# Contrasting approaches to dual diagnosis from Australia and other countries

**Dr Enrico Cementon**

**VDDI Forum WHAT'S OLD IS NEW AGAIN?**

**25 October, 2016**

# My 14 years with SUMITT & VDDI

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

www.dualdiagnosis.org.au
www.dualdiagnosis.ning.com

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# Victorian Health Department responses to dual diagnosis

**2007**

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

**2012**

Chief Psychiatrist's investigation of inpatient deaths
2008–2010

**2013**

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

**2014**

Victoria's new Mental Health Act 2014

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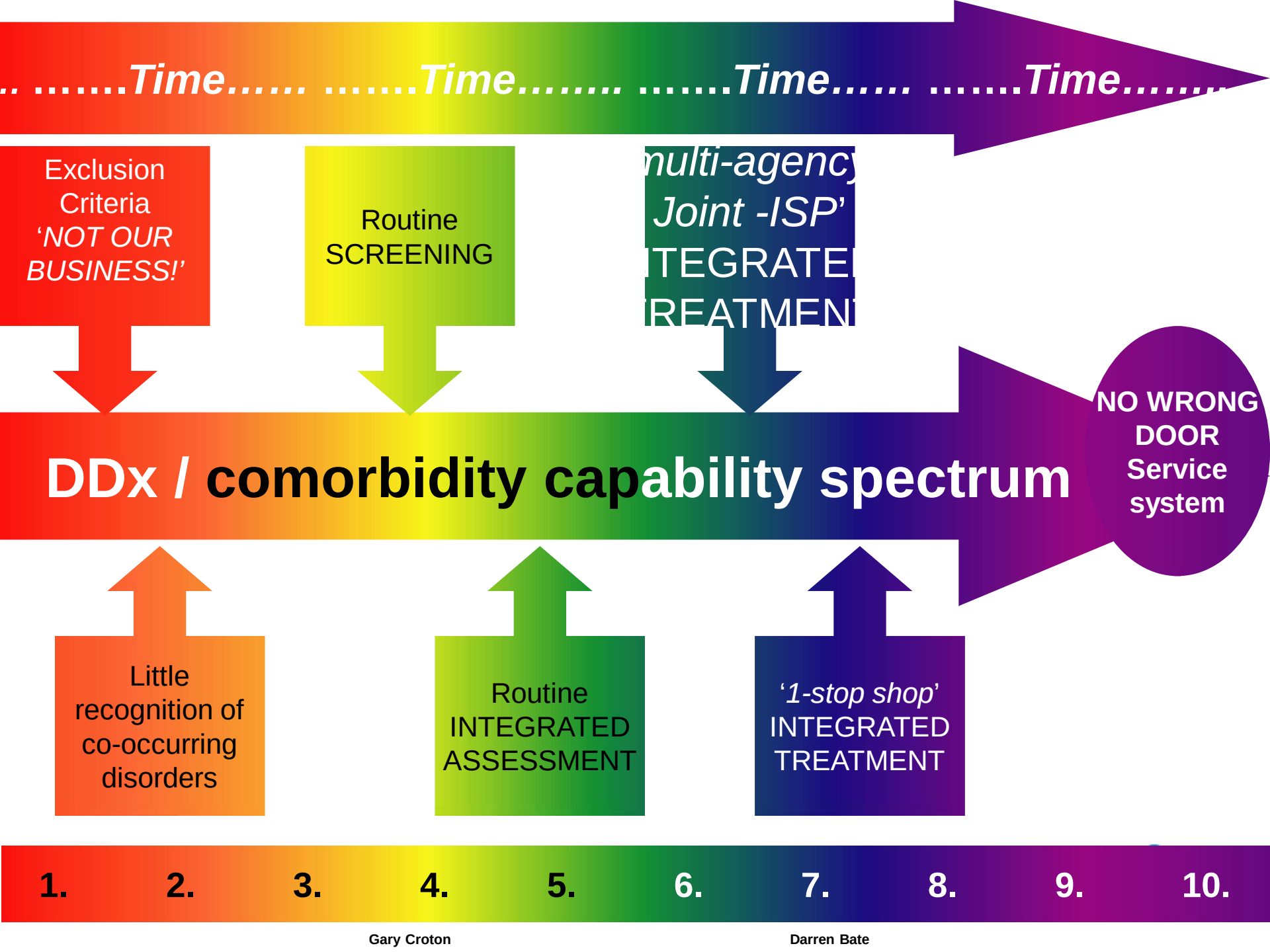
# I grew up in 2 silos in Victoria

MH services

AOD services

# Parallel treatment


.. .....Time..... .....Time..... .....Time..... .....Time.....
Exclusion Criteria 'NOT OUR BUSINESS!'
Routine SCREENING
multi-agency Joint -ISP' INTEGRATE TREATMEN
DDx / comorbidity capability spectrum
NO WRONG DOOR Service system
Little recognition of co-occurring disorders
Routine INTEGRATED ASSESSMENT
'1-stop shop' INTEGRATED TREATMENT
1. 2. 3. 4. 5. 6. 7. 8. 9. 10.
Gary Croton
Darren Bate

# Victorian Dual Diagnosis Initiative when I finished up at SUMITT 2014

- High profile
  - High prevalence, ‘the expectation, rather than the exception’
- Widespread screening & assessment
- Low adoption of integrated treatment models
  - Psychiatrists’ and other clinicians attitudes
  - Stigma of AOD misuse
  - Reluctance to adopt ‘No Wrong Door’ or DD as ‘core business’
  - Interprofessional cultural conflicts
  - Few resources to support government policy

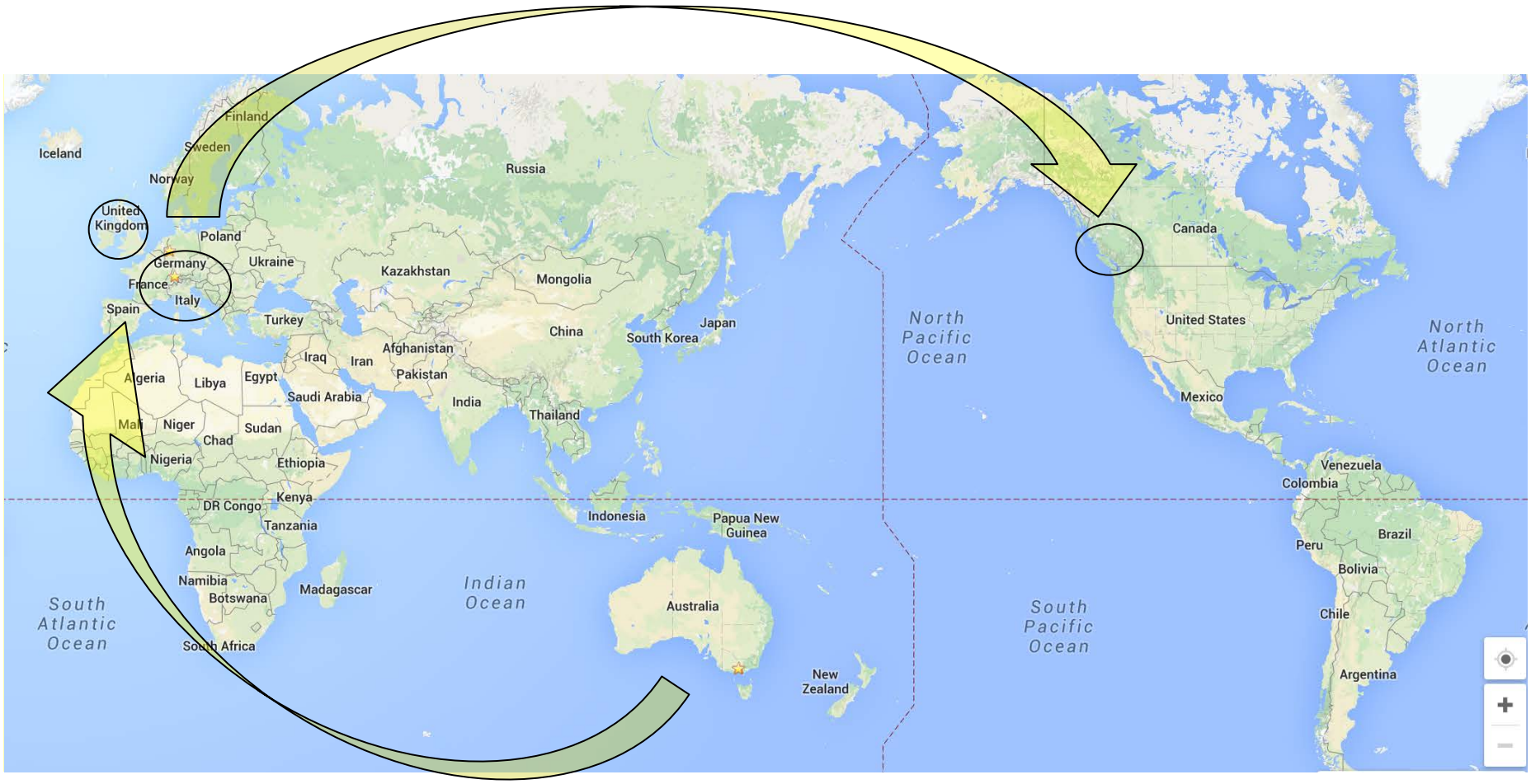
*Roberts & Mayberry (2014)*

# What assists clinical services in becoming dual diagnosis capable?

- Clinical leadership
  - Clinical practice changes
- Training & education
  - Acquiring new competencies
- Communication
  - Partnerships & agreements between services
- Institutional support
  - Policies, resource allocation

*Brouselle et al (2010)*

# What is the international approach to dual diagnosis & integrated treatment ???




Zurich, Basel, Monza, Modena, Bologna, Pisa, Leeds, Birmingham & Vancouver

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# Features of integrated approaches

- Resourcing
  - Human
  - Financial
- Integration or co-location of AOD & MH services
- Clinical programmes
- Supervision
- Workforce development
- University affiliation
- Research

# Good resourcing

- Human
  - Physicians as clinical leaders
  - Psychiatrists, GPs, addiction & infectious disease physicians
  - Nursing & Allied health: psychology, social work, health assistants, ‘Recovery practitioners’
- Financial
  - State-funding often inadequate
  - Insurance schemes

# Integration or Co-location of MH & AOD services

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

# Clinical programmes

- **Longer-term options**
  - Stabilisation, detox & rehab
  - Diagnostic clarification


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- **Outreach**

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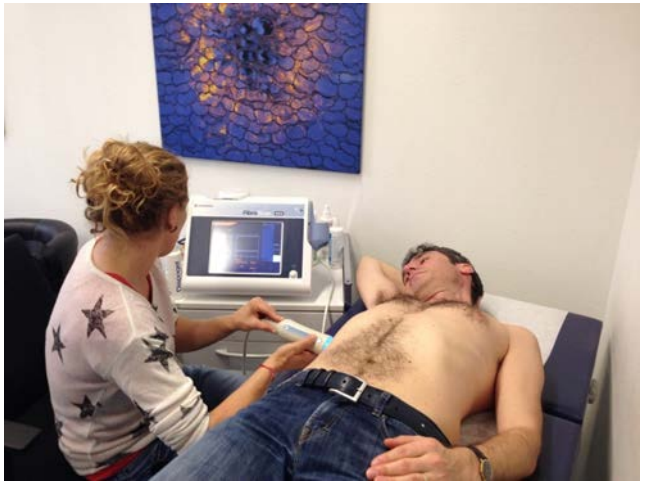
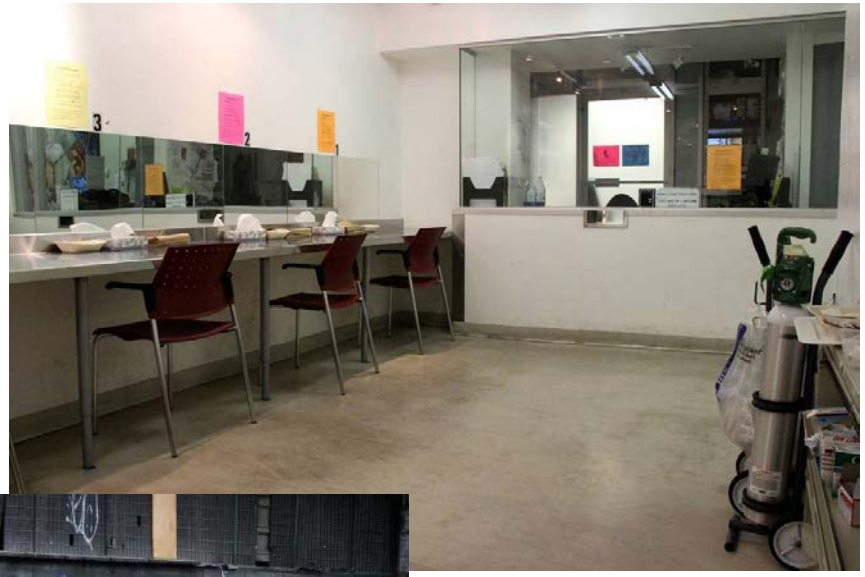
- Longer-term options
  - Stabilisation, detox & rehab
  - Diagnostic clarification
- Outreach
- Day hospital
- **General medical** e.g. BBV

# Clinical programmes

- Longer-term options
  - Stabilisation, detox & rehab
  - Diagnostic clarification
- Outreach
- Day hospital
- General medical e.g. BBV
- Forensic
- Supervised consumption rooms
- Links with mutual help groups e.g. AA/NA/Smart

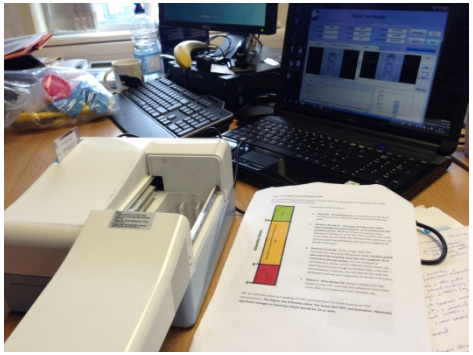
# Supervised drug consumption rooms

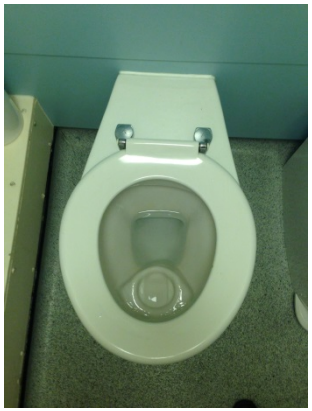



# Psychosocial therapies

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

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





# Pharmacotherapies


- Low v medium threshold OST
  - Methadone v Suboxone v LA Morphine
- Tobacco cessation
- Novel therapies
  - Heroin substitution
  - GHB
  - Ropinirole


# Supervision & Workforce development

- Dual diagnosis teams
  - ‘Compass’ in Birmingham
  - When integrated services not present
- Supervision of staff & trainees
- Training & education
  - Multiple levels: basic compulsory, advanced targeted, specialist embedded in specific teams e.g. Early Intervention
  - Addiction psychiatry specialty not widespread

# University affiliation & Research

- Neuroscience of addiction
- Clinical treatments
  - Psychosocial
  - Pharmacotherapies
- Collaboration with other departments
- Teaching
  - Under-graduate & post-graduate

# Barriers & future challenges

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

# Conclusions

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

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

# Acknowledgments


| | |
|---|---|
| *Zurich* | *Dr M. Herdener* |
| *Monza* | *Prof M. Clerici* |
| *Modena* | *Assoc Prof G. Galeazzi* |
| *Pisa* | *Prof I. Maremmani* |
| *Leeds* | *Dr G. Tober* |
| *Birmingham* | *Prof A. Copello* |
| *Vancouver* | *Assoc Prof C. Schutz* |

# Thank you!

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