Queensland Health Policy

Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems)

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Queensland Government
Queensland Health

Policy statement

Individuals experiencing dual diagnosis or co-occurring mental health (MH) and alcohol and other drug (AOD) problems and their families have multiple and complex needs that require a high level of responsiveness across all services, levels of care and throughout all phases of recovery including engagement, screening, assessment, treatment, rehabilitation, discharge planning and aftercare.

People with dual diagnosis are the core business of mental health and alcohol and other drug services. Effective services for these people, based on their individual needs, rely on the provision of comprehensive, holistic, person-centred interventions and care.

Background

Co-occurring mental health and alcohol and other drug problems, also known as "dual diagnosis", covers a broad spectrum of MH and AOD problems that a person experiences concurrently. The *National Drug Strategy 2004–2009* identifies the need to build strong partnerships between Mental Health (MH) and Alcohol, Tobacco and Other Drug (ATOD) services to enhance responses for people with co-occurring conditions, and the *Queensland Drug Strategy 2006-2010* identifies the need for improved treatment services for individuals with dual diagnosis. The need for a comprehensive approach is also indicated in the draft *Queensland Plan for Mental Health 2007-17* which includes a focus on enhancing services for people with dual diagnosis, strengthening the capacity for cross sector collaboration at a local level, and workforce, quality and safety priorities. This holistic approach is moreover consistent with the recovery model endorsed by Queensland mental health services (Sharing Partnerships for Recovery, 2005)

The provision of integrated care is essential to enable the delivery of effective treatment for people with a dual diagnosis (Queensland Health Dual Diagnosis Strategic Plan, 2003). Integrated care entails the coordination of interactions and relationships within and across services in order to secure the best possible service system response for a person with a dual diagnosis, and does not imply the structural realignment of service systems. At the service level, a core feature of integrated care is the provision of mental health and substance use services in a single setting wherever possible, and if not possible, then linkage with services via agreed clinical pathways should occur. 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, cooperation and effective working relationships between the MH and AOD service sectors and broader network of social welfare services (Queensland Health Dual Diagnosis Strategic Plan, 2003).

The principles and responsibilities outlined below are based on evidence- and consensus-based research and clinical practices for people with dual diagnosis that have been articulated and validated across the mental health and alcohol and other drug treatment fields (COCE, 2006; Minkoff, 2001).

Principles

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.

2. 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 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. Services must facilitate the seamless delivery of mental health 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 a 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 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.

9. Within the treatment context, both mental health and alcohol and other drug problems are **considered of primary importance to the clinical presentation**. As mental health symptoms and alcohol and other drug use can vary over time and strongly interact, both mental health symptoms and alcohol and other drug 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 mental health and alcohol and other drug 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 Islanders, 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 recognized and supported in treatment planning and consumer advocacy.

Scope and application

This policy applies to all Queensland Health Alcohol, Tobacco and Other Drugs and Mental Health Services.

Responsibilities

Services are responsible for providing evidence and consensus-based practices for people with dual diagnosis that have been articulated and validated across the mental health and alcohol and other drug treatment fields, including:

1. MH and ATOD 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.

2. MH and ATOD 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.

3. MH and ATOD 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.

4. MH and ATOD services treat people with a 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.

5. MH 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. This includes the identification of risks for co-occurring problems to interrupt the potential development into an entrenched diagnosis

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.

7. 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 MH services, ATOD services or with other health services (eg. 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.

8. Where MH and AOD disorders are **both of moderate-high level severity or complexity**, MH services 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 ATOD services is to occur via agreed clinical pathways. Co-case management or shared care with respective service providers is 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.

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.

10. Assessment of co-occurring conditions includes a **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.

11. MH and ATOD 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. This involves the delivery of treatment using a 'stepwise' approach (eg. engagement, persuasion, active treatment, relapse prevention), stage-specific treatment within the context of a person's stage of change and phase of recovery (acute stabilization, motivational enhancement, prolonged stabilization, rehabilitation and recovery).

12. The development of a **comprehensive treatment plan**, including regular review of the treatment plan, involves the person's active participation wherever possible. According to the provision of consent, primary carers, family or significant others involved in a person's care are actively involved in decisions about treatment and care.

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.

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.

15. MH and ATOD 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.

16. MH and ATOD staff provide integrated care in accordance with the **unique needs of special populations** such as youth and young people, aboriginal and Torres Strait islanders, culturally and linguistically diverse populations, women and older people.

17. MH and AOD 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. If required, referral should be considered to child-centred services (e.g. Child Health, Child and Youth Mental Health Services, private practitioners, non-government organisations) to enhance the well-being of children in the care of adult clients. All health professionals are obligated to report a reasonable suspicion of child abuse and neglect to the Department of Child Safety.

Definitions

- Dual diagnosis or co-occurring conditions are defined as the co-occurrence of two or more disorders or problems, at least one of which is a mental health problem and at least one of which relates to the use of alcohol and other drugs.
- Integrated care refers to the provision of treatment for both MH and AOD problems by a single clinician or treatment 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 Alcohol, Tobacco and Other Drug and Mental Health services 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 MH and AOD problems is determined by the range and impact of an individual's presenting symptoms on their *level of functioning*, rather than diagnosis alone.

References

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Queensland Health (2005). *Sharing responsibility for recovery: Creating and sustaining recovery orientated systems of care for mental health*. Queensland Government, Brisbane.

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Effective date

September 2008

Compliance

All Queensland Health Mental Health Services and Alcohol, Tobacco and Other Drugs Services are expected to comply with this policy.

Review cycles and responsibilities

Biannual review by Queensland Health Mental Health Branch and Alcohol, Tobacco and Other Drug Branch.

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