant use.

- Antipsychotic medication effects are best monitored in the context of a therapeutic relationship. Special attention needs to be given to monitor the potentially irreversible side effect of tardive dyskinesia with typical antipsychotic medications.
- Adequate written and verbal information and education regarding use and potential side effects needs to be given to the client (and carers) prior to prescription of antipsychotic medication.
- Clients receiving anti-psychotic medication need to be monitored regularly for signs of motor disturbance, galactorrhea, sedation, weight gain, Type 2 Diabetes, Metabolic Syndrome and seizures.
- Clients prescribed Clozapine need to be monitored according to the Clozapine patient monitoring system.
- Prescribing depot antipsychotic medication should occur following a period of assessment and monitoring of ongoing psychotic symptoms, and be informed by diagnostic criteria and clinical need.

Practice tip

The completion of a thorough alcohol and drug assessment, including collecting information on the history of alcohol and drug use and collateral information, is an integral component of formulation and pharmacotherapy treatment planning. This is particularly important in early psychosis cases or substance related psychoses where diagnostic ambiguity may be evident.

Medications used for disturbances in mood and affect

Antidepressants

The biological basis of depression has been theorised to be the result of depletion in serotonin or noradrenaline levels in the brain. Most antidepressants work on increasing the levels of one or both of these neurotransmitters. There are several classes of antidepressants.

Table 4 Antidepressant agents

Tricyclic antidepressants	Selective serotonin reuptake inhibitors
Amitriptyline	Citalopram
Clomipramine	Escitalopram
Dothiepin	Fluoxetine
Doxepin	Fluvoxamine
Imipramine	Paroxetine
Nortriptyline	Sertraline
Trimipramine	

Noradrenaline serotonin reuptake inhibitors	Tetracyclic antidepressants
Venlafaxine	Mianserin
Desvenlafaxine	Mirtazapine
Duloxetine	

Reversible monoamine oxidase inhibitors	Noradrenaline reuptake inhibitors
Moclobemide	Reboxetine

The most commonly prescribed group of antidepressants is the selective serotonin reuptake inhibitors (SSRIs). These medications have few side effects and are generally well tolerated. They do not generally require dose alterations and are taken as a single tablet in the morning. The main side effects include some initial gastrointestinal disturbance and sexual dysfunction. There is some evidence that drugs combining effects on serotonin and noradrenaline may be more effective. The older tricyclic antidepressants, although effective, have numerous side effects including sedation, blurred vision, dry mouth and postural hypotension.

Antidepressants are widely used in the community. They are principally used to treat an episode of major depression which usually requires six to 12 months of treatment. Antidepressants have also been useful in the treatment of anxiety disorders with the doses necessary to achieve an effect often higher than that used for depression. Antidepressants are also used in the treatment of Post Traumatic Stress Disorder, Obsessive Compulsive Disorder, chronic pain, and urinary incontinence.

Serotonin toxicity

Serotonin toxicity is a condition associated with the use of both prescribed and recreational drugs that have an effect on serotonin activity in the brain. This effect can be caused by SSRIs. The risk is increased if more than one of these drugs is taken. Serotonin toxicity is characterised by symptoms which reflect neuromuscular excitation (for example — hyperreflexia, hypertonia and rigidity); autonomic stimulation (for example — hyperthermia, tachycardia and sweating); and changes to mental state (for example — agitation, anxiety and confusion) (Isbister et al. 2007). The severity of this condition can range from mild to moderate to severe resulting in a serotonin crisis or toxicity. If serotonin toxicity is suspected, urgent medical assessment should be sought.

The main differential diagnosis with serotonin toxicity is NMS followed by delirium tremens (severe alcohol withdrawal), hepatic encephalopathy and central nervous system infections.

Further information

Further information on the management of psychostimulant toxicity and intoxication are outlined in *The Management of Psychostimulant Toxicity Guidelines for Emergency Departments* (Queensland Health 2008). These guidelines provide information on sedation, medical management, behavioural management, post-sedative management and follow-up care. These guidelines are a useful resource accessible on QHEPS at health.qld.gov.au/atod/documents/psychostimulant_toxic.pdf

Prescribing and administration issues for antidepressants

A comprehensive assessment of pre-existing depressive illness is required to support the prescription of antidepressant medication.

- In the absence of a pre-existing or co-morbid mood disorder (meeting diagnostic criteria for an independent mood disorder), the prescription of an antidepressant is not well supported by the literature. Doctors should undertake a comprehensive assessment and ensure ongoing monitoring (including levels of risk) and combine psychosocial treatments and substance use treatments to manage low level mood disturbance.
- The establishment of a therapeutic alliance, including attentive listening, is vital to the recovery of people prescribed antidepressants.
- Prior to prescription, clients (and carers) need to be given written and verbal information regarding the effects and potential side effects of antidepressants.
- Drug interactions particularly with alternative medicines (for example — St John's Wort) need to be assessed prior to the prescription of SSRIs.
- Regular assessment of adverse effects (for example — serotonin toxicity) needs to be adhered to, particularly with clients with a history of stimulant use including amphetamine derivatives, cocaine and MDMA (ecstasy).
- Clients prescribed SSRIs need to be informed of the risk of Discontinuation Syndrome with rapid stopping or reduction of dose. Reduction of dose slowly over a two week period will minimise this.
- During the early period of treatment, clinicians need to be aware that the client's energy levels may lift however depressive symptoms may not, and there is a risk that clients may act on suicidal thoughts. It is therefore imperative that a risk assessment be carried out at each client contact (Queensland Health 2004).
- Clinicians need to monitor suicidal intention of clients prescribed antidepressant medication.

Clinicians need to monitor suicidal intention of clients prescribed antidepressant medication.

Mood stabilisers

Mood stabilisers have been used for many years in the treatment of Bipolar Affective Disorder to reduce mood swings. They are sometimes used in conjunction with an antidepressant for people with depression.

Table 5 Mood stabilisers

Mood stabilisers	
Carbamazepine	Lithium Carbonate
Olanzapine	Sodium Valproate

Lithium Carbonate was one of the earliest mood stabilisers and remains a commonly prescribed medication in cycling mood disorders. Medications used for the treatment of epilepsy were also found to have mood stabilising properties. The most widely used of these is Sodium Valproate but other drugs from this group are also used. Some antipsychotics have recently been found to have mood stabilising properties.

Side effects vary depending on the medication. Common side effects include weight gain and sedation. With the exception of antipsychotics, all of these medications can cause toxicity if the prescribed dose is exceeded. As a result, most of these medications require blood tests to determine their level in the blood. Lithium and the anticonvulsants may have adverse effects on the foetus during pregnancy.

Prescribing and administration issues for mood stabilisers

- Consumers need to be advised to continue to take their medication as a prophylaxis even when they are feeling well and have no symptoms.
- When prescribed Lithium, consumers need to be educated about the importance of regular blood tests; adverse risks including toxicity; the need to maintain adequate fluid (at least two litres per day) and sodium intake; and to replace fluid and sodium when exercising.
- When prescribed anticonvulsants, consumers need to be advised to avoid abrupt cessation of the medication.

Medications used for anxiety and sleep disturbances

Anxiety disorders may respond well to psychological treatments. If medication is considered then antidepressants have been shown to give favourable outcomes. Although drugs of the benzodiazepine class are effective in relieving acute symptoms of anxiety, they readily promote dependence and produce the secondary complication of benzodiazepine dependence. Benzodiazepines can also be problematic as they can impair cognition and memory, and lead to loss of inhibition and unwanted behaviour. They can, however, be useful for the short-term management of acute agitation or insomnia.

Table 6 Anxiolytics/hypnotics

Benzodiazepines	
Alprazolam	Bromazepam
Clobazam	Clonazepam
Diazepam	Flunitrazepam
Lorazepam	Midazolam
Nitrazepam	Oxazepam
Temazepam	Triazolam

Non-benzodiazepine anxiolytic/hypnotic	
Buspirone	Zolpidem
Zopiclone	

Benzodiazepines: dependence and withdrawal

Clients with dual diagnosis are more at risk of developing a physical and psychological dependence on, or misusing benzodiazepines. Sudden cessation of benzodiazepines can precipitate withdrawal syndrome which can be severe, therefore a weaning process is recommended as per clinical protocols for detoxification (Saunders and Yang 2002).

Prescribing and administration issues for benzodiazepines and no-benzodiazepine anxiolytic/hypnotic

- Consideration of the abuse potential of medications should be undertaken prior to prescribing and further assessment undertaken if indicated.
- Alternative medications should be considered if the client has a history of abusing prescription medication or abuse potential is identified in medication naive clients.
- Treatment regimes should be of brief duration and monitoring of adherence undertaken regularly.
- Involving carers/family and significant others in the administration of medication regimes may reduce the potential for abuse of prescription medication.
- Withdrawal symptoms may mimic anxiety and clinicians should undertake a thorough assessment of possible withdrawal.
- Any indication of withdrawal should be assessed immediately and consideration given to urgent medical care if indicated.
- The use of a benzodiazepine withdrawal scale to identify the severity of symptoms can support the assessment of withdrawal and inform the treatment plan.
- Doctors/clinicians should be mindful that ceasing or reducing the dose of some drugs may impair natural sleep cycles.
- Pharmacological treatments to manage sleep disturbance should be accompanied by monitoring of activities, dietary consumption, other drug use and sleeping patterns. Engagement in psychological treatments to address sleep disturbance as an adjunct to pharmacological treatments is recommended.
- As a general rule non-pharmacological treatment should be considered before pharmacological treatment is used.

Medications used for alcohol and other drug problems

Medications used in the management of substance misuse include medications to manage effects of dependence, including drug cravings and the withdrawal syndrome.

Medications for alcohol dependence

Thiamine

Thiamine is also known as Vitamin B1. Prolonged alcohol use may increase the risk of developing brain damage from a lack of Thiamine. Permanent brain damage associated with Thiamine depletion is known as Wernicke-Korsakoff's Syndrome. To reduce the risk of developing Wernicke-Korsakoff's Syndrome, Thiamine should be taken as a standard part of treatment. Deficiencies in other B complex vitamins and of Vitamin C are also common. Taking a multi-vitamin supplement for this is also beneficial (National Drug and Alcohol Research Centre (NDARC) 2003).

Further information

Refer to Clinical Protocols for Detoxification in Hospitals (Saunders and Yang 2002): health.qld.gov.au/atod/documents/24904.pdf

Acamprosate

Acamprosate acts to decrease glutamatergic transmission in the brain by modulating N-methyl-D-aspartate (MDA) glutamate receptor activity (Usher et al. 2009) and is an effective agent in reducing the incidence of relapse. Acamprosate is generally taken three times a day and has relatively few side-effects. It is not uncommon for clients to remain on Acamprosate for 12 months or longer.

Naltrexone

Naltrexone is an opioid receptor antagonist used to reduce the incidence of relapse, and in the treatment of opiate dependence. As it blocks opiate receptors, patients need to be aware that prescribed opiate medication will not work. Naltrexone should be used with caution in clients with impaired liver function.

Disulfiram

Disulfiram was used in the past to assist with relapse prevention. It blocks the metabolism of alcohol and leads to an accumulation of acetaldehyde in the body. If the client then ingests alcohol, it usually causes a severe, adverse reaction that may require hospitalisation. Because of this, disulfiram is now rarely used. However, it still has a place for people in whom it has worked previously who show a high level of motivation to maintain abstinence. Disulfiram is not subsidised by the Pharmaceutical Benefits Scheme (PBS).

Medications used in the long-term treatment of opioid dependence

Medications are available that substitute for illicit opioid use. These include Methadone and Buprenorphine. The rationale for their use is due to their longer half life (approximately 24 hours for Methadone) which provides a more stable level of opioid effect and therefore reduces the peaks and troughs in levels characteristic of illicit opioids such as heroin, which result in the feelings of intoxication, withdrawal and craving. This reduces the drive to find illicit opioids and allows the opportunity for improvement in overall function. Other benefits include reducing the risks of blood borne diseases as well as improvements in overall health. As a result, it also reduces criminal and high risk behaviours.

Methadone

Methadone has been considered the gold standard for the treatment of opioid dependence. It is a synthetic opioid available as methadone syrup or liquid 5mg/ml called Biodone. Under the Queensland Opiate Treatment Program (QOTP), methadone is dispensed daily under supervision. There is also a tablet formulation called Physeptone used in the management of chronic pain. Starting doses are generally 10–30mg. Doses to achieve stability maintenance therapy vary greatly, but most clients require 60–100mg per day.

Buprenorphine

Buprenorphine is a sublingual preparation dispensed under supervision. The formulations used in the QOTP are Subutex and Suboxone. Subutex is Buprenorphine alone, whereas Suboxone is a formulation that includes Naloxone. Naloxone is the powerful opiate antagonist used in opiate overdoses. It was added to the Buprenorphine to make Suboxone less attractive for diversion and injection purposes. In most clients Suboxone can be regarded as equivalent to Subutex.

Prescription

Methadone and Buprenorphine are prescribed under regulation by the QOTP. This is done in public clinics as well as by private prescribers who have completed training to become authorised prescribers. Clients on QOTP undergo an initial process of stabilisation.

Medications for nicotine dependence

Several types of medication are available for use in the treatment of nicotine dependence. They all work better in the context of psychological intervention. Overall, nicotine abstinence is difficult to achieve and relapse rates are high.

Nicotine replacement therapy is the most common treatment. Delivery methods vary and include trans-dermal patches, gum, lozenges and inhalant nicotine. The dose of nicotine is progressively reduced over nine to 12 weeks.

Two medications are prescribed in Australia:

- **Buproprion:** an antidepressant that was found to increase rates of nicotine abstinence. Side effects include seizures and it is contraindicated in people who have epilepsy or who are on antidepressants.
- **Varenicline:** a drug specifically targeting nicotine receptors in the brain to block nicotine effects. Although more successful than other treatments, there are concerns about its use in people with mental illness.

Withdrawal management

Withdrawal management or detoxification is not a stand alone treatment; it is the first step along a pathway to recovery. The treating team should be planning for discharge and linking the client into medium to long-term care during the early phases of withdrawal management. It is only one stage in the continuum of care and must be accompanied by ongoing intervention in order to improve the outcome of treatment for the client.

Withdrawal management is the process by which an alcohol or drug dependent person ceases the use of a psychoactive substance, in a supervised manner so that withdrawal symptoms and the attendant risks are minimised. Detoxification implies neurological adaptation by repeated exposure to substance use and the need for treatment to prevent or minimise withdrawal symptoms while neuroadaptation gradually reverses. It is imperative that all clinicians screen clients presenting to services for withdrawal and consider the need for management of withdrawal symptoms, especially when regular heavy substance use has been identified.

Signs of withdrawal

Withdrawal management takes from 24–48 hours to two to three weeks, depending on the predominant substance used and the severity of dependence.

Withdrawal management/detoxication can be undertaken:

- at home under the supervision of a health professional with the support of a carer (this setting is suitable when an uncomplicated withdrawal management is anticipated)
- on an outpatient basis through a participating ATOD service
- in a community residential setting, usually a non-government organisation, with staff including health or personal care workers, nurses and minimal or on call medical staff
- in general and mental health units (when withdrawal management becomes a secondary issue to the primary diagnosis)
- in specialist withdrawal management units (which are suitable for complex withdrawal symptoms which require a high level of medical and supportive care).

Further information

Further information on withdrawal management is available from the Alcohol and Drug Information Service (ADIS) 24 hours on 1800 177 833.

Further information on withdrawal, please refer to Clinical Protocols for Detoxification in Hospitals and Detoxification Facilities at health.qld.gov.au/atod/documents/24904.pdf

Physical health concerns

The literature has shown that people with severe mental illness have higher rates of physical illnesses, leading to a considerably shorter life expectancy compared to the general population (Brown et al. 2000; Lambert et al. 2004; Osborn 2001). The incidence of poor physical health and self care is also high in individuals with dual diagnosis (Queensland Health 2003). Poor physical health is related to multiple factors such as higher rates of smoking, alcohol and drug use, lack of exercise, poor diet, isolated living conditions, poverty, medication side effects and delayed health seeking behaviours. Furthermore, the literature shows that consumers with dual diagnosis experience multiple barriers to accessing and receiving adequate physical health care from general practitioners and Mental Health Services (MHS).

Difficulty accessing appropriate treatment for dual diagnosis also presents barriers to accessing treatment for physical health concerns. Opioid misuse may result after analgesia used for pain caused by an undiagnosed problem. This presents an additional level of complexity for the management of such clients. It is important for the clinician to gather background history on the client's physical health and encourage engagement with a general practitioner for ongoing care and monitoring. Regular communication and collaboration in treatment with the primary care sector is required in order to address the holistic health needs of the client. Clinicians should regularly monitor the engagement of clients with their general practitioner and facilitate ongoing treatment for physical health concerns where required. Refer to the primary health care checklist for dual diagnosis and the section on opioids in Chapter 4.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems (2008)

Principle 6

Integrated service provision involves a **biopsychosocial approach** comprising an array of physical, psychological and social service interventions in the provision of engagement, assessment, treatment and care.

Dental/oral health

Poor oral hygiene is a common outcome of harmful substance use and methadone treatment (Department of Human Services 2001). Rotting and discoloured teeth and mouth ulcers are common in people who have misused substances and may affect the person's self esteem even following cessation of substance use. It is important that good oral hygiene is encouraged and clients are educated regarding the effects of substance use on their oral health. Clinicians should promote good dental health and encourage clients to access government dental clinics or private dentists to address poor oral health (American Dental Association 2003).

Further information

For information on dental hygiene, please refer to health.vic.gov.au/healthpromotion/downloads/fr_knox.pdf

Further information on the impact of psychostimulants on oral health refer to nobledentist.com.au/education/oral_health_methamphetamine.php

The Medicare chronic disease dental scheme was introduced in November 2007. This scheme allows chronically ill people, including those suffering from dual diagnosis, who are being managed by their general practitioner under an enhanced primary care plan, access to Medicare rebates for dental services. To be eligible, clients must have a chronic medical condition and complex care needs that impact on their oral health, or are likely to impact on their general health. This scheme was expanded to include the Medicare teen dental plan in July 2008.

Further information

For more information call Medicare Australia on 132 150 or visit the Department of Health and Ageing website at health.gov.au/dental

Table 7 Primary health care checklist for dual diagnosis clients

General physical health checks

1. Does the client see a GP regularly for a routine check up?
2. Does the GP know of the client's drug use and mental health problems?
3. Are there any other prescribed medications that may adversely be affected by the recreational drug use? Discuss with the client the benefits of all drugs in their life, and also the potential harms of polypharmacy.
4. Discuss the benefits of a regular GP check-up to identify early warning signs of disease.

Clients who use drugs are increasing their risk of major health complications including:

- cardiovascular diseases (stroke, heart and circulatory problems)
- cancers
- diabetes
- blood born viruses (Hepatitis B and C and HIV)
- sexually transmitted diseases
- blood borne infections (Septicaemia, joint disease such as septic knee or hip syndrome)
- fungal infections (Candida Endophthalmitis affecting the eye)
- loss of limbs through injection caused vascular damage
- oral diseases (Department of Human Services 2001).

Dental /oral health checks

1. Ensure clients have access to a toothbrush and toothpaste. Basic brushing twice a day and rinsing with a mouthwash can prevent most oral health complications.
2. Free oral health care can be accessed for eligible clients from the public dental clinics located at each hospital.
3. A diet that includes fruit and vegetables, and plenty of clean water (2L per day) will assist with prevention of oral diseases.
4. It is important to discuss the oral health implications of drug use, as poor oral health has potentially serious outcomes for general health and mortality.

Commonly used substances associated with oral health problems include:

Tobacco/nicotine

- periodontal disease — caused by reduced supply of oxygen rich blood to gums. This results in blackening of the gums, infections (tooth abscess), and tooth loss. Serious complications of periodontal disease include septicaemia (blood poisoning)
- oral cancer
- congenital defects — such as cleft lip and palate in children
- suppression of the immune system's response to oral infection
- compromised healing following oral surgical and accidental wounding
- accelerates periodontal degeneration in diabetics.

Opioids

- Methadone syrup no longer contains cariogenic sugars, however poor dental health is common in those on maintenance due to opioid induced dry mouth (xerostomia) and poor self care (Department Human Services 2001).

Psychostimulants

- 'Meth Mouth' is described as rampant tooth decay, with descriptions including teeth that blackened or stained, rotting, crumbling or falling apart which is caused by:
  - the acidic nature of the drug
  - dry mouth due to reduced saliva production
  - drug-induced craving for sugary foods
  - grinding and clenching teeth which may occur during withdrawal.

Central nervous system depressants

- tooth decay from loss of protective saliva.

Cannabis

- pre-malignant lesions within the oral mucosa
- oral infections (Cho et al. 2005).

chapter 8

motivational enhancement approaches

dual diagnosis
clinical guidelines

key points

- Motivational interviewing approaches in the treatment of dual diagnosis are the most strongly supported psychosocial intervention with this client population.
- The use of the Stages of Change Model to guide the treatment interventions and the application of a stage wise approach to treatment with a dual diagnosis is encouraged.
- Modification to traditional motivational interviewing has been applied to clients with severe mental illness and co-occurring alcohol and other drug use.

Evidence for the efficacy of an integrated approach to treatment for people with dual diagnosis has indicated that people with severe mental illness respond to the provision of integrated treatment (Kavanagh et al. 2008; Mueser et al. 2003; Queensland Health 2003 Strategic plan for people with a dual diagnosis; SAMHSA 1998; Hawkings and Gilburt 2004). The provision of assertive outreach and longitudinal stage wise case management, utilising a motivational approach, appears to enhance treatment outcomes (Mueser et al. 2003) for this client group.

The limited number of randomised controlled trials on the benefits of psychological interventions for co-morbid disorders in the current literature, impacts on the availability of evidence-based support for various psychosocial treatment options and current evidence in the Australian health service context. However, numerous sources have cited the efficacy of psychosocial treatments in reducing the impact of substance use and consider that these are likely to reduce the impact of dual diagnosis (Jané-Llopis and Matysina 2006). Given this, there is insufficient evidence to recommend any specific psychological treatments, although support for Motivational Interviewing is well demonstrated in the literature and contingency management approaches appear most promising (Adamson and Sellman 2008; Baca and Manuel 2007).

However, there is a growing body of evidence that supports the recovery of clients with severe mental illness and co-occurring substance use disorders over months and years, and in stages (Drake et al. 2008). The evidence on best practice interventions for co-occurring anxiety or depressive disorders and substance misuse is also rapidly developing. At the time of the completion of this document, there are several trials either underway or awaiting publication. Current evidence suggests that standard treatment for substance use disorders continues to be effective in people with co-occurring anxiety or depression. Although treatment for depression still works to some extent in people with substance use disorders, there is some evidence that it may lose some of its impact, although the data is inconclusive. The picture on integration of treatment in co-occurring substance misuse and anxiety or depression appears complex, and relative effects of integrated versus single-focused treatments may vary, depending on the measure that is used, the gender of participants and when measures are obtained.

Clinicians should refer to accepted treatments for substance use disorders and consider treatment options showing promising results and generalisability from other areas of clinical practice. Further psychosocial treatment options are briefly outlined in the following chapter.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems (2008)

Principle 6

Integrated service provision involves a **biopsychosocial approach** comprising an array of physical, psychological and social service interventions in the provision of engagement, assessment, treatment and care.

Motivational Interviewing

Motivational Interviewing (MI) is a style of therapy that may be used to increase a client's motivation to change substance-using behaviour. The focus is on assisting the individual to develop insight into the impact of their behaviour, including alcohol and drug use, on both their goals and their mental health (Adamson and Sellman 2008; Baca and Manuel 2007; Carroll et al. 2006; Sitharthan et al. 1999; Hides et al. 2007). It is a directive, client-centred counselling strategy that aims to engage ambivalent or resistant individuals in the treatment process. A growing body of evidence suggests that MI is the most strongly supported psychological intervention that can be applied in the management of individuals with a dual diagnosis (Carroll et al. 2006; Sitharthan et al. 1999, and Hides et al. 2007).

Motivational interviewing involves a non-confrontational conversation which seeks out and highlights the ambivalence in the client's attitudes. This conversation can be used to highlight the benefits of changing behaviour. Flexibility, consumer choice, self efficacy, and the overall responsibility of the client in determining their goals are emphasised in MI. It is based on four principles designed to foster an open therapeutic exchange and subsequent 'change talk'. These principles include:

- expression of empathy
- developing discrepancy
- rolling with resistance
- supporting self efficacy.

The development of mutual trust is dependent upon the clinician expressing respect and empathy for the individual's position. The adoption of a collaborative, stage wise approach to treatment can reduce resistance and foster open and honest communication.

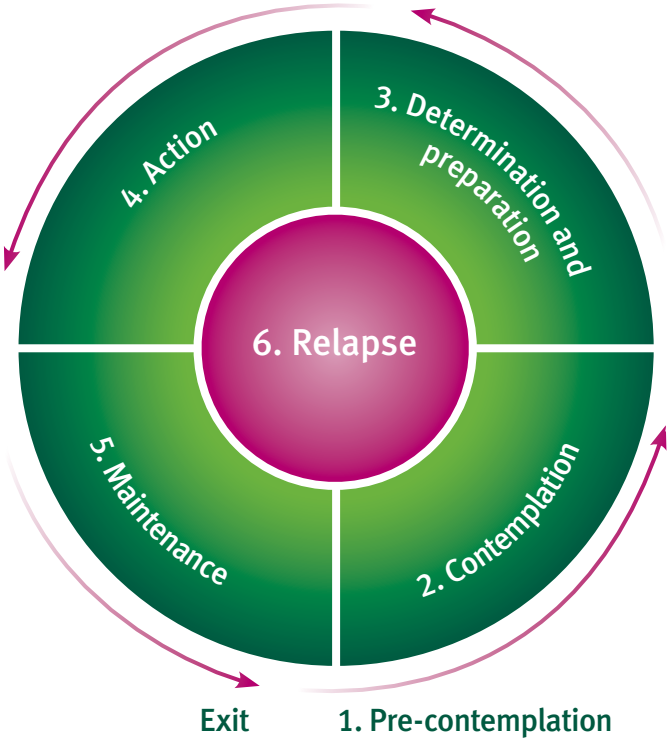
The Stages of Change Model

Prochaska and DiClemente (1986) have described an individual's insight and commitment to engaging in change behaviour as a cycle. The Stages of Change model provides a useful tool for clinicians to apply motivational interviewing approaches to facilitate change behaviour. The cycle has been described as the Transtheoretical Model (Prochaska and DiClemente 1986) which outlines that individuals vary in regard to their readiness to change by moving through six discrete stages. These stages include:

1. pre-contemplation
2. contemplation
3. determination (preparation)
4. action
5. maintenance
6. relapse.

Although the development of this model emerged from the alcohol and drug field, the scope of application has been expanded to encompass a range of domains including mental health. Principles of MI and the Stages of Change Model can easily be applied to a range of problems including treatment non-adherence.

Figure 8 The Stages of Change
(Prochaska and Diclemente 1986)



The emphasis on this process being a cycle highlights that individuals do not move in a linear fashion between the stages. An individual may move in and out of these stages before sustained change is made.

Pre-contemplation

Individuals in pre-contemplation may not recognise they have a problem and are not considering a change in their behaviour.

Contemplation

Individuals in the contemplation stage may be weighing up the pros and cons of their alcohol or drug use. However, they may not yet be committed to changing their behaviour.

Determination/preparation

The determination or preparation stage describes the phase entered as an individual decides to change their substance using behaviour and considers what action needs to be taken.

Action

An individual in the action phase of change would be actively engaged in strategies to address their alcohol or drug use.

Maintenance

Individuals in the maintenance stage would have already made progress toward ceasing their alcohol or drug use and be actively working on strategies to maintain this behaviour.

Relapse

Relapse is a stage where some individuals may return to previous alcohol and drug using behaviour.

The emphasis on this process being a cycle highlights that individuals do not move in a linear fashion between the stages. An individual may move in and out of these stages before sustained change is made.

Issues to consider

It is important for clinicians to match their interventions to the appropriate stage of change that the client is experiencing. Clinicians are often focused on interventions in the action stage of this model whilst clients may be in the contemplation or pre-contemplation stages. This incongruence is reflected in inappropriate treatment matching or care planning for the client.

The clinician may be perceived as pushing the client to engage in change behaviour when they may be demonstrating significant ambivalence about changing. Attempts to persuade or direct the client to change will be counter productive and will most likely result in increasing the client's ambivalence. This conflict between the client and clinician may impact negatively on the therapeutic relationship and produce barriers to effective change. In addition, clinicians are likely to experience frustration and burnout by focusing their efforts on interventions that are inappropriately matched to the client's presentation and therefore likely to be ineffective. This in turn will decrease clinician satisfaction with their role and perceived self efficacy as a clinician.

For example, if a client is clearly in the pre-contemplation stage, aiming for cessation of substances then attendance at a relapse prevention group is incongruent. The client might benefit instead from educational strategies to highlight the interaction between their mental health problems and substance use, motivational techniques to enhance their commitment to change and the provision of a safe environment that minimises risk (that is, dry hostel where substance use is not accepted to reduce the amount of substance use in the client's environment).

Clinicians should also be mindful to apply the Stages of Change Model in a flexible manner and not use it as a rigid method of classification to inform treatment interventions but to guide the choice of appropriate interventions. The model provides a broad framework to conceptualise the consumer's readiness to address their dual diagnosis concerns and the appropriateness of particular interventions. Interventions from various stages may still be applicable depending on the client's individual circumstances and clinicians should consider a range of interventions and match them appropriately to the client's needs.

Practice tip

The clinician should ensure interventions are tailored to the client's stage of change.

Table 8 Example interventions for the stages of change

Stage of Change	Characteristics	Techniques
Pre-contemplation	Not currently considering change: *'I'm happy just the way things are thanks'*	▪ Use a non-judgmental, informative approach; begin a discussion on the benefits the consumer perceives from their substance use; and briefly explore the downsides of this substance use. Accept their decision and offer information for making an informed decision such as safe drinking tips, safe injecting and alternatives to injecting. ▪ Ask permission to discuss later. Inform the consumer that it will remain on the agenda for further discussions.
Contemplation	Ambivalent about change: *'Sitting on the fence'* Considering changing sometime.	▪ Use MI; discuss the pros and cons of using. Discuss the pros and cons of not using. ▪ Emphasise the cons of using in order to develop dissonance and be explicit (e.g. going to jail/hospital, losing job, having no money for rent or food). Emphasise pros of not using by finding out what consumer wants (e.g. to stay out of jail, visit children, or to get a better life).
Preparation	Some experience with change and are trying to change: *'Testing the waters'* Planning to act within 1 month	▪ Use MI; discuss the consumer's goals for change (what they will get out of it) and provide encouragement. Focus on past successes with change (e.g. other times when quit attempts were made — focus on the successful aspects). Assist with planning for the change. Discuss possible obstacles and strategies to manage these. Show empathy by acknowledging that change is sometimes a little scary — validate this with the consumer.
Action	Practicing new behaviour for 3–6 months	▪ Explore with the consumer their own social supports, coping skills and reservations about the future. ▪ Show empathy — explore any feelings of loss and grief that may be associated with change. Discuss these issues as a normal part of the change process and review as needed, including medications and mood. ▪ Build self efficacy; remind the consumer of their successes so far. Discuss any challenging events coming up and strategies for dealing with these.
Maintenance	Continued commitment to sustaining new behaviour Post: 6 months – 5 years	▪ Encourage consumers to identify the positive changes that may have occurred and the negative impact of substance use, which may emerge since they began their attempt to change their substance use. ▪ Plan for follow-up support. Continue to build self efficacy by reminding the consumer of success, and explore plans with the changed situation in mind (e.g. starting a fitness program, getting a job or having the children overnight). ▪ Discuss coping with relapse as part of normal conversation. Introduce challenging situations and offer to role play these to practice new skills.
Relapse	Resumption of old behaviours: *'Fall from grace'* which can happen at any stage	▪ Show empathy; evaluate the triggers for relapse, explain this is normal and there is much to be learned from the experience. ▪ Build self efficacy; congratulate them on a job well done in making the change and maintaining it for the time it was done, and encourage it to be seen as a goal post. ▪ Reassess motivation and barriers. ▪ Re-evaluate coping strategies and adjust as needed.

Stage-wise treatment

There is a growing body of evidence that supports the recovery of clients with severe mental illness and co-occurring substance use disorders over months and years, and in stages (Drake et al. 2008). Clinicians providing case management for people with co-occurring disorders need to be aware of the stage or readiness for treatment of their client and provide interventions according to these motivational states (Osher and Kofoed 1989 cited in Mueser et al. 2003). This Stages of Treatment Model has been derived from the Stages of Change Model (Prochaska et al. 1992) described above.

Practical interventions for each treatment stage are included below (Adapted from Mueser et al. 2003).

Engagement stage

The key purpose of interventions at this stage of treatment is the establishment of rapport or the development of the therapeutic alliance. Establishing rapport with this client group is particularly important due to the frequently chaotic nature of their presentations, past negative experiences with the treatment system and low self efficacy due to previous failed attempts at treatment.

Consumers under the *Mental Health Act 2000* may be more difficult to engage due to the involuntary nature of their treatment. It is therefore important for clinicians to be approachable, honest, and helpful to consumers in order to facilitate the development of rapport.

Interventions during the engagement stage include:

- therapeutic alliance that is non-confrontational, empathic and respectful of the client's subjective experience
- assertive outreach
- meeting of immediate needs (for example — food, clothing, and housing)
- crisis intervention
- stabilisation of substance withdrawal or psychiatric symptoms
- harm minimisation
- assistance in managing legal penalties
- close monitoring.

Persuasion stage

The focus of interventions at this stage is on the development of the client's awareness of the negative consequences of their continued substance use and/or poor illness management. Strategies of MI to enhance the client's motivation to change are appropriate at this stage. It is important for clinicians to be seen as aligning with the client through the provision of unconditional positive regard. The clinician should maintain the focus of the mental illness and substance misuse as the cause of the adverse consequences not the client themselves.

Interventions during the persuasion stage include:

- developing an awareness that substance use is a problem and increasing motivation to change whilst avoiding confrontation and fostering resistance in the client
- presentation of objective assessment data (for example – liver function test, urinalysis, vital signs, psychological screen results and drink/drug diaries)
- balance sheets identifying the pros and cons of continued use
- exploration of barriers to the attainment of future goals
- reframing problems or past events emphasising the influence of substance misuse
- encouraging structured activities (for example – supported employment, volunteering, hobbies, church or social organisational involvement)
- the use of medications to treat unstable psychiatric illness that may have a secondary benefit of decreasing drug and/or alcohol use.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems (2008)

Principle 5

The development and maintenance of a **therapeutic alliance**, or quality treatment relationship based on mutual respect, is an essential component of effective treatment for individuals with a dual diagnosis. Empathy, respect and belief in the individual's capacity for recovery are fundamental service provider attitudes and values.

Active treatment stage

At this stage of treatment, active strategies to target behavioural change should be engaged. Strategies could include skills building, relapse prevention to address mental health and alcohol and drug problems, time management/ activity planning and vocational rehabilitation. It may take the client and clinician extended periods to reach this stage and may initially involve a reduction in substance use or acceptance of their mental health treatment. At this stage, slips or lapses into substance use should be viewed as learning experiences and the target for further intervention rather than failures.

Interventions during the active treatment stage include:

- self monitoring
- substituting activities for substance use (for example — work or sport)
- stress management and coping skills
- individual psychotherapy
- individual and family problem solving
- social skills training to address substance related situations
- pharmacological treatments to support abstinence (for example — acamprosate or naltrexone for alcohol dependence)
- self help groups (for example — 12 step groups Alcoholics Anonymous or Narcotics Anonymous)
- peer support groups (active treatment groups).

Relapse prevention stage

This stage focuses on maintaining gains achieved through the active treatment phase and the extension of recovery to other areas of the client's life (for example — relationships and work). At this stage, awareness should be maintained on the potential for relapse and enhancing client efficacy in engaging in relapse prevention. In addition, discrepancies between current progress and life goals can be identified to facilitate the development of motivation for the improvement of the client's overall lifestyle. It is important to reinforce and continually assess the client's commitment to these goals in order to maintain abstinence and adherence with mental health treatment.

Interventions during the relapse prevention stage include:

- lifestyle improvements (for example — smoking cessation, healthy diet, regular exercise or stress management techniques)
- social skills training to address other areas
- family problem solving
- expanding involvement in supported or independent employment
- obtaining independent housing
- self help groups
- becoming a role model for others.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems (2008)

Responsibility 11

Services provide **interventions that are matched to a person's presentation** including consideration of acuity and severity of each condition, phase of recovery, stage of treatment and stage of change.

Motivational Interviewing for individuals with a dual diagnosis

Motivational interviewing (MI) is particularly consistent with the principles of treatment for people with a dual diagnosis. There is significant evidence of the low levels of intrinsic motivation of individuals with mental illness and co-occurring alcohol and drug problems resulting from their severe and disabling symptoms, frequent failed treatment episodes and poor functional adjustments. The importance of engagement and motivational enhancement strategies are the cornerstone to working effectively with individuals with a dual diagnosis. Key MI strategies focus on the development of motivation to change, change talk, and strategies to manage resistance. These strategies are widely applicable to this client group.

Individuals with a dual diagnosis may use substances to manage or reduce anxiety or negative symptoms of psychosis including blunted affect, depersonalisation, or social inhibition, or to reduce distress associated with positive symptoms such as auditory hallucinations or delusions. Clinicians must take these factors into consideration and target therapy toward the individual needs of this client group including their cognitive capacity to engage in therapy, and by exploring the impact of substance use on their MH and vice versa. Special consideration of consumers with severe mental illness and co-occurring alcohol and drug problems needs to be given as the ongoing presence of positive and negative symptoms may influence attention and the ability to comprehend treatment sessions and actively participate in treatment. To address these factors, several modifications to the traditional MI approach have been developed (Martino et al. 2002). The following recommendations by Martino and colleagues (2002) have been found to reduce substance use in people with severe mental illness.

Modifications to traditional motivational interviewing therapy include:

1 Adopt an integrated dual diagnosis approach that targets more than substance use

Research has shown that an integrated approach to managing individuals with severe mental illness and alcohol and other drug problems is most effective (Department of Human Services 2007; Queensland Health 2003, SAMHSA 1998 and 2003). The Queensland Health Dual Diagnosis Policy endorses this approach. In some cases, individuals with dual diagnosis may use substances to help manage their positive or negative symptoms. It is important for the clinician to identify the client's reasons for using substances and address this in treatment.

2 Target a wider range of behaviours including treatment and medication adherence

It is common for individuals to attribute their positive symptomatology to their use of substances rather than their mental illness. In some circumstances this may have a direct effect on the consumer's willingness to engage in treatment for their mental health disorder. Given these factors, it is necessary for the clinician to apply MI techniques to a wider range of behaviours including medication and treatment compliance. Non-adherence to treatment goals must be addressed due to the numerous adverse consequences of the use of substances in this client group. Resistance may be demonstrated toward one problem and not toward the other. This would be evidenced in the consumer being at a different stage of change for each problem and would therefore require different interventions for each disorder. Motivation to address each problem can be ascertained using the Hunter New England Mental Health Service Integrated Motivation Assessment Tool and *Psychiatry and Substance Use* (DVD) (Clancy and Terry 2007) — see *Clinician Tool Kit*.

3 Accommodate cognitive impairment and disordered thinking

Individuals with severe mental illness may demonstrate signs of cognitive impairment. In addition, these clients may also have persistent symptoms which will impact upon their ability to engage in, attend to, and process treatment effectively. Cognitive impairments commonly demonstrated by individuals with a dual diagnosis include: problems with attention, concentration, short-term and working memory, organising and abstracting information, and mental flexibility (Martino et al. 2002). Strategies to address these limitations include: the use of repetition, using simple and concrete verbal and visual materials, breaks within sessions and using a structured treatment session (Carey et al. 2007; Martino et al. 2002). Addressing delusional or material with emotional content may heighten arousal and distress. Addressing these issues is discouraged when attempting to engage the client to motivate them for change.

4 Modify micro skills

Techniques of MI emphasise the use of open ended questions, reflective listening and summarising when interacting with clients. This approach is integral to treatment with this client group. However, individuals with dual diagnosis may be unfamiliar with such therapy styles as they may have previously experienced a more directive and authoritarian interview approach, common in other treatment settings. It is recommended by Martino and colleagues (2002) that clinicians first introduce this new style of working with clients by describing the principles of MI.

5 Simplify open-ended questions

The use of open-ended questions is a key strategy of the MI approach. However, cognitive limitations or poverty of speech may influence the consumer's ability to grasp the concepts and generate an open-ended response. It is recommended that clinicians ask questions in a clear and concise manner and avoid compounding (asking questions with two distinct questions included, also called double barrel questions) which may be difficult for the consumer to understand.

6 Refine reflective listening skills

Reflective listening techniques are another key skill used in MI. Reflective listening requires the clinician to carefully attend to all the client has said and paraphrase or summarise this information back to the client for clarification of understanding. This may be particularly difficult if the client is disordered in their thinking, tangential and experiencing positive symptoms. The ability of the client to effectively engage in reality checking may also be impaired. Some minor modifications to reflective listening techniques are recommended. Martino and colleagues (2002) recommend that clinicians:

- use simple and concise language
- reflect often
- use metaphors and examples
- logically organise the client's statements and summaries
- avoid excessive focus on despairing statements and negative life events (whilst recognising and assessing risk)
- give clients enough time to respond to reflections.

7 Heighten the emphasis on affirmation

Another key micro skill used in MI is affirming the consumer. Affirmation of the consumer acknowledges their personal qualities and efforts to promote change. The use of this micro skill is integral in working with individuals with dual diagnosis. It is particularly common for these individuals to have experienced multiple, failed treatment attempts, invalidation and social stigma associated with their mental health problems and their substance use. The historical difficulty in providing effective treatment for both problems may have also created a sense of not fitting into the system. Counter-transference and negative clinician attitudes may also contribute to this experience. The use of affirmations may facilitate the development of effective rapport and establish a supportive and collaborative treatment environment. The clinician could state 'you seem to have coped with that really well' or 'that must have been really tough, I don't know how you did it'.

Modifications to specific motivational interviewing strategies

Common MI strategies include the use of evocative open ended questions to elicit self motivational statements, managing resistance and providing personalised feedback. Individuals with a dual diagnosis may demonstrate significant resistance which may be heightened by delusional symptoms and involuntary mental health treatment. A significant modification to traditional MI strategies by Martino and colleagues (2002) is the development of discrepancy in the consumer's perceptions of their problems. To achieve this, modifications to the use of personalised feedback strategies and constructing a decisional balance matrices to enhance discrepancy are suggested.

1 Use personalised feedback concerning dual diagnosis concerns

It is important for the clinician to provide feedback on psychiatric symptoms, the relationship between the person's alcohol and drug use and mental health problems and the impact on their functioning (Carey et al. 2007). Personalised feedback needs to be presented in a format that can be processed by the individual. The general therapeutic techniques described above can be used to achieve this. For example, comparing the client's level of substance use with the norm for their age and gender can often be a powerful form of feedback. This is especially true of those whose peers are using substances, as the client may perceive their own substance use to be normal.

2 Construct decisional balance matrices appropriate for individuals with a dual diagnosis

One of the most common techniques used in MI is the decisional balance matrix. This technique focuses on normalisation of ambivalence toward change and the development of discrepancy through exploring the positive and negative impact of behaviours and of changing these behaviours. This technique can also be used to explore the consumer's insight and ambivalence toward their mental health treatment. Combining the two issues into the one decisional matrix simplifies this process for the consumer whilst addressing all key concerns. The integrated motivational assessment tool (IMAT) developed at the dual diagnosis service, Hunter Health Service (Clancy and Terry 2007), may also be used to assist in this process. This tool plots motivation to change substance use and motivation to address mental health issues on two different axes simultaneously and allows the clinician to adequately assess which issue is considered more problematic by the consumer.

3 Consider other clinical issues

The use of MI relies on verbal and logical reasoning. If persistent mental health symptoms and/or substance dependence exist, they may impair the individual's ability to logically attend to this content. The ability of the client to remain in reality is imperative to the use of this therapy style. It is important to consider the ability of the client to make informed decisions and properly attend to their basic needs. If the client has impaired capacity to make decisions this style of therapy is considered inappropriate. Other issues of clinical significance include the need for ongoing risk assessment and crisis intervention where indicated. It is also important for the clinician to have knowledge of common medications and side effects of medications. Side effects may impact on the individual's willingness to engage in treatment and motivation for the continuing use of substances. These issues should be assessed and addressed in treatment.

Clinical supervision to develop and refine the clinician's ability to provide MI for individuals with a dual diagnosis is considered of high importance. Mastery of these therapeutic techniques requires ongoing practical application and revision. The effective use of these techniques is integral to the management of resistance and promoting willingness and commitment to change.

Adapted by Martino et al. (2002)

Further information

Training programs in MI are available through the Queensland Health Alcohol and Drug Training and Resource Unit (ADTRU). Further information on the availability of training programs can be obtained by contacting the Alcohol and Drug Information Service on 1800 177 833.

Please refer to the work of Martino and colleagues for further information on the adaptation of MI for individuals with dual diagnosis.

chapter 9

psychosocial treatments

dual diagnosis
clinical guidelines

key points

- People with dual diagnosis benefit from a range of psychosocial treatments provided within an integrated treatment approach.
- The establishment of an effective therapeutic alliance is essential.
- Mental Health Services (MHS) and Alcohol, Tobacco and Other Drug Services (ATODS) should adopt a stepped care approach to the provision of treatment and care for people with a dual diagnosis.
- Brief interventions are beneficial and should be offered at any opportunity.
- Cognitive Behaviour Therapy (CBT) is well supported in the literature in particular for people with high prevalence disorders.
- Assertive community treatment is the preferred case management model for people with serious mental illness and co-occurring substance use.
- A range of other psychosocial approaches should also be considered including Dialectical Behaviour Therapy, Acceptance and Commitment Therapy, Interpersonal Therapy, Mindfulness, family support, psychoeducation, contingency management, rehabilitation services, self help groups, supported employment, and addressing housing needs.

There are several psychological treatment options that can be applied for the management of people with dual diagnosis. Providing a full overview of the various treatment options available is beyond the scope of these guidelines. Clinicians are encouraged to seek further information and training on the provision of psychosocial treatments. The use of expert advice, support and supervision from a Mental Health Dual Diagnosis Coordinator (MH DDC), clinical supervisors and the corresponding service is encouraged in order to improve clinical skill and capability to effectively manage dual diagnosis issues.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Principle 5

The development and maintenance of a **therapeutic alliance**, or quality treatment relationship based on mutual respect, is an essential component of effective treatment for individuals with a dual diagnosis. Empathy, respect and belief in the individual's capacity for recovery are fundamental service provider attitudes and values.

This document describes a range of interventions and does not recommend the use of any one treatment modality over another, aside from the use of the motivational enhancement approaches described in the previous chapter.

Therapeutic alliance

There are various treatments available for use by clinicians, however, the core of any successful psychological treatment is the therapeutic alliance (Johnson et al. 2008; Escudero et al. 2008; Simpson et al. 2008; Davis 2007; Meier. 2005; Del Giudice et al. 2007; Livesley. 2007; Martin et al. 2006; Summers and Barber 2003).

People with substance use and mental health problems are often considered one of the more difficult groups to engage in a helping relationship (Redko et al. 2007). The relationship between the client and therapist is positively related to the client's motivation and readiness for change, which in turn, increases treatment retention and sustance treatment outcomes (De Weert-Van Oene et al. 2001; Simpson, Joe and Rowan-Szal 1997). Establishing a therapeutic alliance early in treatment is important and influences successful engagement in a therapeutic relationship (Meier, Barrowclough and Donmall 2005; Petry and Bickel 1999). Although not an intervention, the therapeutic alliance is crucial for the therapeutic process, regardless of theoretical underpinnings (Hubble, Duncan and Miller 1999).

The therapeutic alliance can be defined in terms of the collaborative and affective bond between the clinician and client (Bachelor and Horvath 1999). There are three themes that are consistently present in the alliance: the emotional connection between therapist and client; the collaborative nature of the treatment; and the agreement on goals of treatment (Bordin 1994). According to Greenson (1965), the therapeutic alliance is always reality-based; it is the emotional attachment and working together to achieve goals that evokes clients' motivation to change. Similarly, Wolff (1971) has suggested that the 'development of a person does not occur in isolation, but always in relation to persons'. From this premise, the therapeutic alliance can be seen as the impetus that generates change through gradual transformations in the client's sense of self. However, the working alliance is not, in and of itself, considered curative, but the vehicle through which therapeutic aims may be achieved (Horvath and Luborsky 1993).

Clinicians should be mindful that the establishment of an effective therapeutic alliance is essential when managing clients with dual diagnosis as these clients are often chaotic and difficult to engage. The importance of engagement is discussed in relation to the assessment process in Chapter 5, dual diagnosis assessment, and again in Chapter 11, clinician burnout and self care.

Stepped care approach

When working with people with co-occurring mental health and alcohol and drug problems a stepped care approach has been proposed as an effective framework to guide decision making and treatment planning (Kay-Lambkin et al. 2004; Sobell and Sobell 2000). Stepped care involves interventions of progressively increasing intensity, which are given if the person does not respond to ones of lower intensity. Alternatively, this approach can be used if the person's presentation has features that strongly suggest that lower level interventions will not be effective. Unless stated otherwise, interventions at all levels involve integrated psychological treatment that takes account of the dual diagnosis in its focus and delivery, incorporates both mental health problems and alcohol and drug use in treatment strategies, and is delivered by a single clinician or clinical team.

People with dual diagnosis are a heterogeneous group in terms of type, severity and readiness to address their various problems, which implies that treatment interventions identified for one person may not necessarily benefit another. The stepped care approach begins with the least intensive intervention and, depending on the monitored response, progression to more intensive interventions may be required.

Stepped care approaches have demonstrated effectiveness in the treatment of depression, anxiety, alcohol problems, smoking and heroin dependence (Lee et al. 2007). At any stage during these steps a client may present requiring crisis intervention which may be around a medical, self harm, suicidal or withdrawal management issue. These clients will require immediate action or referral for resolution of these issues.

The suggested stepped care framework includes:

Step 1 – Comprehensive dual diagnosis assessment and feedback

If the person does not meet eligibility criteria for immediate outpatient treatment by MHS or ATODS:

- provide assessment feedback, brief advice a motivational interview plus self help resources
- if other treatment or support is required, refer to appropriate services and assist with service engagement if indicated (that is, assertively engage the individual if significant needs, and motivation or resources present a high risk that the required service will not be obtained).

Step 2 – Further brief intervention

If reassessment indicates a lack of response to Step 1, or it is clear that some additional intervention will be required and criteria for immediate case management or inpatient treatment by MHS and ATODS are not met:

- provide further brief intervention (for example — additional Motivational Interviewing, goal setting and planning, focused skills training or pharmacotherapy)
- offer referral for, and the provision of, follow-up assessment and appropriate support. The primary service provider must ensure that the facilitation of linkage to appropriate support services is provided before handing over care.

Step 3 – More extensive skills training or case management

If reassessment indicates lack of response to Step 2, or it is clear that more extensive skills training or support is required and criteria for inpatient treatment by MHS and ATODS are not met:

- provide extended skills training or therapy, support group or case management
- provide follow-up assessments, referral to, and facilitate linkage with, any other services that are required. The primary service provider must assertively engage the individual and ensure that the facilitation of linkage to appropriate support services is provided before handing over care.

Step 4 – Intensive case management, inpatient care, or supported accommodation

The highest intensity of care is restricted to people who at reassessment show a lack of response to Step 3, or whose initial assessment indicates an immediate need for more intensive case management, treatment, collaborative care or a compensatory environment.

Brief interventions

Brief interventions are often one-off interventions, using various techniques from a variety of interventions, with little or no likelihood of follow up. Although there are standard steps to brief interventions, it is often a process which is opportunistic and conducted in settings which are not necessarily conducive to a more comprehensive intervention. Brief interventions can be particularly relevant for people with dual diagnosis given the higher likelihood of treatment non-adherence. There are many types of interventions that can be offered to clients and their families, some of which may be more appropriate than others, depending where the person is in the process of considering changing their substance use.

The most commonly used brief interventions are a combination of the following:

- printed information
- short advice session
- Motivational Interviewing (MI)
- brief counselling
- questionnaires and self assessments
- self help manuals
- controlled drinking programs
- drink driver programs
- videos.

FRAMES
is a model which can guide a brief intervention

Feedback
- provide personalised feedback about risks associated with behaviours based on patterns, problem indicators and health status.

Responsibility
- emphasis on the individual's responsibility and choice to abstain/reduce using behaviours.

Advice
- provide clear advice about the importance of changing behaviours.

Menu
- provide a menu of alternative change options.

Empathy
- a warm, reflective and understanding approach is more effective than an aggressive, confrontational or coercive style.

Self efficacy
- instill optimism in the person so that goals can be achieved utilising motivational techniques.

(Bien et al. 1993)

Cognitive Behavioural Therapy

Cognitive Behaviour Therapy (CBT) is a modality of treatment that encompasses many different therapeutic approaches. It explores the relationship between a person's thoughts, feelings and actions. It is aimed at teaching people new and more effective skills for improving their health, anticipating and managing stress, behaving more effectively and coping with unpleasant thoughts and feelings.

Cognitive Behavioural Therapy has been found to be effective in the treatment of a range of disorders including co-morbid mental health and alcohol and drug disorders (Lee et al. 2007; Beck et al. 2001). It has been used in alcohol and drug treatment to identify unhelpful or irrational thoughts about drug effects or drinking expectancies. CBT also explores the relationship between a person's feelings and drug using behaviour, and the development of effective management strategies for dealing with negative emotions.

The PsyCheck program is an evidence-based CBT program developed for the management of anxiety and depression in alcohol and other drug treatment settings (Lee et al. 2007). A screening tool has been developed and validated to accompany this program and its use is promoted in alcohol and other drug treatment settings across Australia.

The OnTrack website is another useful resource for both consumers and clinicians. OnTrack provides free online treatment programs, information and advice about accessing services for a range of mental health and substance use problems. Various other CBT programs for the management of alcohol and other drug use are available. These programs may be beneficial for the clinician wanting to learn more about the application of CBT to dual diagnosis issues in either the mental health or alcohol and other drug treatment sector.

Further information

Further information on PsyCheck can be obtained at psycheck.org.au/

Further information on OnTrack can be obtained at ontrack.org.au/web/ontrack

Further information on CBT training programs and resources, clinicians can refer to the Australian Association for Cognitive Behavioural Therapy (AACBT) website aacbt.org/

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Principle 6

Integrated service provision involves a **biopsychosocial approach** comprising an array of physical, psychological and social service interventions in the provision of engagement, assessment, treatment and care.

Evidence-based case management

Case management is the preferred community treatment model for people with co-occurring disorders. Case management has been described as a process or method that ensures service users are provided with whatever services they need in a coordinated, effective and efficient manner (Simpson et al. 2003). The needs of people with co-occurring disorders may include not only mental health and medical care but family and social relationship interventions; addressing basic needs like food and safe accommodation; employment; leisure; and cultural and spiritual interventions (Rosen and Teesson 2001). However, services required by people who have been seriously affected and have subsequent complex care needs will differ from those who recover quickly and return rapidly to a reasonable level of functioning. Within this context, case management can be seen as a suitable vehicle for providing integrated treatment.

Case management models

Within the Queensland Health mental health case management policy framework: positive partnerships to build capacity and enable recovery (2007), two broad categories of case management have been identified:

1. standard/supportive case management which includes brokerage/managed care and clinical models
2. intensive case management which includes intensive, assertive community treatment and rehabilitation-orientated models (Samele et al. 2002; Schaedle et al. 2000).

The Strengths Model has also been identified as a framework for case management services. The purpose of this model is to assist consumers in identifying, securing and sustaining the range of resources – both environmental and personal — needed to live, play and work in a normal interdependent way in the community (Rapp 1998).

The six principles of the Strengths Model include:

1. a focus on individual strengths rather than pathology
2. the community is viewed as a resource
3. interventions are based on client self-determination
4. the case manager–client relationship is primary and essential
5. assertive outreach is the preferred mode of intervention
6. people suffering from major mental illness can continue to learn, grow, and change.

(Simpson et al. 2003; Nehls 2000; Howgego et al. 2003; McNeese-Smith 1999; Rapp 1998; McLellan et al. 1999; Graham et al. 1990).

Assertive community treatment has been identified as the preferred case management model for people with serious mental illness and co-occurring substance use who rarely seek out support (Queensland Health 2007). The major features of this model are: unobtrusive assertive outreach, preferably in people's homes; low clinician to consumer caseload ratio (1:10); 24 hour availability; assistance with practical supports in daily living, such as shopping, laundry and transport; time unlimited services; multidisciplinary team work; and being proactive rather than reactive (Drake et al. 1998; Mueser et al. 2003; Simpson et al. 2003; Queensland Health 2007; Schwartz et al. 2000).

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 13

Linkage of people with severe and complex needs to other health and welfare services involves an **assertive case management approach** whereby staff proactively coordinate and negotiate services on behalf of a person to ensure service continuity across service sectors and that people do not fall between service systems.

Relapse prevention

It is extremely likely that clients will be exposed to alcohol or drug use or encounter situations which trigger the likely return to previous substance using behaviour and the potential relapse of their mental health condition. Relapse prevention is an important component of all alcohol and drug and mental health treatment. Interventions should be addressed in a format that is suitable to the client's intellectual capacity, cultural orientation and stage of change (Queensland Department of Corrective Services and Queensland Health 1999).

Relapse prevention comprises several key elements including:

- identifying and developing strategies for high risk situations
- craving management
- drug refusal skills (assertiveness)
- distraction techniques (cognitive, behavioural, relaxation or social)
- activity scheduling (introducing non-drug related activities)
- stress management
- support (social supports, peers, health services, non-government organisations or family/carers).

(Marlett and Gordon 1985)

It is important that clinicians advise clients on how to avoid lapsing into alcohol and drug use in the future. High risk situations involve the people, places and things that trigger cravings to use alcohol or drugs. Learning how to avoid these triggers (times or places), or to develop alternative responses to these triggers, will assist the individual to manage these feelings and not to use. It is important to consider real life examples of potential high risk situations and to plan alternative actions to prevent lapsing into previous substance using behaviour. There are a range of strategies used in relapse prevention. The above topics can serve as a guide for areas to address when providing treatment for individuals with a dual diagnosis.

Dialectical Behaviour Therapy

Dialectical Behaviour Therapy (DBT) is a structured approach to the management of Borderline Personality Disorder. Linehan (1993) developed DBT using significant modifications to standard CBT including the introduction of validation and dialectics to the framework of the standard CBT approach. The significant overlap between individuals with Borderline Personality Disorder and co-occurring alcohol and drug problems suggests that this treatment approach may be applicable for this client group.

The DBT framework categorises treatment into various structured stages and targets. Treatment is focused chronologically on behaviours that could lead to the client's death, premature termination of therapy, behaviours that destroy quality of life, and finally to the development of alternative coping skills. In DBT, treatment skills are acquired, strengthened and generalised through the combination of skills groups, phone coaching, in vivo coaching, and homework assignments (Linehan 2008).

The provision of DBT requires extensive training by accredited DBT training providers. A range of health service districts in Queensland offer formalised DBT programs and variations on these programs. The interested clinician should explore the availability of this treatment option in their local district.

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT) applies both mindfulness/acceptance, as well as commitment and behaviour change processes to people with substance use disorders (Hayes et al. 2006). The aim of ACT is to increase psychological flexibility, which Hayes defines as 'the ability to contact the present moment more fully as a conscious human being, and to change or persist in behaviour when doing so serves valued ends' (Hayes et al. 2006). Originally developed for psychological disorders (Hayes, Strosahl and Wilson, 1999), ACT has been applied to a variety of conditions, including substance use disorders. Preliminary studies have shown ACT to be an effective treatment for preventing relapse in people on methadone maintenance (Hayes et al. 2004), for promoting smoking cessation (Gifford et al. 2004) and reducing cannabis use (Twohig et al. 2007) as well as reducing stigmatising attitudes and burnout in alcohol and drug counsellors (Hayes et al. 2004). A recent literature review by Zgierska et al. (2009) supported the effectiveness of ACT for substance use disorders.

Further information

For more information on ACT see contextualpsychology.org

Interpersonal Psychotherapy

Interpersonal Psychotherapy (IPT) is a brief, highly structured, manual based psychotherapy that addresses interpersonal issues in depression. This style of therapy focuses solely on the interpersonal context. Attachment theorists view the experience of loss, and to a lesser degree disordered attachment, as underlying human psychopathology. IPT indirectly addresses these issues within this therapeutic framework.

Aims of IPT are to intervene specifically in social functioning by addressing and reducing mental health symptoms. Personality is not the focus in this style of therapy.

Interpersonal Psychotherapy has been adopted for clients with cocaine and/or opioid dependence. However, there is limited evidence for its use with people with a dual diagnosis. Therapeutic interventions aim to facilitate recovery through creating a supportive social network. The focus on depressive symptoms has been redirected to focus on reducing or ceasing drug use and the interpersonal problems common to individuals abusing alcohol or drugs including substance abusing peer networks, as a maintaining factor in ongoing substance use (Klerman et al. 1984).

Mindfulness training

Mindfulness is a type of meditation originating in Buddhist teachings, which is proving to be effective as a clinical intervention for reducing stress and promoting mental health and wellbeing. Clients with dual diagnosis often experience anxiety and depressed mood accompanied by negative automatic thoughts about using substances or cravings to use. Mindfulness techniques can divert the person away from such thoughts and feelings by encouraging the individual to focus on the present moment (for example — walking, eating, and breathing) without judgement.

Mindfulness based interventions show promising and growing evidence for the management of stress and promoting wellbeing. It has particular relevance for alcohol and other drug problems and co-occurring mental health disorders (Baer 2003; Bowen et al. 2006).

Mindfulness has been incorporated into Marlatt and Gordon's (1985) Relapse Prevention Model for substance use treatment and has been included in an eight-week group program Mindfulness Based Relapse Prevention (Witkiewitz et al. 2005).

Working with families

Families and/or carers play an important role in the lives of people with a dual diagnosis. Families can assist in the recovery of substance use and mental health problems or in some cases may inadvertently contribute to, or maintain, a consumer's substance use or mental health problems.

Between 25 per cent and 50 per cent of clients with a dual diagnosis live with a family member and even more see their families on a regular basis (Clark 1996).

Working with families of individuals experiencing first episode psychosis is prescribed by the Australian early psychosis guidelines (National Early Psychosis Program 2006).

Evidence for the effectiveness for family interventions as part of dual diagnosis treatment is emerging. Mueser and Fox (2004) report on a family intervention that promotes collaboration between families and professionals to achieve positive outcomes for consumers with dual diagnosis. In addition, the support of family members should be considered if the family member's presentation indicates that they may require additional support, individual mental health input, or case management to address their mental health needs.

Examples of core interventions for families include:

- engaging family members as a valued partner throughout the care giving process
- provision of relevant, evidence-based and jargon-free information about mental illness, substance use and the interactions between the two disorders
- provision of support to help families work with services to get the consumer's and family's needs met
- providing problem solving interventions to resolve conflict and difficult situations
- a recognition that the behaviour of the client may have impacted on the family relationship including parents and siblings and their perception of the role they play within the family.

The interested clinician should also refer to the youth section in Chapter 10 for further information.

Practice tip

Clinicians should actively encourage the involvement of families in the recovery process where possible.

Treating clinicians should ensure families are supported and are provided with educational material, information on local support groups and referral to family programs and family therapy both within and external to the service.

Further information

The Queensland Health Carers Matter website is a useful resource containing information and support for families and carers of people with a mental illness, see health.qld.gov.au/mhcarer/default.asp

Further support for families can be sourced from local and national support groups such as the Association of Relatives and Friends of the Mentally Ill (ARAFMI) see arafmiaustralia.asn.au/

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Principle 11

The active participation of the **person, primary carers, family or significant others** in the treatment and care of people with dual diagnosis occurs wherever possible.

The involvement of families in assessment, planning and delivery of care of clients with dual diagnosis is crucial to their involvement and support, and ultimately to the outcome for the consumer with dual diagnosis (Mueser et al. 2003).

Psychoeducation

The term psychoeducation or 'illness education' refers to the provision of information about psychiatric and substance use disorders, using didactic and interactive methods to ensure comprehension of the relevant material (Anderson et al. 1986; Goldman and Quinn 1988).

Psychoeducation is an important part of a dual diagnosis care plan that provides consumers and carers with information to enable them to understand and be better able to cope with both substance use and mental health problems. Psychoeducation can also reinforce a consumer's own strengths, resources and coping skills.

Strategies for conducting psychoeducation include:

- presentation of information appropriate to the consumer's age, culture and developmental stage
- reviewing educational handouts on different topics
- asking questions to assess the consumer's understanding of presented information
- prompting consumers to explore how pertinent information is related to their personal experiences
- adopting the consumer's language to ensure good communication and avoid misunderstandings and conflict
- assigning homework to read or review written materials on educational topics (for example — handouts on specific mental illnesses or substances)
- probing to identify gaps in knowledge and a desire for additional information
- reviewing previously covered topics by asking questions.

Practice tip

Providing psychoeducation can include providing feedback on the quantity of alcohol consumed, the effect of substance use on medication compliance and/or mental state or information on substances. This intervention should be documented in the client's clinical chart.

Clinicians should ensure they follow up with the client at subsequent sessions to assess their understanding and recall of the psychoeducation information provided at previous sessions.

This will provide the client with the opportunity to ask questions and provide the clinician with the opportunity to start exploring the interaction between mental health and substance use.

Contingency management

Contingency Management (CM) is a behaviourally based treatment used to facilitate behaviour change in clients. Contingency management aims to improve outcomes for individuals using substances by offering tangible rewards for a change in their substance using behaviour. The reinforcement of pro-social behaviours should encourage further engagement in such behaviours, and may contribute to longer-term behavioural change and treatment success. The principles of reinforcement theory underpin this treatment modality and it is anticipated that positive reinforcement will generalise to natural rewards (available in the client's environment) following the cessation of artificial rewards (contingent reward).

Contingency management is well supported in the literature in the United States, however limited support or application of this approach has been found elsewhere (Cameron and Ritter 2007). This approach has been linked with improvements in treatment retention, drug use and other behaviour such as attendance at counselling (Bickel et al. cited in Cameron and Ritter 2007). Recent research has explored the applicability of contingency management approaches, with promising results for people with dual diagnosis (Drake et al. 2008).

An American study has indicated that the use of contingency management for individuals with severe mental illness has shown promising results with reductions in substance use of cocaine, cigarettes and cannabis (Tidey and Ries 2008 in Higgins et al. 2008). Promising results are also evident for those with high prevalence disorders although more work is required in this area. Given the extent of support for contingency management in substance using populations and preliminary results with individuals with dual diagnosis, contingency management approaches are considered appropriate for this population. Contingency management approaches to treatment with people with severe mental illness are also being promoted to address behavioural change in a range of other areas including: participation in vocational rehabilitation programs, medication adherence and treatment engagement.

Further information

Currently Turning Point Australia is undertaking trials of contingency management approaches in the Australian context. Further information can be obtained at turningpoint.org.au

Rehabilitation services

Rehabilitation is the process of improving overall psychosocial functioning and developing a sense of positive self esteem and self worth in individuals with substance use problems. Rehabilitation services include residential and non-residential treatment programs. The literature demonstrates positive outcomes from long-term residential rehabilitation services particularly for individuals who have not previously responded to other forms of treatment (Drake et al. 2008). Residential rehabilitation is suitable for people who have a medium to high substance dependency. It can follow substance withdrawal management and allows people to live in a structured and safe drug free environment. In some health districts there are rehabilitation services specific to Aboriginal and Torres Strait Islander peoples, philosophical approach, gender and age (that is, youth services for clients up to 24 years of age).

There are several types of rehabilitation models and all should attempt to address the person's individual needs, understand their specific alcohol and drug problem, address physical and mental health needs and the interaction with other lifestyle factors. Treatment models may not always be consistent with the goals, beliefs and spiritual orientation of the client and referral to treatment services should be matched appropriately to the individual client's needs. Various models for rehabilitation include:

- 12 Steps Model (AA)
- Therapeutic community (Minnesota Model)
- Family Systems Therapy
- Relationship Development Model
- Cognitive behavioural and social learning models
- Dialectical Behaviour Therapy
- Personal and skill development
- Faith based models.

It is beneficial for an individual who is considering rehabilitation to contact prospective centres to discuss with them the philosophy and expectations of the rehabilitation service.

In Queensland, the majority of alcohol and drug rehabilitation services are operated by non-government organisations with some available through private hospitals. Programs vary in length from three weeks to nine months depending upon the requirements of the client. Private hospital clinics usually require private health insurance, whilst non-government organisations request approximately 85 per cent of the individual's social security payment. All services require an initial assessment and have various residential rules for successful operation.

Rehabilitation services in Queensland are generally residential and are attended on a voluntary basis unless otherwise mandated through legislation (although this is infrequent and not available under the *Mental Health Act 2000* for co-occurring disorders). Some clinics offer day programs which may require the client to make initial contact in order to demonstrate their motivation and readiness to engage in treatment.

Psychosocial rehabilitation services generally focus on a range of issues impacting on the functioning of the individual. Core elements of rehabilitation programs address alcohol and other drug use, relapse prevention, client schemas/beliefs and dysfunctional behavioural patterns, relationships, building self esteem and self efficacy, physical and oral health, and developing non-substance using social networks.

It is important to note that many rehabilitation services may have a waiting list and it may be prudent to make enquires in the first instance.

Further information

Further information regarding rehabilitation services in Queensland contact the Alcohol and Drug Information Service on 1800 177 833.

Evidence-based supported employment

The role of employment or meaningful activity is integral to how a person perceives themselves and their contribution to society. Employment is valued in our society and the impact of employment cannot be underestimated as a vehicle for recovery. Research has identified that having meaningful employment can positively impact upon an individual's mental health (Waghorn et al. 2008). Employment assists individuals to attain financial independence, contribute to society and create meaning for the person. Integrating vocational services into public MHS is recognised as an essential component of psychosocial rehabilitation for people with a severe mental illness.

The benefits of employment for an individual with dual diagnosis include:

- having more money to pay for expenses
- feeling new meaning and purpose in their life
- increasing independence, self esteem and confidence
- preventing boredom by having enjoyable activities to engage in
- providing structure to a person's day
- learning something new every day
- increasing a sense of empowerment and control over one's life
- expanding social networks by meeting new people and making new friends
- contributing to the community
- increasing work skills
- increasing career opportunities.

(Waghorn et al. 2008)

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 10

Assessment of co-occurring conditions includes an holistic, recovery-oriented approach to a person's general health and social welfare needs. This includes attention to family, relationships, accommodation, **employment**, financial and legal needs. Plans to address identified needs are incorporated into a comprehensive treatment plan.

The research identifies that almost everyone with a mental illness, including dual diagnosis, can succeed at employment with appropriate assistance (Waghorn et al. 2008). Employment should not only be seen as a goal for those who have stabilised their mental illness and stopped using substances. It is not necessary for the individual to be completely recovered from their co-occurring problems in order to achieve and succeed at employment.

Attaining employment is often a vehicle for recovery from dual diagnosis and provides many of the benefits traditionally associated with clinical interventions. Engagement in meaningful activity can also be a substitute for substance using activities, as it is generally expected that consumers will not be using substances whilst they are engaged in work related activity.

The first and most important step is wanting a job. If the individual identifies employment as a goal, facilitating and supporting them to achieve this goal can assist their recovery from mental health and alcohol and drug problems.

Clinicians of MHS and ATODS can assist consumers to attain and maintain employment. Clinicians can assist their consumers by:

- asking about the consumer's employment goals
- valuing the consumer's employment goals and believing in the possibility of success in employment
- encouraging and supporting the consumer to take reasonable risks by seeking appropriate assistance, trying a new job and finding ways to perform well at work whilst managing their mental health and alcohol and drug problems
- monitoring the consumer's mental health and alcohol and drug use and reviewing treatment plans following the commencement of employment
- learning more about evidence-based approaches to supportive employment
- helping the consumer to identify performance challenges at work and considering whether changing the treatment plan could improve work performance
- being available to communicate regularly with the consumer's employment consultant and clarifying goals, activities and the assistance provided
- writing brief reports when requested to identify the consumer's employment assistance needs so that they can obtain the best assistance available.

(Waghorn et al. 2008)

There are various programs, services and government initiatives to support individuals with mental illness including those with dual diagnosis, to attain employment. The first step in exploring employment options is for the consumer to seek advice from Centrelink or to contact a local Disability Employment Network provider. Clinicians are encouraged to support and assist their consumers to take this step. Centrelink or the Disability Employment Network provider will provide the consumer with a job capacity assessment and assign the consumer to an employment consultant. This consultant will assist the consumer to identify employment goals, plan the management of personal information and identify the consumer's work skills and job preferences.

Supported employment programs can also assist the consumer with the job seeking process, interview process, attaining employment and the management of their illness during their employment. Returning to employment can be stressful at first. It is important for the clinician to be aware of their consumer's plans to return to work and incorporate appropriate support and management strategies into the care plan. Effective links with the broader social service network surrounding the individual is required to meet the range of complex needs experienced by people with dual diagnosis. The use of a collaborative approach to care includes engaging with the consumer's employment consultant and maintaining effective links and communication in order to support the consumer to succeed in employment.

A recent initiative of Queensland Health and Disability Employment Network providers has seen the co-location of an employment specialist within community MHS teams in selected sites around Queensland. The purpose of the Queensland Health Employment Initiative is to support consumers to gain employment or to participate in vocational rehabilitation activities.

Clinicians are encouraged to promote vocational goals to their consumers and explore access to the Queensland Health Employment Initiative in their local district.

Further information

Further information on the Queensland Health Employment Initiative, contact the Mental Health Alcohol and Other Drugs Directorate at qheps.health.qld.gov.au/mentalhealth/default.htm

Further information on supported employment programs available in your local area, please contact Centrelink, disability, sickness and carers line on 13 27 17 or at centrelink.gov.au, or search for a local Disability Employment Network provider at jobsearch.gov.au/provider/ProviderLocation.aspx?ProviderType=DOE&

Housing needs

Co-occurring mental health and alcohol and other drug problems play a significant role in contributing to some individual's homelessness or risk of homelessness. Dual diagnosis may contribute to keeping people on the streets, poor physical health and vulnerability to abuse and violence.

Unstable housing conditions may also impact upon the mental and emotional wellness of the individual. Treating clinicians should be mindful of the relationship between wellness and stable accommodation and seek to reduce the impact of unstable and inappropriate housing on their client's wellbeing and success in treatment.

Some strategies for reducing the impact of unstable accommodation include:

- Identify and facilitate linkage to appropriate local supports including services focused on the maintenance of current housing options where possible.
- Assist the client to obtain suitable housing in an alternate location.
- Provide practical assistance during any necessary relocation.

Clinicians can assist their client to overcome housing difficulties using a range of strategies. Where clinicians are unable to provide direct assistance with access to, and maintenance of, stable accommodation, linkage with appropriate support services in the community to achieve this goal is paramount. Clinicians should actively engage the assistance of accommodation and support services and apply the principles of collaborative care with other services involved in care. In addition, practical assistance may be provided to the client if relocation is required. Clinicians can assist with access to non-clinical supports during this period.

In addition, the clinician should be mindful that the existence of a local support network plays an important role in maintaining housing stability. The location and type of housing may impact upon ongoing health concerns and contribute to the maintenance of mental health and alcohol and other drug use problems. Appropriate accommodation and support is important for the prevention of relapse.

The Stages of Treatment Model (Osher and Kofoed 1989 cited in Mueser et al. 2003) provides a useful guide for matching interventions to client need (refer to Stages of Treatment in Chapter 8). Consideration of appropriate interventions will assist the clinician to maintain engagement and retain the individual in treatment. Housing that has an allowance for appropriate legal substance use (that is, alcohol) may need to be considered depending on the individual's circumstances.

The Queensland Health Homeless Initiative is a statewide response involving numerous district health services with a primary focus on mental health and alcohol and other drugs. The initiative has funded the development of specialist mental health teams, known as Homeless Health Outreach Teams (HHOT), who provide comprehensive case management, assessment and intervention for homeless persons who are experiencing mental illness. The initiative also funds alcohol and other drug specialist positions to work collaboratively with MHS to provide assessment, treatment and prevention programs for homeless persons with co-occurring substance use concerns. Where the homeless person experiences a dual diagnosis the mental health and alcohol and drug teams work collaboratively to provide appropriate integrated care.

Additionally, the initiative funded the creation of Transitional Housing Teams (THT). These teams work in partnership with community housing providers to provide transitional accommodation, and intensive domestic and community rehabilitation for people with mental illness who cannot be discharged from hospital because they lack adequate support or suitable accommodation. If discharged without this support, they may be at risk of homelessness.

The Council of Australian Governments (COAG) National Action Plan on Mental Health 2006–2011 funded the development of a collaborative partnership between Queensland Health, Department of Communities (Housing and Homelessness Services and Disability Services), and non-government organisations, the Housing and Support Program (HASP). HASP supports people with a psychiatric disability to live independently in the community through the provision of social housing, clinical and non-clinical support. Support is tailored to the individual client's needs, to promote recovery, social inclusion, community connectedness and enhanced quality of life.

Clinicians should explore the availability of these services in their local district.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Principle 1

Effective **collaborative partnerships** between mental health and alcohol and other drug services, and with professionals in primary care social services, **housing**, criminal justice, education and related fields are required to meet the complex needs of people with dual diagnosis and to sustain recovery. This includes service providers across the government, non-government and private sectors.

Further information

Further information refer to the Queensland Health Statewide Guidelines, Processes and Protocols developed to guide local Homeless Health Outreach Teams. Copies of these guidelines are available from your local HHOT.

Self help groups

Self help groups assist people in working together to maintain abstinence from substance use through the provision of emotional support to maintain change in their substance using behaviour.

Self help groups include recovery programs incorporating twelve principles that are based on the assumption that substance dependence is a spiritual and medical disease (Ferri et al. 2006). The 12 steps that underlie these programs incorporate traditional spiritual practices. Meetings are designed to respect all religious traditions and do not promote any particular theology or belief system.

Self help groups are most often facilitated by recovering alcoholics or drug users although some may be facilitated by health professionals. Group members support each other to maintain sobriety through group sessions and one to one support. Alcoholics Anonymous (AA) is the most common self help group in Australia although others exist including Al-Ateen (for youth with alcohol problems), Al-Anon and Nar-Anon (for partners and families of those with alcohol and narcotic problems), Narcotics Anonymous (for those with opiate dependence), Emotions Anon and Co-Dependents Anon. In addition, other groups such as Grow and Emotional Fitness look at emotional wellbeing. Alcoholics Anonymous is widely available across Australia and its prominence in the community offers continuing support and assistance outside formal treatment.

Alcoholics Anonymous and other 12 step groups recognise that not all problems can be dealt with in a group context which is provided by peers. These groups advocate that individuals also seek professional assistance.

Further information

Further information can be obtained from Alcoholics Anonymous Australia aa.org.au/

Details regarding the availability of self help groups in your local area can be obtained in the local telephone directory, the internet or through the Alcohol and Drug Information Service (ADIS), on 3236 2414 or 1800 177 833.

chapter 10

tailoring the response

dual diagnosis
clinical guidelines

key points

- Aboriginal and Torres Strait Islander peoples require clinicians to expand their assessment and treatment approaches, incorporating a holistic approach to health and seek guidance and direction from the broader community on available services and supports.
- Clinicians should be aware of the significant incidence of dual diagnosis within culturally and linguistically diverse (CALD) populations and access information to understand the various adjustment issues and cultural aspects of mental illness and substance misuse.
- Individuals with a mental illness who are also involved with the criminal justice system (forensic) have a higher prevalence of dual diagnosis. Clinicians need to consider factors such as increased risk of violence, physical health concerns and cognitive deficits that may impact on service provision.
- A range of alcohol and drug programs are available for people within the criminal justice system in Queensland.
- Alcohol, Tobacco and Other Drug Services (ATODS) and Mental Health Services (MHS) should develop an understanding of mental health and alcohol and drug use issues affecting older people and address barriers to service provision.
- High rates of dual diagnosis are reported in young people and this rate increases for young people within diverse populations. A number of ethical, engagement and assessment factors arise that are specific to this age group. Services need to ensure a 'no wrong door' approach to reduce the short and long-term impact of an untreated dual diagnosis on the young person.
- Parents with a dual diagnosis also pose a complex challenge for clinicians to balance the individual's treatment and care with the needs of their dependant children.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 16

Staff provide integrated care in accordance with the **unique needs of special populations** such as youth and young people, Aboriginal and Torres Strait Islander peoples, CALD populations, women and older people.

Aboriginal and Torres Strait Islander peoples

Co-occurring mental health and substance use problems in Aboriginal and Torres Strait Islander communities continues to be of concern for health care providers. Queensland data indicates that hospitalisation for a mental and behavioural disorder due to psychoactive drug use, is four to five times higher for Aboriginal and Torres Strait Islander people compared with non-indigenous consumers (ABS 2002; AIHW 2005). The Queensland Government is currently addressing alcohol and other drugs, mental health and welfare reform in select Aboriginal and Torres Strait Islander communities through the provision of integrated community based social health services.

Cultural considerations

In order to provide the best possible health care and treatment to Aboriginal and Torres Strait Islander people, it is important that non-indigenous health care professionals possess an understanding of Aboriginal and Torres Strait Islander cultures. Cultural respect and awareness of the importance of a holistic approach across the continuum of mental health and wellbeing to mental illness are critical in the delivery of services to Aboriginal and Torres Strait Islander peoples.

The National Aboriginal and Islander Health Organisation (NAIHO) (1982) and more recently the National Aboriginal Community Controlled Health Organisation (NACCHO) define health as follows:

"Health does not just mean the physical wellbeing of the individual but refers to the social, emotional and cultural wellbeing of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total wellbeing of their communities." "This is an evolving definition."

(DoHA 1995)

When working with Aboriginal and Torres Strait Islander peoples, clinicians must conceptualise mental health problems within this broader, holistic concept of health and wellbeing. Health services are to acknowledge:

"For Aborigines, mental health must be considered in the wider (Aboriginal concept of wellbeing) context of health and wellbeing. This requires that this health issue be approached in the social emotional context and that both social emotional health and psychiatric disorders encompass oppression, racialism, environmental circumstances, economical factors, stress, trauma, grief, cultural genocide, psychological processes and ill health."

(DoHA 1995)

Personal, familial, environmental, systemic and political factors have influenced the ill health status of Aboriginal and Torres Strait Islander individuals, families and communities, contributing to an increased risk of their developing co-occurring mental health and substance use problems. Cultural and spiritual factors influence symptomatology, interpretation of the problem, the acceptability of treatment and ultimately the outcome for the client. In some cases, normal or expected cultural experiences may be misdiagnosed as illness. It is important for clinicians to confirm with the clients' family or significant others if thoughts and behaviours are consistent with cultural norms. There is now widespread recognition of the effectiveness of cultural awareness training as a way of ensuring culturally appropriate service delivery (Queensland Health Cultural Awareness Policy 2005).

Consultation with Aboriginal and Torres Strait Islander health workers is encouraged to support and inform clinicians of MHS and ATODS on how to provide the most appropriate interventions for Aboriginal and Torres Strait Islander peoples.

Cultural Capability

The Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033 has been developed to guide changes to education, policies, planning and practices so that our services are responsive to the cultural needs of Aboriginal and Torres Strait Islander peoples. This Framework identifies four guiding principles for enhancing Aboriginal and Torres Strait Islander cultural capability in Queensland Health Services. These principles are:

- cultural respect and recognition
- communication
- relationships and partnerships and
- capacity building.

These principles provide overarching guidance to Queensland Health services to enhance the organisation's cultural capability and to deliver culturally responsive health services to Aboriginal and Torres Strait Islander peoples across Queensland (Queensland Health 2010).

All clinicians are encouraged to refer to this document to ensure sensitivity to the needs of Aboriginal and Torres Strait Islander peoples accessing Queensland Health services.

Further information

Further information on the Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033, contact the Queensland Health Aboriginal and Torres Strait Islander Branch at www.health.qld.gov.au/atsihealth/default.asp

Family and kinship

Aboriginal and Torres Strait Islander people regard family and kinship as fundamental to life. Each member of the family, including extended family members, plays a pivotal role in ensuring the integrity of the family unit. Family members should be invited to be involved in all health interventions. Refer to Chapter 9 in the section entitled Working with families.

Gender

The sharing of information with appropriate persons of the same gender is traditionally known as 'men's business' and 'women's business'. The clinician's gender should be matched with that of the client.

Language and communication

For some Aboriginal and Torres Strait Islander people, English is spoken as a second language. Where appropriate, involve an Aboriginal and Torres Strait Islander health worker or family member to act as an interpreter. Direct questioning can be inappropriate, particularly when communicating with Elders or older members of the family. Where spoken language is a barrier, consider using visual aids and health promotion resources. Refer to the following section in this chapter, Culturally and Linguistically Diverse populations.

Cultural diversity

Each group has its own set of cultural practices and beliefs. Programs should be considerate of, and cater for, the needs of distinct language groups. Consult with local Aboriginal and Torres Strait Islander health workers to identify protocols for engagement, consultation and intervention.

Dementia

Zann (cited in Pollitt 1997) found high incidences of alcohol related dementia (Korsakoff's Syndrome) in Aboriginal and Torres Strait Islander people within an aged care units and/or boarding houses. Clinicians should be alert to the higher prevalence of Wernicke's Encephalopathy and Korsakoff's Syndrome in Aboriginal and Torres Strait Islander populations.

Foetal Alcohol Spectrum Disorder

Foetal Alcohol Spectrum Disorder (FASD) is a term used to describe a spectrum of disorders which include Foetal Alcohol Syndrome (FAS), Foetal Alcohol Effects (FAE), Partial Foetal Alcohol Syndrome (pFASD), and Alcohol Related Neurodevelopment Disorders (ARND).

Foetal Alcohol Spectrum Disorder is the leading preventable cause of birth defects, intellectually disability and neuro-developmental disorders. The prevalence is 0.06 per 1,000 live births in those aged under 15 years within the non-indigenous population and 8.11 per 1,000 (De Plevitz et al. 2008) for the Aboriginal and Torres Strait Islander population. Foetal Alcohol Spectrum Disorder can cause physical, mental, behavioural and learning complications, with those affected requiring assistance throughout their life. The only cause is prenatal alcohol consumption. Clinicians should seek assistance and information on treatment from specialist services such as paediatricians, psychologists, speech and occupational therapists.

Principles of engagement

'Current writing in Indigenous health and in general psychiatry has challenged old ways of thinking about mental health care. The focus has moved from specific therapeutic approaches delivered in isolation towards broader concepts of the helping process. In this way, mental health care becomes an empowering and enabling experience that involves many people with different skills and contributions' (Australian Integrated Mental Health Initiative, in print).

Practice tip

Consider the 'big picture'; adopt an approach that appreciates the value of the individual as a part of the world and vice versa.

Establishing a therapeutic relationship with the person is paramount in effecting positive outcomes.

Validity of the interview should be assessed in terms of the process utilised and its impact on the person.

The influence of historical and socio-political factors should be considered in formulating an approach to the engagement, screening, assessment and support of the Aboriginal and Torres Strait Islander person (Eley et al. 2006; Westerman 2004). The clinical interview should provide the person an opportunity to explore the significance of cultural, emotional, social, spiritual and physical elements of their wellbeing (Westerman 2004). By supporting the individual to explore the elements of their self and the world around them, the interviewer is better able to identify how intrinsic and extrinsic elements offer both support and a source of distress to the individual (Pratt 2007). The identification of support mechanisms and sources of stress provide the basis for informed care planning (Australian Psychological Society 2003).

The opportunity for the therapeutic relationship to influence treatment outcomes should not be underestimated (Westerman 1997). A traditional question and answer approach to interviewing may not be the best method of collecting information about the biopsychosocial circumstance of the individual (Wettinger 1997; Hunter et al. 2004). By adopting a free flowing interview style, the clinician encourages the person to express the narrative of their life and challenge the fear that their responses might be incorrect (Tsey et al. 2005; Pratt 2007). It is important to acknowledge the emotional experience of the interviewee and provide an opportunity for them to express their view of the interview as a culturally valid or invalid process. Refer to the section on the therapeutic alliance in Chapter 9.

The process of information gathering during the interview has the potential to bias information obtained. It is important to ascertain the level of distress experienced by the consumer during the interview and the potential impact of their emotional state on the accuracy of information collected. Where appropriate, the person being interviewed should be provided with the opportunity to select the setting where their interview is conducted. It is important that the person being interviewed feels at ease. Where appropriate ask if they would like a cup of tea or coffee or a glass of water and perhaps some food and enquire if the person would appreciate a support person being present during the interview. A view of the outside can also help the Aboriginal and Torres Strait Islander person to feel relaxed. Be aware that some settings, places and spaces (that is, institutions, buildings and geographic locations) have historical and/or cultural significance to Aboriginal and Torres Strait Islander people (Queensland Health 2005; National Aboriginal and Torres Strait Islander Health Council 2004).

The clinician should consider the feasibility of collecting information over a prolonged period rather than in one sitting. The clinical interview procedure should encourage quality of responses and the establishment of a therapeutic relationship (Hunter et al. 2004; Westerman 2004).

Consider the following questions:

- Is it likely that the individual will consider my mannerisms threatening?
- Am I conducting this interview as a matter of appropriateness or convenience?
- What socio-political, personal, historical and cultural variables might complicate the interview and how can I address the risk that these will invalidate procedure?
- What risk is associated with my not conducting this interview here and now?
- Is there a need for an interpreter and/or support person to be present?
- Have I provided an opportunity for family and friends of the person to inform the interview?
- Is the assessment process familiar to the interviewee?
- What information is necessary, supplementary or irrelevant as part of the suggested assessment process?
- Is it likely that by asking particular questions of the interviewee, I will distress them?
- If in the course of the interview the person becomes distressed, how will I address this?
- Have I sought advice from Aboriginal and Torres Strait Islander colleagues?

Screening and assessment

Validated screening tools for co-occurring and substance use disorders for Aboriginal and Torres Strait Islander populations are limited (Schlesinger et al. 2007). Clinicians rely on standard assessment protocols and screening tools which have not been validated with Aboriginal and Torres Strait Islander populations and therefore results must be interpreted with caution (Dawe et al. 2002).

An Aboriginal and Torres Strait Islander screening tool that has been developed in Queensland which assesses alcohol, drug and mental health risk is the Indigenous Risk Impact Screen (IRIS). This tool has been statistically validated within this population. It is a low cost, reliable, easy to use and effective screening resource for Aboriginal and Torres Strait Islander people (DoHA 2007). The IRIS allows for early identification of alcohol misuse and mental health issues. Clinicians supporting Aboriginal and Torres Strait Islander consumers should consider the use of this tool. The use of the IRIS requires training in administration and scoring.

Further information

Further information on the IRIS can be obtained from the ATODS site at health.qld.gov.au/atod/prevention/iris.asp

The Westerman Aboriginal Symptom Checklist – Youth (WASC-Y) is a culturally validated measure that identifies the risk of depression, suicidal behaviours, anxiety, drug and alcohol use, impulsivity and cultural resilience in Aboriginal youth (Westerman 2000). The use of the WASC-Y requires training. The tool and other resources can be purchased following completion of the training program.

Further information

Further information on this resource can be obtained from indigenouspsychservices.com.au

Principles of care planning

Community organisations and contacts can provide unique opportunities to the person as their focus may differ to that of government service providers (Australian Integrated Mental Health Initiative, in print). Consider the role and expertise that non-government organisations offer with respect to provision of community based support for people with mental illness and/or substance use issues. The establishment of effective and sustainable partnerships with government, non-government and community based service providers should be a priority for the clinician. The Aboriginal and Torres Strait Islander person, their family, other service providers and Aboriginal and Torres Strait Islander mental health and drug and alcohol specialists should be consulted and provide input into the development and review of the person's care plan (National Aboriginal and Torres Strait Islander Health Council 2003; Hunter et al. 2004).

The role of the Aboriginal and Torres Strait Islander mental health and drug and alcohol specialist must not be underestimated. It is recommended that these professionals are consulted at each stage of service delivery as they possess unique knowledge of the significance and influence of social, emotional, cultural, physical and spiritual aspects of the Aboriginal and Torres Strait Islander person's wellbeing (Stathis et al. 2007; Zann 2004). By identifying the priority and significance of these components in contributing to the wellness of the Aboriginal and Torres Strait Islander person, these professionals can provide input that informs the development of a care plan that is considerate of the holistic nature of the individual in the context of their social, cultural and familial settings.

Practice tip

Community as a whole is larger than the sum of its individual parts.

Seek out and access expertise.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Principle 12

The **contribution of the community** to the course of recovery for people with dual diagnosis and the contribution of people with dual diagnosis to the community must be explicitly recognised and supported in treatment planning and consumer advocacy.

The application of a collaborative framework recognises the value added by the incorporation of multiple perspectives informing holistic, recovery oriented care.

Treatment

A range of treatment programs have been developed that cater specifically for Aboriginal and Torres Strait Islander people. These structured programs include:

- AIMhi – a relapse prevention program
- Smokecheck – a brief intervention for smoking
- Queensland Indigenous Alcohol Diversion Program
- Wellbeing Centres (Royal Flying Doctors Service).

Clinicians should source the availability of such programs in their local area. Information about the Wellbeing Centres can be obtained from the Commonwealth Department of Health and Ageing.

Culturally specific issues need to be considered when introducing an Aboriginal and Torres Strait Islander person to any group or program. Involvement of the person in cultural events, men's groups and women's groups is encouraged. Some models of rehabilitation include fishing programs, young mother's groups, drop-in centres, art and music groups and cultural days (for example — NAIDOC, Mabo Day and Reconciliation Week).

Rural and remote settings

Literature suggests that dual diagnosis issues are more prevalent and problematic for Aboriginal and Torres Strait Islander people in rural and remote settings. Transportation, housing and compliance with treatment impact on service delivery and consequently the health of Aboriginal and Torres Strait Islander people living in rural and remote settings. Ensuring adequate care for these consumers requires flexibility, innovation and understanding of commonalities and differing perspectives of both health care professionals and the consumers who live and work in these settings.

In Queensland, the geographical reach of a district may be large, serving a dispersed population (for example — West Queensland and Cape York). A review of literature suggests that while residents in these communities are often opposed to fly in/fly out models of service delivery, this is often the best option available (Kreger and Hunter 2005).

Collaborative practice

Collaborative practice is being promoted across Queensland Health through a range of initiatives. Principles informing these frameworks incorporate inclusive consultation and practice with health service colleagues, communities, consumers and carers. The application of a collaborative framework recognises the value added by the incorporation of multiple perspectives informing holistic, recovery oriented care. Refer to collaborative care in Chapter 2.

Culturally and linguistically diverse populations

Over the years Australia has become one of the most culturally diverse countries in the world. The Australian Bureau of Statistics (2006) revealed that 21 per cent of Australians use a language other than English at home and Australians speak almost 400 different languages and come from 250 countries.

The impact of dual diagnosis on individuals from a CALD background can be significantly greater due to language barriers, different cultural beliefs on the causation and ways to deal with such problems, difficulties accessing culturally appropriate services, lack of accurate information and the shame and stigma attached to these issues within their own community.

Limited research has been conducted into the effectiveness of treatments for dual diagnosis in this population. However, a range of current studies are underway. To date, research and consensus opinion indicates that the use of an integrated treatment model where program goals address both alcohol and other drug problems in the one program, is the most appropriate for individuals from diverse backgrounds (Jacobson and Wright 2008). Some current programs are also examining the use of less stigmatising program titles addressing wellbeing to target mental health and substance use rather than mental illness or addiction services (Pawsey 2008).

It is now accepted that the process of acculturation, whereby a migrant adapts to the new culture, presents major mental health and substance misuse risk factors (Unger et al. 2004; Conway et al. 2007; Nguyen et al. 2007; Davidson et al. 2008). Migrants vary in the degree of acculturative stress that they experience. Those that experience severe and chronic acculturative stress, such as inability to learn English, unemployment, marital and/or family conflict, racism, and in general those who fail to integrate into the host society, are at risk of developing co-morbid mental health and substance use problems.

For example, Conway et al. (2007) found that the degree of acculturation related family stress was positively associated with co-morbid substance and psychiatric disorders. Importantly for clinicians working with consumers with dual diagnosis, research shows that intervention with the family to relieve the acculturative stress may diminish the development of this co-morbidity and assist in the implementation of successful treatment of substance related problems (Conway et al. 2007). Refer to working with families in Chapter 9.

It is also important to gain an understanding of what is acceptable behaviour in regard to substance use in the culture of the client. The decision to use a mood altering substance is made within a socio-cultural context. For example, it is common practice in Papua New Guinea and other Asian and Pacific cultures to regularly chew betel nut, a mild narcotic. This same behaviour in Australia would be deemed problematic. This also goes for the use of kava by Pacific Islanders, and the use of khat by Somalis and Middle Easterners. The use of alcohol in many Islamic countries is considered sinful and illegal, while the smoking of hashish is acceptable social behaviour. The important issue for clinicians to consider is the length of time the individual has been in Australia and the level of acculturation they have reached. It is not uncommon for newly arrived migrants to continue culturally acceptable practices; however after many years in Australia the same behaviour may be less appropriate.

According to Castillo (1997), migrants and refugees with differing cultural values or stigmatised social identity may experience difficulties adapting to the values of the new host culture. These cultural differences can result in legal, social and occupational consequences related to the use of mood altering substances. In these cases, the goal of clinical treatment should be to allow the client to adapt to the dominant culture in a way that does not impair their health, legal, social and/or occupational status (Castillo 1997).

Given there is vast diversity across and within various cultural groups, it is not realistic to capture the intricacies of working with each individual culture, so this chapter will focus on best practice recommendations and issues for consideration when working with all multicultural Australians.

Best practice recommendations

According to Castillo (1997) there is no single reason why people may develop substance use problems and there may be a number, or a combination, of factors involved including cultural customs. Castillo (1997) provides the following suggested clinical guidelines:

1 Assess the cultural identity of the client

Due to various cultural customs regarding the use of mood altering substances, clinicians should be aware that individuals from different cultural groups are at different risk for substance-related disorders. Therefore it is imperative to assess the cultural identity of the presenting client.

2 Assess the cultural schemas regarding substance use

The meaning of taking substances can vary dramatically across cultures and the reasons for use can include religious, social and/or economic. Substance use can be culturally supported for certain people within some societies, and so the cultural schemas of each client regarding such use must be assessed.

3 Assess substance use within the cultural and psychosocial environment

Clinicians need to see the client and his/her substance use within the total sociocultural context of the client, including sources of social stress that may be motivating the substance use as self medication. Self medication could be a response to the acculturative stress described earlier in this chapter, or could be a response to a hypersensitive nervous system resulting from emotional trauma. For example, refugee survivors of torture and/or trauma may well be susceptible to this as well as acculturative stress.

4 Assess the cultural aspects of the clinician-client relationship

Clinicians should critically assess their own concepts of substance use and consider how these concepts may be projected onto the client. Models of addictions should not be seen as universally applicable across all cultures. Other issues such as gender and age match between the clinician and the client should be considered from cultural perspectives. As pointed out earlier in this chapter, the shame of discussing such problems outside of the family is huge in many cultures, and a successful therapeutic encounter will depend on the therapeutic relationship between the clinician and the client, and possibly the family as well. Refer to the therapeutic alliance in Chapter 9.

5 Negotiate clinical reality

It is important to ascertain how the client explains the causation and nature of their problems and therefore a negotiation should occur between the client and the clinician to arrive at a consensus of the problem and the appropriate treatment. Cultural and settlement issues, such as acculturative stress and other psychosocial stressors, should be included. Co-morbidity issues need to be discussed to ascertain what should be the initial focus of treatment. It is important that this negotiation takes place, as the literature and anecdotal experience demonstrates that a major reason for treatment non-compliance or drop-out by people of CALD backgrounds is due to a lack of a shared clinical reality (adapted from Castillo 1997, pp. 168–170).

Other tips when working with a client from a Culturally and Linguistically Diverse background

Avoid making assumptions

Making assumptions about particular cultures can typecast clients which can in turn, negatively affect clinical judgement. Remember to ask your client; he or she is their own cultural expert (Manderson 1998).

Respect difference

Some cultures may value independence and self discipline while others may value submission and conformity. Similarly, some cultures may encourage displays of emotion, while for others the hiding of emotions is expected. Never assume to know what a client is thinking, feeling or believes. Show consideration and respect for a client's beliefs and values; it is not a matter of agreeing but rather of accepting (Manderson 1998).

Importance of families

For some cultures, family is very important. Extended family members may expect to be involved throughout the treatment process and it may be important to include them in consultations about the client's condition and discussions regarding possible courses of action. Family composition may also be different to the Western nuclear style; extended families and patriarchal values may be common (West Australian Transcultural Mental Health Centre 2002). Refer to working with families in Chapter 9.

Stigma and shame

Stigma is a problem for many people suffering from mental illness and substance misuse irrespective of their cultural background. However, the problems that result from stigma can be more debilitating for those from ethnic minority groups as they can occur in conjunction with pre-existing issues such as racial discrimination and exclusion. For those from culturally diverse backgrounds, stigma can occur in both the wider Australian community and their community of origin. Carers of family members with a mental illness and substance use problems frequently face difficulties related to the stigma and shame of having a family member who is unwell. Clients themselves may feel shame or be reluctant to discuss their experiences and this will require sensitive recognition and response from clinicians.

Gender and age

Gender issues may be of significance within specific cultures. In some cultures, the status of a man or a woman may largely influence their feelings towards the presenting problem which can affect their sense of wellbeing. Women may be reluctant to address problems of mental health and substance use for fear of rejection or persecution from their community. Older men may not want to work with younger males or females. Refer to the previous section in this chapter, Aboriginal and Torres Strait Islander cultural considerations.

English proficiency

Many clients who access services may speak limited English or no English at all. Clinicians need to advise clients that appropriate interpreting and other language services will be provided at Queensland Health expense and ensure written information in other languages on health service matters is available.

Language styles

Many cultures do not have a custom of professional talk-based therapies and as a result this style of intervention may be regarded with wariness and scepticism. Clinicians also need to be mindful that some cultures may describe their psychological state in terms of physical symptoms or use uncommon language like nerves, wind, cold or hot to describe what they are experiencing (West Australian Transcultural Mental Health Centre 2002).

Refugees/asylum seekers

Refugees and asylum seekers are diverse groups. People from a wide range of cultures may end up in the same situation as a result of political and economic disorder. This may result in Post Traumatic Stress Disorder and possibly a range of other conditions including anxiety and depression. As clinicians, being aware that clients share common circumstances or issues can help to better understand their health needs. Clinicians also need to be aware that they may have to work very hard to establish trust with refugees and asylum seekers, as past experiences may have lead to a reduced capacity to trust others.

Inter-generational conflict in regards to maintaining culture

Young people may be torn by competing needs to fit into the Australian lifestyle and uphold their own cultural identity. In some cultures adolescents may be thrown into an adult role at a young age, due to better language skills and ensuing work opportunities (Department of Human Services 2000).

Further information

The information in this chapter is designed as a way of enhancing your competency when working with people from diverse backgrounds. It is by no means all inclusive and clinicians are advised to contact the Queensland Transcultural Mental Health Centre (QTMHC) or health.qld.gov.au/pahospital/qtmhc/default.asp if they have concerns or queries regarding the provision of culturally appropriate care.

The QTMHC is a statewide Queensland Health service which provides an information, referral, resource and clinical consultation service. All services are provided free of charge. As a resource unit, the QTMHC has an ongoing and strategic role in assisting Queensland's MHS in the areas of training, planning, service delivery and review. Some districts have multicultural mental health coordinators who also can be utilised to assist clinicians when working with CALD clients.

Forensic consumers

Forensic consumers are those individuals with a mental disorder who come into contact with the criminal justice system. This group includes persons:

- who are placed on a forensic order after being found by the Mental Health Court to be currently unfit for trial or unsound mind at the time of committing an offence
- on remand or sentenced prisoners transferred from custody to hospital as a classified patient under the *Mental Health Act 2000*
- in custody receiving psychiatric treatment from the Prison Mental Health Service.

In each group, there are high rates of not only substance use, but substance dependence (Butler, Andrews and Allnutt 2006; Heffernan et al. 2003; Ogloff, Lemphers and Dwyer 2004). Forensic consumers therefore require the same types of mental health and substance use treatment as other people with a dual diagnosis. However, there are some special considerations that need to be taken into account.

1. Mental illness, especially active symptoms, increases the risk of violence. When mental illness and substance use are both present, this risk increases substantially (Douglas, Guy and Hart 2009; Fazel et al. 2009; Mulvey et al. 2006). Substance use also increases the risk of symptom relapse. Substances such as amphetamines can also induce psychosis and violence in persons who otherwise would not be psychotic. See Chapter 6 for information on risk assessment.
2. Forensic consumers with a dual diagnosis often have other co-morbidities, such as cognitive impairment and personality disturbance. Cluster B personality traits (for example — antisocial) may impair establishment of therapeutic relationships and collection of reliable information, and reduce compliance with mental illness and substance use treatment (Swanson et al. 2008).
3. Forensic consumers, like other consumers with dual diagnosis, may have prejudicial backgrounds, which include parental substance use and/or mental health and violence. This background vulnerability may manifest in problematic coping and a deficit in skills leading to difficulties in relationships, employment and accommodation.
4. Forensic consumers, like other consumers with dual diagnosis, are not a homogenous group. Subgroups of forensic consumers, such as Aboriginal and Torres Strait Islander people who are overrepresented in the criminal justice system, will have differing needs. In addition, people with an intellectual disability, the aged and CALD consumers also have diverse needs that will impact on the provision of services.

5. Involvement with the criminal justice system can be extremely stressful, whether the individual is facing criminal charges or being institutionalised in either a mental health or correctional facility. The experience of having been imprisoned can be quite traumatic, while being acutely psychotic in a custodial setting is particularly distressing. Those who have been institutionalised face additional difficulties reintegrating into the community. The first six months post-release (and the first two weeks in particular) is a high risk time for re-offending, suicide and substance overdose (due to a loss of tolerance).
6. Consumers with dual diagnosis and forensic issues face additional stigma which can be a barrier to accessing services.

A fundamental issue facing clinicians working with forensic consumers is the need to balance competing roles — for example, providing treatment versus reporting obligations; ensuring consumers' rights are protected versus community protection (Snowden 2001).

Other tips for working with forensic consumers

Listed below are some practice tips for supporting forensic consumers experiencing dual diagnosis issues.

1. The contribution of mental illness can be masked by more prominent substance use and personality features. A comprehensive, longitudinal history is essential, not just for diagnostic clarification but also to ensure appropriate treatments are provided.
2. Obtain collateral, which includes drug screens. Obtaining accurate and reliable information can at times be very difficult, especially where this might result in the consumer's order being revoked or some other sanction. Collateral will also assist in a more comprehensive assessment of a consumer's offending and violence history, and the factors that have contributed to this history. The details of a consumer's previous violence or offending (for example — harm caused, victims and events leading up to incidents) can provide valuable information regarding the pattern of such behaviour, as well as the role of factors such as substance use and psychosis.
3. Understand the statutory obligations, including any reporting requirements, of your role. This may vary significantly according to context (Gendel 2006).
4. If consumers are on orders (for example — forensic or parole), understand what is required both of you and the consumer, and ensure the consumer is aware of your obligations (for example — to act on breaches of these orders). Orders may require a consumer be abstinent from substance use. The decision as to whether an order should be suspended or breached is a complex one, which will take into account the order, the treatment plan and the consumer's previous and current risk.
5. A practical problem solving approach which offers options is likely to be more successful than a more authoritarian approach. This is not to say limit setting may not be necessary at times (for example — providing structure and defining boundaries are still useful approaches), though forensic consumers may have issues with authority that need to be handled sensitively and in a balanced way.
6. Attend to the range of consumers' needs (for example — there are high rates of Hepatitis among prison populations and lower literacy rates) as these will also significantly impact on service provision.
7. Given the high rates of problematic substance use, persons may present intoxicated and there is a significant risk of substance withdrawal when persons have to suddenly cease use, such as when they are hospitalised or placed in custody. Conversely, there is also the risk of overdose when individuals seek to return to a previous level of use after enforced abstinence.

Criminal justice clients

It is well known that a significant proportion of people involved in criminal justice services experience co-occurring mental health and substance related problems (Allsop 2008; Pritchard 2007).

In terms of treatment, the preferred option for this group of people is to try to divert them away from the criminal justice or correctional system. Compulsory alcohol and/or other drug treatment in Queensland includes a number of criminal justice programs which have a mandate in legislation and are available for people with alcohol and or other drug problems. It includes a wide range of programs from diversion into optional treatment through to court ordered mandated treatment, including treatment ordered as part of a sentencing order.

Further information

Further information on programs available in Queensland, please refer to the ATODS website at health.qld.gov.au/atod/default.asp

Programs available in Queensland include:

1. Queensland Illicit Drug Diversion Initiative (QIDDI): QIDDI originates from the Coalition of Australian Government, National Illicit Drug Strategy (1999) covering the prevention of illicit drug use and early intervention. The QIDDI aims to reduce the number of people appearing before the courts for and being convicted of, minor drug offences; provide incentives for minor offenders to address their drug use; and increase access to drug education and treatment.

   Programs under this initiative include:

   – Queensland Police Diversion Program: this program is offered to people found in possession of 50 grams or less of cannabis and who meet the strict eligibility criteria. If eligible, people are offered the opportunity to be diverted from the criminal justice system to attend a Drug Diversion Assessment Program (DDAP) rather than being charged for the offence.
   – Illicit Drugs Court Diversion Program: this program can be offered by any magistrate's court in Queensland to people, including youth, charged with possession of an illicit substance for personal use, who admit to the offence. The program involves attendance at a drug assessment and education session whereby no conviction will be recorded.
   – Queensland Magistrates Early Referral into Treatment Program (QMERIT): this program enables adults dependent on illicit substances, whose dependency contributed to their criminal behaviour, to undergo treatment whilst on bail (Pritchard et al. 2007).

2. Queensland Drug Court Program: this program exists within the Magistrates Court structure for individuals who are likely to be imprisoned. If accepted, the individual appears before a special drug court magistrate and is placed on an intensive drug treatment order which takes approximately 12–18 months to complete. This order involves tailored drug treatment and periodic monitoring by the Drug Court. Once completed the drug court magistrate reviews progress and reviews the original sentence and adjusts this sentence accordingly (often a non-custodial sentence is imposed). This program is available in a limited number of locations. Treatment case management is provided by Queensland Health.

3. Queensland Indigenous Alcohol Diversion Program (QIADP): this pilot program is a voluntary option for Aboriginal and Torres Strait Islander people living in Queensland; appearing in the magistrate's court for alcohol related offences; or where alcohol has contributed to involvement by the Department of Child Safety.

Further information

For more information access health.qld.gov.au/atod/

Older people

Substance use problems have traditionally been associated with youth and younger adults. In the older population substance use problems have been largely under-diagnosed and under-treated. Though the problem is less prevalent in this age group, it is one that poses serious personal and social consequences and has been termed by some as 'the hidden epidemic' (Widlitz and Marin 2002).

The commonly quoted prevalence rates of alcohol use problems range from 0.1 per cent to 15–20 per cent in some studies. As the baby boom cohort ages, it is predicted that there will be a substantial increase in the number of older adults needing treatment for substance abuse problems (Gfroerer et al. 2003). Data derived from the United States National Household Survey on Drug Abuse in 2000 and 2001 suggest a 50 per cent increase in the number of older adults in, and 70 per cent increase in demands on, the substance abuse treatment system by 2020, particularly driven by the use of illicit substances and non-medical use of prescription medications.

This is supported in the 2009 National Survey (Department of Health and Human Services 2009) that found that for adults aged 50 to 59 the rate of current illicit drug use increased between 2002 and 2009 from 2.7 to 6.2 or 130 per cent. This trend partially reflects the ageing of the baby boom cohort, whose rates of illicit drug use has been higher than those of older cohorts.

Australian data from the 2007 National Survey of Mental Health and Wellbeing indicated a 2.5 per cent prevalence of substance abuse (i.e. the harmful use and/or dependence on alcohol and/or drugs) by people 55 years of age and older. The 2007 National Drug Strategy Household Survey (AIHW 2008) revealed that although older people tend to consume less alcohol during any one session than younger people, the highest proportion of daily drinkers in 2007 were those over 60 years old. Around 11 per cent of people aged 60 years or more drink above National Health and Medical Research Council (NHMRC) 2001 guideline levels for short-term harm; and about 6 per cent drink above NHMRC 2001 guideline levels for long-term harm (AIHW 2008). The Australian Bureau of Statistics, more recently quoted a 2.1 per cent prevalence rate of substance use disorders in the elderly, 65 years and older, from the 2007 National Mental Health and Wellbeing Survey.

There are a number of important reasons to support increasing the awareness and detection of substance use problems in the elderly. These include the growing population of people over the age of 65; the likelihood of increasing MHS utilisation among future cohorts of older people; the presence of fewer abstainers among successively younger cohorts; the tendency for health professionals to mistake the effects of use in older people; and the high costs involved in treating substance abuse.

Issues specific to the older population

- Older people with alcohol and drug problems are often an invisible group. The clinician should first consider their own biases in order to challenge ageist attitudes and to help avoid the direct and indirect discrimination of the older person that can contribute further to stigma and defeatism.
- Ethical considerations such as issues of confidentiality and capacity to make decisions about lifestyle and health care may be prominent in the older person's case. Be aware of ethical principles governing assessments and care provision and have a clear understanding of the aspects, guidelines and boundaries of the *Guardianship and Administration Act 2000* and *Mental Health Act 2000*.
- Barriers to detection in the older person may include: faulty assumptions and myths by health care providers and family where tolerance of drinking may be seen as justifiable responses to the stresses of ageing; ignorance of treatment resources and pessimism about prognosis in both family and clinicians; denial, a hallmark of the disease, is exacerbated by beliefs that alcohol misuse is a moral weakness or character defect; fewer social warning signs such as relationship and work dysfunction; masking of alcohol-related pathologies by concurrent medical conditions and medications; and unknowing addiction to other substances such as over-the-counter preparations that might contain high alcohol concentrations (Menninger 2002).
- Isolation is a tremendous problem; it is a potential risk factor for substance use problems, as well as a barrier to both detection and management strategies. Consider not only the older person presenting directly to health professionals, but also those home-bound due to poor mobility or lack of transportation; those in rural and remote settings; the elderly in hospital inpatient settings; and older people in residential age care facilities.
- Assessment settings need to be appropriate and time allocation adequate and sensitive to the older person — there is often more life history to gather, slower psychomotor ability and frailty, and possible hearing and visual impairments. It is essential to gather collateral, especially if denial is present and/or cognitive impairment is an issue. This may include, but is not exclusive to, family members, carers, community services providers and other health providers. Collateral information is crucial to objectively clarify the extent and impact of the substance use problems. It may be necessary to conduct the assessment over several short sessions rather than perform one lengthy interview.
- Alcohol is most frequently recognised as a problem substance, but screening in the elderly needs to be broad enough to cover prescription medications (especially Benzodiazepines, and analgesics), over-the-counter medications (such as cold preparations, laxatives, vitamins and antacids), as well as illicit substances, particularly as younger cohorts age. Males are widely accepted to carry a greater risk for alcohol misuse, however females seemed to be at greatest risk factor for prescription drug dependence in some studies.
- Risk factors for substance use problems vary somewhat to younger populations. Potential risk factors highlighted in older people include: physiological changes with age; co-existing chronic conditions; chronic insomnia; and multiple significant life events/losses. Older people are more vulnerable to the effects of alcohol due to changes in their body composition, decreased metabolic capacity, presence of co-morbid conditions and medications that regulate these conditions (Aira et al. 2005).
- Issues of consequent risk are somewhat more complex and at times less apparent than in younger populations. These risks are significantly increased with harmful levels of use of alcohol and other substances. Risks include: deliberate self harm and suicide; unintentional harm (falls, accidental injuries and motor vehicle accidents); aggression to and from others; vulnerability to abuse and neglect; neglecting existing medical care; malnutrition; and mishandling of medications which can lead to falls, delirium and drug toxicities. A population-based study of adults aged over 75 years found that among those using alcohol at any level, almost 87 per cent also regularly used medications that had potentially adverse interactions with alcohol (Aira et al. 2005).
- As substance misuse may present in a variety of ways, and is further complicated in the older individual who often already suffers from other common and age-related problems. The issue of diagnostic clarification is an important one, particularly as the American Psychiatrist Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR®)* (2000) and World Health Organization's *International Classification of Disease (ICD-10)* (2007) systems were developed from research in younger populations. Biological and lifestyle differences in the older adult can lead to under-diagnosis. Social and occupational functioning are less affected as older people are likely to be retired, widowed, isolated or not driving. Indicators for dependence and tolerance tend to not develop dramatically in the elderly and deleterious effects of relatively 'small amounts' of alcohol consumed may still occur. It may be better to focus on consequences of drinking (for example — falls and other accidents, nutritional deficiencies, social isolation, family problems and medical problems associated with the misused substance) rather than the amount consumed.

- Co-morbidity is common, with high rates of chronic medical illnesses and co-morbid psychiatric conditions (such as depression, dementia, psychosis and delirium) present. This tri-directional relationship means assessment and treatment is even more complex in the older population. This may mask underlying substance misuse symptoms, or result in atypical symptoms being reported. Chronic medical conditions may make it difficult to recognise the effect of alcohol or other psychoactive substances in decreased functioning and quality of life. Memory loss, poor balance and somnolence may be overlooked and incorrectly considered as a normal part of ageing. Again, the potential for medication interactions and mismanagement is also very high.
- Diagnosis ultimately relies on good clinical assessments that must be thorough and take in complete details of medical and psychiatric histories, medications, all substance use, social circumstances and environments, supports and collateral sources. It may be useful to augment clinical assessment with screening tools such as the CAGE or the Michigan Alcoholism Screening Test – Geriatric version (MAST – G).
- Be aware of, and address, barriers to treatment that may include ethical issues of confidentiality, perception that treatment programs are not successful or not suited to the older person, long waiting periods, distant treatment services and lack of transportation. It is noted that although there is little research data on the effectiveness of management interventions in the elderly, what is currently available suggests that older people may respond just as well to traditional treatment strategies as younger populations.

Youth

Prevalence

Mental disorders are the leading cause of disability among young Australians aged 15–24 years and account for almost 50 per cent of the burden of disease in this age group (Australian Institute of Health and Welfare 2007). Amongst young people 16–24 years, in the year prior to the 2007 National Survey of Mental Health and Wellbeing:

- A mental disorder (comprising affective, anxiety and substance use disorders) had been experienced by 26 per cent of young people, which is a rate higher than any other age group.
- Young people with a mental disorder were more than five times as likely as those without mental disorders to have misused drugs, 1.6 times more likely to have used alcohol, and twice as likely to be current smokers.
- Amongst those with a mental disorder, young people had the lowest rate of help-seeking behaviour (23 per cent) of any age group. Those with a substance use disorder were least likely to seek help (11 per cent), compared with those with an anxiety disorder (32 per cent) or affective disorder (49 per cent).

(Australian Bureau of Statistics, 2010).

In addition to the young people from diverse backgrounds already identified in the chapter, those at increased risk of dual diagnosis include: young parents; those in foster care; homeless or transient young people; those who have disengaged from school; young people who identify as lesbian, gay, bisexual or transgender (LGBT); and children of parents with a mental illness and/or substance use.

Amongst clinical populations, however:

- approximately 50 per cent of adolescent mental health inpatients have a co-occurring substance problem, of which a further 50 per cent are polysubstance users (Caton et al. 1989)
- of young people seeking treatment for substance use, 77 per cent were found to meet criteria for at least one mental disorder (Rogers et al. 2005)
- substance-using young people are up to three times more likely to have a psychiatric diagnosis (Kandel et al. 1999), which is a higher rate than for adults (Beitchman et al. 2001).

Common dual diagnoses in adolescent populations include depression, anxiety, bipolar disorders, conduct disorder and Attention Deficit Hyperactivity Disorder (ADHD) (Deas and Brown 2006). As with adult populations there is a significant overlap between substance use and trauma as well as affective disorders (including the frequently related behaviours of self harm and suicide attempts/completion) (Queensland Health 2004). There are also a number of presentations of particular relevance to young people. For example, Conduct Disorder has been commonly associated with early onset tobacco smoking, drinking, illegal drug use and risk-taking behaviours (Allsop 2008). The co-occurrence of ADHD and learning disorders with substance use problems is also common. The literature on first episode psychosis indicates the age of onset is frequently by or during young adulthood, with increasing accounts of psychotic episodes being induced by cannabis or amphetamine use (Hinton et al. 2008 in Allsop Ed. 2008). As with adults, young people with dual diagnosis are at increased risk of entering the forensic system.

Impact

The definition of 'youth' is accepted as young people aged between 10–24 years, thus traversing a wide range of developmental milestones. These include the establishment of a young person's self and sexual identity, individuation from family, expansion of their emotional and behavioural repertoire and the emergence of abstract thought. The life-course approach to human development (as utilised in the Queensland Health training program Bridging the Gap) identifies critical periods and times of transition (such as those characterising adolescence) as being potential peaks for the onset of health concerns (Halfon and Hochstein 2002). An estimated 75 per cent of adults with mental illness (and related substance use disorders) experience the onset of health concerns by the age of 25 years (Kessler et al. 2005).

The disruption brought about by dual diagnosis can have serious and long-term repercussions for young people (Crome and Bloor 2005). These include an adverse impact on a young person's self confidence, strain on relationships and finances, disruption to education and vocational pathways and possible limitation of their psychological and social development (Department of Health and Ageing 2004). Intervention during adolescence is thus of key importance in interrupting the developmental trajectory of dual diagnosis into adulthood.

Services need to ensure young people also encounter a no wrong door approach to eligibility, whereas young people presenting for assistance receive appropriate support from whichever service provider they present to. In addition to those identified elsewhere in these guidelines, barriers to service access specific to young people include the fact that their symptoms are less likely to meet diagnostic entry criteria, and that adult MHS may not be perceived as youth-friendly (NSW Association for Adolescent Health 2003).

Further information

To read the experiences of young people and their families in accessing treatment for youth dual diagnosis (including recommendations for service providers), refer to the Blamed and Ashamed (2000) report at download.ncadi.samhsa.gov/ken/pdf/KEN02-0129/KEN02-0129.pdf

Presenting issues specific to young people

Mental health

In addition to encompassing diagnoses unique to young people such as Conduct Disorder, mental health problems can present differently in younger age groups compared with adults. For example, depression may manifest more as irritability than sadness/dysthymia. This may lead to mental health symptoms being misattributed to hormonal changes. Symptoms may be misattributed by significant others as a phase, and a vital opportunity to intervene may be missed. Young people may be more vulnerable to systemic influences beyond their control such as a family break-up or change of school. They may also be increasingly aware of the social or academic impact of any developmental or behavioural problems, including Asperger's Syndrome, ADHD and learning disorders. The diagnosis of an adjustment disorder can sometime best capture and validate their reactions to such contextual influences. It should also be noted that the formal diagnosis of a personality disorder cannot be made until the age of 18 (excluding Antisocial Personality Disorder) unless the features have been present for at least one year (American Psychiatric Association 2000). In addition, diagnosing episodic illnesses (especially bipolar disorder) may be premature due to the need to build up a profile of symptoms over time. Finally, the recovery model may need to be modified for younger populations to include a focus on resilience to more appropriately reflect the young person's changing developmental needs (Friesen 2007).

Substance use

Seeking out a range of new experiences may be considered a rite of passage for some young people. Experimentation with substances itself may, in some circumstances, be considered age-appropriate and does not automatically lead to problematic use or dependence. Factors contributing to problematic youth substance misuse are multi-faceted and may include early initiation to use, poor parental control and supervision, poor family bonding, drug use among family members and peers, low self esteem, academic failure, leaving school early and poor connection with family, school and community (Lambert et al. 2004; Spooner 1999). The presence of these risk factors heightens the risk of the development of problematic substance use in the future but does not predict the development of such problems.

When considering substance use in young people, attention should be paid to:

- **Age of initiation:** Early use of substances may preclude young people from a range of positive experiences, with research increasingly identifying the adverse impact of substances on the developing adolescent brain (Lubman et al. 2007). Young people who initiated substance use early may have missed the opportunity to develop relevant coping skills usually acquired during this developmental phase. Compared with those who start using later, they have been found to have poorer short and long-term outcomes across a range of psychosocial domains (Hingson, Hereen and Winter 2006).
- **Pattern of use:** Young people often use substances in greater quantity and higher frequency than adults, are less likely to have a primary drug of choice (polydrug users) and report a lower tolerance when initiating use. They may also be quite opportunistic users, with their source of supply frequently being friends or relatives. Young people have reported initiating the use of pain-killers/analgesics for non-medical purposes over a year before tobacco and alcohol, with the prevalence of risky drinking remaining relatively stable amongst young people in recent years. There have been increasing reports of harm relating to youth intoxication, particularly amongst females (Australian Institute of Health and Welfare 2008) with young people often demonstrating a binge style pattern of use.
- **Balance of positive and negative experiences:** Young people may initiate substance use if it helps meet a developmental need, including contributing to the establishment of a peer group (identity) and aspiring to become adult-like. They are also less likely than adults to experience the intensity or frequency of hangovers. Such factors may instil positive expectancies about initiating substance use, although the reasons for starting and maintaining their use may not always be the same.

Ethical considerations in working with young people

Working with young people in particular can bring to the fore a number of ethical issues, including:

Child protection concerns

During the course of an assessment, a young person may disclose information indicating that they or another child/young person is at risk of harm. It is Queensland Health policy that all Queensland Health clinical staff report reasonable suspicions of abuse and neglect (to those 0–18 years) to the Department of Child Safety.

Further information

For more information on the policy including how to make and document a report, see qheps.health.qld.gov.au/csu/policy.htm

Consent to treatment access/selection

Young people may wish to make health care decisions which are in opposition with a parent's own perceived right to know or decide for them. Gillick competence, endorsed by Australian common law, refers to a young person's level of legal capability to understand the nature and possible consequences of a decision, procedure or treatment without the need for parental permission or knowledge (Department of Communities (Disability Services) 2007; Queensland Nursing Council 2006). Assessing a young person's competence to provide informed consent is a matter for professional judgement, is not age-specific and is made on an individual basis to determine their understanding and intelligence. A young person should be encouraged to inform and involve parents/guardians, but their best interests are to be placed above any parental right to be informed. This confidentiality may be broken if failing to do so would place the young person or someone else at risk of harm. At each point, decisions regarding Gillick competence should be made in consultation with the treating team and supervisors, with all decisions documented.

Engagement of young people with dual diagnosis

Accessing support may often be a young person's first attempt to seek help for their mental health and/or substance use problem. Maintaining engagement with them should thus be a treatment priority as the quality of this first experience can also have an enduring impact on future help-seeking behaviours. For young people with a dual diagnosis, this requires a flexible approach to service delivery including minimising barriers to access, the availability of outreach, providing a range of consultation times and establishing a youth-friendly space for appointments (National Youth Affairs Research Scheme 2004). Such an approach is being adopted by the Community of Youth Services – Headspace, established nationally, including services based at a range of locations around Queensland, for more information see headspace.org.au.

It is especially important to form a working alliance with the young person to enable mutual inquiry into their concerns.

Listed below are some practice tips for engaging with young people:

- If meeting them with family members, greet the young person first.
- Define confidentiality, being clear on when and how it may need to be broken.
- Avoid taking on the role of a parent, as this is likely to ostracise young people.
- Gather information gradually whilst at the same time fostering a close relationship. This may require more time than for adult clients, or for young people with only one problem.
- Use visual cues and prompts where necessary to facilitate conversation and explore strengths.
- Do something for them, such as finding out information that will improve their immediate situation.
- Remember that the young person will often see substance use as a solution to their problems, not a cause or a contributor; overlooking this will risk disengagement.

Practice tip

The clinician should always attempt to engage the young person in a dialogue about their individual circumstances around their drug use. Engaging a young person in discussion may be more effective than attempts to coerce them into treatment.

Assessment of dual diagnosis in young people

Often young people present for assessment following a situational crisis, which may detract time and clinical attention away from ascertaining the extent of underlying problems such as dual diagnosis. While young people may report lower levels of symptom severity which do not indicate the presence of a major disorder, their problems can have a significant impact on functioning. In addition, ambiguity may be evident with emerging problems and fluctuating symptoms making accurate diagnosis difficult. As with all age groups, the need for ongoing assessment is therefore imperative with this client population.

Listed below are some practice tips for assessing young people with a dual diagnosis:

- Normalise exploration of concerns, including using stress to help conceptualise their behaviours.
- Obtain information on their pattern of use and reasons for both initiating and maintaining use.
- Ask them to explain a term you don't understand (for example — for a substance) as this will enable them to feel they are contributing to your knowledge base.
- Administer standardised assessment suites (for example — the drug screen) in as conversational a manner as possible to maintain engagement.
- With their consent, seek collateral information from significant others (including relevant school/assessment reports).
- Pay attention to the day to day living/lifestyle problems associated with their dual diagnosis.

In addition to a clinical interview and completion of routine outcome measures, the clinician may wish to have the young person complete a standardised tool appropriate to their age. The Strengths and Difficulties Questionnaire (Goodman 1997) has been widely validated as a concise measure of behaviours, emotions and relationships in children and young people. It is free, youth-friendly and widely accessible on the internet (see sdqinfo.com). The format has been adopted for a new measure to screen for and monitor adolescent substance use, namely the Substances and Choices Scales (Christie et al. 2007). In the case of alcohol misuse specifically, instruments that tap psychological symptomatology including craving and loss of control (such as the TWEAK), are considered more appropriate to young people than those that assess physiological dependence and alcohol-related problems, such as the Michigan Alcohol Screening Test (MAST) and CAGE (Dawe et al. 2002).

If assessment indicates the young person is in acute withdrawals and requires detoxification services, clinicians should immediately involve a medical practitioner and consider referring the young person to the Adolescent Drug and Withdrawal Service (ADAWS). This service is a residential detoxification service based at South Brisbane for young people aged 13–18 years from across Queensland. The program comprises an 11 day program with a daily relapse prevention focus, as well as a range of recreational activities. The Hothouse Youth Community Team (at 2 Finney Road, Indooroopilly phone (07) 3878 3911) has considerable experience in managing and supporting young people with substance use disorders, with medical input and support from Biala.

Further information

For more information contact ADAWS, phone (07) 3163 8400 or visit kidsinmind.org.au

Management of dual diagnosis in young people

While there is limited literature and research available, cautious application of interventions developed for adults appears suitable for use with young people. This requires modification of integrated treatment to consider the young person's developmental needs. Crome (2004) suggests the best approaches are those that combine addiction treatments for adults with treatments for young people with behavioural problems. The latter may include a greater emphasis on involving significant others. Recent evidence has shown that effective treatments for young people include family behaviour therapy and individual cognitive problem-solving therapy (Bender, Spring and Kim 2006). Hides et al. (2007) provide a useful summary of integrated Cognitive Behaviour Therapy (including a number of practical clinical exercises) for young people with depression and co-existing substance use.

Practice tip

When working with young people, clinicians must consider psychological delays to adolescent development caused by either mental health or substance use. Interventions should target the young person's psychological age not their chronological age.

Below are some practice tips for supporting young people with a dual diagnosis:

- Assist them to develop greater recognition of their own emotional state so they can internally monitor and ultimately better manage any changes in their distress. Using visual means (such as the drawing of a thermometer with a 0–10 scale) can help them develop this capacity for self regulation.
- Highlight the links between mental health and substance use, including trigger points for each. The Feeling Good (2005) booklet, or the Queensland Health youth dual diagnosis comic book When the Party is Over, may be of use.
- Encourage young people to delay the initiation of any new substances for as long as possible.
- Recognise that abstinence may not be an option young people in particular are willing to consider (although it still needs to be offered and documented). If so, explore harm reduction strategies.
- While education regarding standard drinks is important, without additional harm reduction strategies they may learn to buy higher-alcohol drinks to become intoxicated more economically.
- Facilitate discussion on the short-term disadvantages of use that matches their developmental needs, such as how it affects their appearance, finances or relationships. (They may be aware of long-term harms, especially for tobacco, but this may not be sufficient to change their current behaviour).
- Link them in with age-appropriate resources (including those available via multimedia technology) to seek extra support, including information on how to help a friend in the event of an overdose.

Offering age-appropriate treatment over time may also require offering treatment targeting a number of developmental phases, including moving from secondary to tertiary education, leaving home, or transitioning from child and youth to adult services. This will require liaison with their educational institution, workplace and/or other service providers to enhance consistency, maximise support and enhance their functioning.

Further information

For additional suggestions, see:
Hanna and Hanna (1999) for strategies in counselling young people with challenging behaviours.

Good practice guidelines for working with young people at risk of suicide or non-fatal deliberate self harm who present at Queensland Health facilities (2002).

The Feeling Good and When the Party is Over resources are available for order from the Alcohol and Drug Information Service on 1800 177 833.

The Red Cross offers a first aid program specific to this issue, see saveamate.org.au

Specialist youth research and information centres in Queensland

Dovetail

Dovetail comprises a consortium of equal partners from government and non-government agencies, who share expertise and experience in the field of youth health service delivery from across Queensland and interstate. ***Dovetail's*** activities aim to assist the youth sector in achieving its vision to enhance and strengthen service delivery to young people across Queensland who are affected by drug or alcohol issues. ***Dovetail*** provides a wide range of resources which are accessible on their website.

Centre for Youth Substance Abuse Research

The Centre for Youth Substance Abuse Research (CYSAR) was established as a partnership between the University of Queensland and Queensland University of Technology to:

- understand the pathways to substance misuse among young people
- be at the cutting edge of research into new and innovative ways of preventing and treating substance misuse among young people
- make significant and tangible improvements to youth service provision
- influence state and national drug strategy relating to youth substance misuse, its policing, prevention and treatment.

Further information

For further information on ***Dovetail***, see dovetail.org.au

For further information on CYSAR, see uq.edu.au/health/cysar

Involving significant others

Involvement of the family in treatment may be challenging, and yet is of particular importance when providing care to young people. Families can be a source of accurate information and a resource for initiating change. Reduction of familial tension may reduce stress and conflict for the client and contribute to positive treatment outcomes (Pourman, Kavanagh and Vaughan 2005). Moreover, family members deserve attention because of the enormous distress and difficulties young people afflicted by mental illness or substance use problems can cause (Australian National Council on Drugs 2007). The Australian Clinical Guidelines for Early Psychosis (National Early Psychosis Project 1998) provide clear standards for engaging families. It should be noted that parents are not always the primary caregiver, and so grandparents, kinship guardians, foster carers or significant others may need to be involved to provide similar support. In each case, the parent/carer may be assigned their own clinician to access individual support as well as orchestrate joint sessions with the young person and their clinician.

Lysaught and Wodarksi (1996) highlight the importance of addressing contextual influences on youth dual diagnosis, such as through parent groups and/or peer group support. In doing so it is also vital to recognise the needs of siblings, who are often overlooked with much of the family's attention being focused on the young person with the dual diagnosis. This may include referral for their own support, the provision of psychoeducation or strategies delivered through clinical support to the parent. Refer to working with families in Chapter 9.

Parents with a dual diagnosis

It has been estimated that among Australian children:

- 22 to 24 per cent (approximately one million) live in households where at least one parent has a mental illness (Mayberry et al. 2005)
- 13.2 per cent of children under 12 years are at risk of exposure to binge drinking by at least one adult (in many cases a parent) in the home environment
- 2.3 per cent live with someone who uses cannabis at least daily
- 0.8 per cent resides with an adult who uses methamphetamines at least monthly. (Australian National Council on Drugs 2008)

Given the high co-morbidity between mental health and substance problems, many thousands of children therefore have at least one parent affected by dual diagnosis. A survey of Queensland mental health consumers found that 35 per cent were parents, of whom half had children under the age of 16 years, although less than half of these consumers were residing with their children at the time (Hearle et al. 1999).

Those with a dual diagnosis are often very capable in their care-giving role despite the range of challenges every parent can face in raising children. However, dual diagnosis can adversely affect parenting capacity in a range of ways, including the following:

- Parents with a dual diagnosis may have particular problems interacting and communicating with their children. In the case of infants and young children it may contribute to attachment difficulties, particularly if the parent themself experienced poor parenting including possible exposure to neglect or abuse. Either or both problems can lead to poor emotional regulation, where those affected may become irritable or less tolerant of their children's behaviour.
- Chaotic lifestyles associated with obtaining drugs, intoxication, drug withdrawal and a disordered mental state may mean that finances become redirected from family responsibilities, or a parent has reduced capacity to support their child's access to schooling and other prosocial activities.
- Problems due to parental dual diagnosis can place the family at a higher risk of transient accommodation or homelessness, thus jeopardising the health and welfare of children.
- Memory and consciousness may be affected by intoxication and/or withdrawal, increasing the risk that children and young people may be left unsupervised or with unsuitable carers. Children may be exposed to illegal activity and drug taking behaviours, increasing their risk of abuse and neglect.
- Lack of support or difficulty accessing services for people with a dual diagnosis can affect parenting and help provided to families. Parents may fear that asking for help for themselves or their children could mean that they have their children removed from their care.

A recent amendment to Section 20: Issues for Specific Areas of the Queensland Health Protecting Queensland Children Policy Statement and Guidelines for the Management of Child Abuse and Neglect in Children and Young People (0–18 years) outlines that staff who are involved in counselling or treating people with alcohol or other drug use issues need to be proactive in making routine enquiries about their capacity to cope with the care of their children. All assessments should include questions to ascertain whether the client has any children in their care and if there are any concerns about the care of these children.

Maybery and Reupert (2006) noted a number of barriers identified by adult mental health workers in discussing such issues with consumers. These included their own perceived lack of knowledge and skills, limited resources and a belief it was not part of their role. This is despite the fact that many consumers may be open to interventions that enhance their parenting capacity (Oyserman et al. 2000), and so may benefit from such an opportunity at least being offered to them.

It should be noted that children of parents with a mental illness and/or substance use may draw meaning and value from their care giving role and do not always want to relinquish it entirely to external supports.

However, children and young people may experience a range of adverse experiences arising from their parent's difficulties, including:

- taking on part or all of the care giving role, such as looking after siblings, monitoring medication or attending to household chores. This can adversely impact on the child's own developmental needs, including completing homework, holding a part-time job or getting adequate sleep or nutrition
- a range of emotions regarding their parent's difficulties, including anger, helplessness, guilt, shame and anxiety. The latter in particular may be due to concern regarding their parent's safety, which may manifest as school avoidance/refusal in their attempt to remain at home to monitor the parent
- social isolation due to feeling that they are the only one going through such experiences, and embarrassment regarding their parent's condition. This may limit their willingness to open up with others, engage in extracurricular activities or have friends stay at the family home
- concern that they may develop their own illness as a result of their parents.

The interaction of such experiences with any underlying genetic predisposition to mental illness and/or substance use means that children of parents with a dual diagnosis have been found to demonstrate higher rates of emotional and behavioural disturbance, and are often over-represented in child protection systems (NSW Dual Diagnosis Support Kit 2005). Children of Parents with a Mental Illness (COPMI) have thus been identified as a priority group at both the national and state levels. District COPMI positions have been developed to enhance systemic responses to support these children, who are often invisible to services. Mental health clinicians are also required to adhere to the Queensland Health Policy Meeting the needs of children for whom a person with a mental illness has care responsibilities (2009).

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 17

Staff provide screening, assessment and treatment planning which includes attention to those **adult clients who are parents**, and facilitating with them a discussion of the reciprocal relationship between their health problems and capacity to provide care and protection for their child/ren.

Completion of the COPMI online learning package Keeping the Children and Families in Mind, may assist in building clinician and service capacity to support families affected by parental mental illness (which may include co-occuring substance use). The package can be accessed for free at the COPMI website. Completion of the six modules (takes a total of approximately eight hours. Modules can be completed individually over time), enables access to free professional development points for registered clinicians. The learning package has been endorsed by the following:

- Royal Australian and New Zealand College of Psychiatrists
- Royal Australian College of General Practitioners
- The Australian Psychological Society
- The Australian Association of Social Workers
- Australia Association of Occupational Therapists
- Australian College of Mental Health Nurses.

Further information

See the Mental Health Alcohol and Other Drugs Directorate website for contact details for current programs at qheps.health.qld.gov.au/mentalhealth/default.htm

See Queensland Health Policy Meeting the needs of children for whom a person with a mental illness has care responsibilities at qheps.health.qld.gov.au/mentalhealth/docs/COPMI_policy_jan09.pdf

Refer to the *Queensland Health Child Protection Act 1999* at legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf

The COPMI online learning package Keeping the Children and Families in Mind, is available at copmi.net.au

It is vital to provide holistic care in acknowledging and supporting the adult client's role as a family member, including facilitating their children's access to appropriate care. This may require collaboration across a number of sectors, including Child and Youth Mental Health Services (CYMHS), education, general practitioners and the Department of Child Safety. It is Queensland Health policy that all Queensland Health clinical staff report reasonable suspicions of child abuse and neglect to the Department of Child Safety. It is important to note that while this process can be stressful for the clinician and may challenge their therapeutic relationship with the client, the policy requires Queensland Health staff to act in a timely manner to protect vulnerable children, including those who may not be the biological offspring of their client.

Further information

For more information on the policy, including how to make and document a report to the Department of Child Safety, see qheps.health.qld.gov.au/csu/policy.htm

Interventions for parents with a dual diagnosis

Some suggested interventions for parents with a dual diagnosis are:

- Advocate for family-friendly clinical environments, including having information relevant to parents in waiting rooms and ensuring private space for children to visit parents in inpatient units.
- Assess and monitor parental responsibilities for all clients throughout their episode of care.
- For expectant mothers, discuss the need to, wherever possible, abstain from substance use, and support their efforts to cut down. Facilitate discussion of the impact of medication on the pregnancy, and help them develop strategies to reduce stress upon the baby's arrival. Thereafter monitor for the emergence of Postnatal Depression as well as relapses in pre-existing conditions.
- Facilitate discussion with parents on contraception options as appropriate.
- Encourage clients to engage with appropriate services, including those that can further support and validate their role as a parent.
- Encourage clients to talk to their children (when they are well) about their dual diagnosis and how it affects them.
- Support clients to assist children and young people by providing information, resources and details of support programs in their community. This may be of use even for those who no longer live with their parent, or who are over the age of 18 years.
- Support clients to write a family support plan, which outlines actions to take when they are unwell or there is an emergency. Keep a copy in their chart for future reference (including regular updating), and encourage clients to provide copies to key support people such as their general practitioner.
- Provide information about safe drug storage (including medication) to minimise access by children.
- Assist children to identify someone who has an ongoing positive role in their life that they can turn to in times of stress, such as a teacher, guidance officer or grandparent.
- Encourage families to maintain routines and celebrations like birthdays, religious festivals and special family activities.
- Provide information on, and refer as appropriate to, specialist programs that support families affected by a parental mental health and/or substance problem. A growing number of Queensland Health districts are providing COPMI–related programs to families, including those affected by parental dual diagnosis.

Further information

Family Planning Queensland may be able to assist with information and resources visit their website fpq.com.au for more information.

A Child Health Line is now included on 13 HEALTH (13 43 25 84).

The publication *Feeling Good* (2005) available through the Alcohol and Drug Information Service (phone 1800 177 833).

Family support plans are available at qheps.health.qld.gov.au/patientsafety/mh/mhform.htm

The Kidsafe House (see kidsafeqld.com.au) may assist with information on safe drug storage.

The Mental Health Alcohol and Other Drugs Directorate for statewide COPMI information or your local district MHS for details on local initiatives.

chapter 11

clinician burnout and self care

dual diagnosis
clinical guidelines

key points

- The provision of services to people with a dual diagnosis is complex, stressful and challenging for the individual, the clinician and the service.
- Services need to ensure that mechanisms such as clinical supervision exist to identify and support clinicians, to reduce burnout which leads to staff turnover and reduced quality of care.
- Individual clinicians may need to adjust their usual goals and expectations and accept that the individual may require long-term treatment and care, and that recovery is an individual and often slow process.

Burnout is a syndrome of emotional exhaustion, depersonalisation and reduced accomplishment which appears to be increasingly common in health care workers. Both mental health and alcohol and drug sectors can be very stressful work environments. The work environment can be difficult and stressful for clinicians, particularly when trying to assist clients with complex co-morbidities. The slow pace of recovery for many clients can influence the clinician's motivation, satisfaction, absenteeism and ultimately clinician turnover. Burnout is often associated with negative and cynical attitudes towards clients and toward health care services in general.

Burnout and emotional exhaustion occur when stressful work conditions are experienced over a prolonged period of time. Signs and symptoms of burnout usually occur in a cumulative fashion and if is not addressed, can lead to a chronic state of stress which may have a more severe impact upon the mental health and functioning of the clinician (Clancy and Terry 2007). The signs and symptoms of burnout are listed on the following page.

Burnout in clinicians managing clients with complex dual diagnoses may result in reduced quality of care and ineffective treatment for consumers. It is important that clinicians working with individuals with dual diagnosis are aware of the impact of clinical burnout and implement strategies to manage emotional exhaustion. Adequate self care will assist clinicians in managing their own stress levels, maintaining hope and providing quality and safe services for clients. Clinicians should engage in adequate stress management, a balanced lifestyle, seek support from peers and regularly engage in clinical supervision in order to reduce potential burnout.

Clinical supervision has preventative and support functions for both the individual clinician and the service (Harms 2007) and will therefore assist in the overall quality of care provided to clients. The role of clinical supervision is the provision of support, debriefing and the management of workplace stress (New South Wales Health 2007).

Queensland Health supports the provision of clinical supervision through current policies and strategies including the practice supervision resource centre for Mental Health Services (MHS), hosted by the Queensland Centre for Mental Health Learning (QCMHL). The role of the centre is to promote and assist in sustaining the implementation of the Queensland Health policy Practice Supervision for Mental Health. This is achieved through encouraging and supporting the provision of effective practice supervision for all Queensland Health mental health clinical staff.

Some agencies may not have formal supervision as part of their workplace structure. However, the provision of supervision is a component of quality care and should be sought by individual clinicians, even on an informal basis, in order to support and enhance their professional development.

Further information

For more information, see Queensland Health policy G5 Practice Supervision in Allied Mental Health (2008) at qheps.health.qld.gov.au/qcmhl/srchome.htm. This policy has been expanded to encompass medical and community-based nurses working in Allied Health.

Regardless of the service sector that clinicians are working within, all clinicians are encouraged to seek out clinical supervision especially if they are working with complex clients.

Table 9 Signs and symptoms of burnout

Behavioural	
Loss of enthusiasm	
Coming late to work	
Not getting much done despite working long hours	
Quick to frustration and anger	
Becoming increasingly more rigid	
Increasing dependence on alcohol and/or other drugs	
Increased withdrawal from colleagues	
Irritation with co-workers	
Difficulty making decisions	
Closing out new input	
Physiological	
Fatigue	Back pain
Irritability	Weight changes
Headaches	Gastro problems
Changing sleep patterns	
Spiritual	
Loss of faith	Despair
Loss of meaning	Changes in values
Loss of purpose	Changes in beliefs
Feelings of alienation	
Clinical	
Cynicism towards clients	Quickness to diagnose
Hostility towards clients	Quickness to medicate
Boredom towards clients	Blaming client
Day dreaming during sessions	

(Extract from Clancy and Terry 2007)

Specific issues for clinicians managing clients with dual diagnoses

As the occurrence of dual diagnosis is often associated with poor treatment outcomes, severe illness and high service use, these clients present a significant challenge for clinicians across both MH and ATODS. In comparison to people experiencing a single disorder, people who experience dual diagnosis have higher rates of physical problems, homelessness, financial difficulties, involvement in criminal behaviour, admissions to acute mental health units, self harm and suicidality (Queensland Health 2003). These factors contribute to the complexity of presentations and clinical outcomes, high rates of relapse and slow progression to recovery. Clients are often seen as lacking insight and demonstrating resistance and a lack of motivation for treatment.

It is important for the clinician to adjust their goals and expectations of treatment to accommodate the stage of change that the client is experiencing. If clinicians work on goals not shared by their clients, their efforts may be met with more resistance and lead to discouragement and a lack of hope.

The use of the Stages of Change Model (for further information refer to Chapter 8) to adequately match the client's presentation, insight and motivation levels to treatment goals, is imperative in order for the clinician to gain some sense of clinical progress and maintain self efficacy.

It is important for clinicians to adopt an incremental approach to treatment and consider the long-term nature of treatment for this client group. Both the stages of change and stages of treatment models have been described in detail in earlier chapters and provide a solid grounding in assessing and formulating treatment goals for individuals with dual diagnosis.

Queensland Health Dual Diagnosis Policy Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) (2008)

Responsibility 15

Staff are provided with **education and skills** in AOD and MH screening and brief interventions respectively, treatment plan development and care coordination services to enable the delivery of fundamental services for people with dual diagnosis in all phases of their recovery.

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Abbreviations

AA	Alcoholics Anonymous
ACT	Acceptance and Commitment Therapy
ADAWS	Adolescent Drug and Alcohol Withdrawal Service
AOD	Alcohol and Other Drug
ARAFMI	Association of Relatives and Friends of the Mentally Ill
ATOD	Alcohol, Tobacco and Other Drugs
ATODS	Alcohol, Tobacco and Other Drug Services
ATOD IS	Alcohol, Tobacco and Other Drug Information System
BBV	Blood Borne Virus
BBV-TRAQ	Blood Borne Virus Transmission Risk Assessment Questionnaire
CALD	Culturally and Linguistically Diverse
CBT	Cognitive Behaviour Therapy
CIMHA	Consumer Integrated Mental Health Application
COPMI	Children of Parents with a Mental Illness
CYMHS	Child and Youth Mental Health Service
DATSU	Drug and Alcohol Treatment Strategy Unit
DSM-IV	Diagnostic Statistical Manual of Mental Health Disorders, Fourth Edition
DSM-IV-TR®	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR®)
FASD	Foetal Alcohol Spectrum Disorder
GP	General Practitioner
HHOT	Homeless Health Outreach Teams
HIV	Human Immunodeficiency Virus

IPT	Interpersonal Psychotherapy
LGBT	Lesbian, Gay, Bisexual and Transgender
MI	Motivational Interviewing
MH	Mental Health
MHAODD	Mental Health Alcohol and Other Drugs Directorate
MH DDC	Mental Health Dual Diagnosis Coordinator
MHS	Mental Health Services
NGO	Non-Government Organisation
OTP	Opioid Treatment Program
PS	Psychosis Screener
PSC	Patient Safety Centre
PSQ	Patient Safety and Quality Improvement Centre
QCMHL	Queensland Centre for Mental Health Learning
QHEPS	Queensland Health Electronic Publishing Service
QTMHC	Queensland Transcultural Mental Health Centre
RBWH	Royal Brisbane and Women's Hospital
SOCRATES	Stages of Change Readiness and Treatment Eagerness Scale
SSRIs	Selective Serotonin Reuptake Inhibitors
WASC–Y	Westerman Aboriginal Symptom Checklist – Youth
WHO	World Health Organization
WHOQoL BREF	World Health Organization Quality of Life

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