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“Shared Care” – INTRA’s Dual Disorder Program

Introduction

In 1999, The Buttery Inc. was successful with a submission made to the Commonwealth, under the National Illicit Drug Strategy. From this funding emerged INTRA. Our brief is to provide outpatient drug treatment to the area defined as the Northern Rivers. This ranges from Grafton to Tweed Heads, from Byron Bay to west of Kyogle and includes towns such as Nimbin, Casino, Lismore and Ballina.

Insight Network Treatment Axis, or INTRA is one of three Buttery Inc. Programs. It co-exists within an organisation that provides drug rehabilitation in a therapeutic community and an area wide gambling addictions counselling service.

INTRA, was created as a response to the obvious service gaps being identified by health professionals and the community in regional northern NSW. These gaps were for drug treatment in the areas of cannabis dependence, relapse prevention, individual and family support and not surprisingly Dual Disorders.

In today’s presentation I will provide you with an overview of how INTRA has approached the challenge of moving beyond the rhetoric of proclaiming a need to address the issues of working with Dual Disorder clients, to actually working with them and other agencies whose primary experience is dealing with the comorbid presentation of a mental health disorder and problematic substance use.

I will briefly describe the defining characteristics of the area in which I work, the Northern Rivers, then move on to a description of INTRA’s model for approaching dual disorders. This will include a comprehensive overview of the program we have developed.

Next I will provide a critical examination of what we have attempted and achieved, to be followed by an indication of where we consider our future efforts need to be focused.

Background

To begin I would like to provide a brief overview of some of the conceptual foundations INTRA has drawn upon in developing a treatment response.

Firstly, terminology:

- Dual disorder or dual diagnosis can refer to the co-existence of any two disorders. In my discussion I will use the term Dual Disorder to refer to the co-existence of a mental health disorder and a substance use disorder.
- There has been considerable discussion in the literature as to what is an appropriate term, which mental health disorders are to be included and what constitutes a substance disorder. Whilst this debate is of importance, it is not the focus of my paper.
- For my purposes, dual disorder refers to the simultaneous presentation of a mental health disorder and a substance use disorder.

Secondly, identification of the target group:

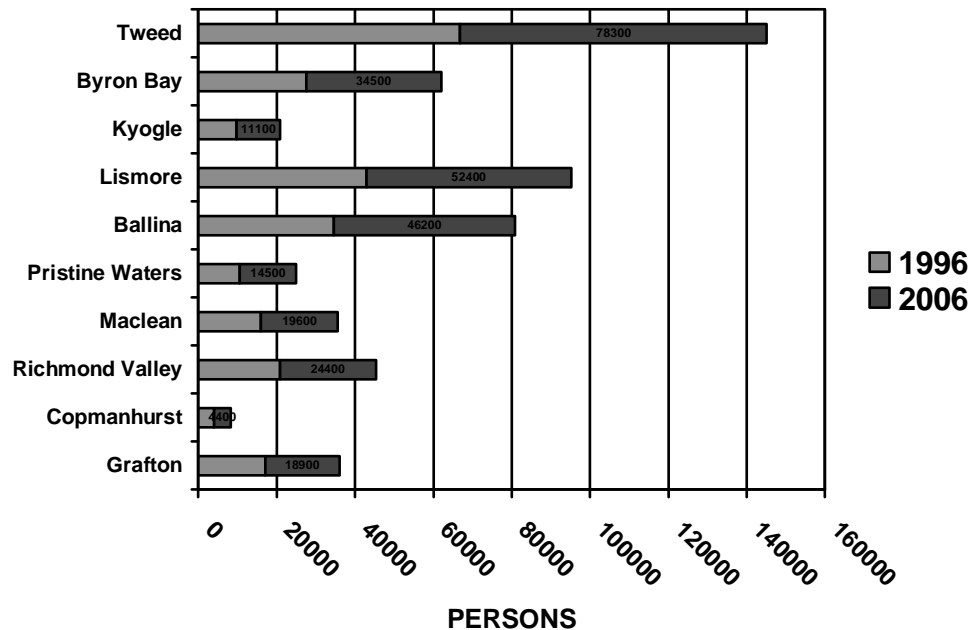
- Many of the individuals who access INTRA programs, other than the Dual Disorder program, identify as having experiences of depression or

anxiety, and many report taking medication prescribed by their doctor for these affective disorders.

- Due to our underlying goal of addressing the needs of clients who often fall through the network of available drug treatment, INTRA's DD program has targeted clients with severe mental illness and substance dependence.

The environment in which we operate:

- The Northern Rivers covers and area of 24,896 sq. kms.



- In 1996 the population was 250,040 and the projection for 2006 is 304,300
- The projected growth in Tweed, Ballina and Byron is of major interest to us as we become increasingly aware of the levels of need for drug treatment in these areas.

Drug Use:

From a summary of statistics prepared by the Premiers Dept. for the Community Drug Action Teams, the following points were made in relation to the Northern Rivers:

- Estimated 2% of population use drugs at hazardous/harmful levels;
- Approx. 4290 people with substance use disorders;
- Estimated 1.7% of total NRAHS hospital admissions are drug related;
- Between 1992-1996 3rd highest rate in NSW for heroin deaths (25); and
- Highest rates of HIV and Hepatitis C in regional NSW.

When comparing all rural areas of NSW between 1997 and 1999, the Far North Coast has the highest rate for:

- Possession and/or use of narcotics (only slightly lower than rate for Sydney);
- Possession and/or use of cannabis;
- Dealing/trafficking in narcotics; and
- Cultivation of cannabis (this has fallen slightly).

Sources: Northern Rivers Areas Health Service documents and Australian Institute Of Criminology

Mental Health

Epidemiological data on the status of mental health in the Northern Rivers is not available, however, one can assume that the trends reported in national and international studies are present in this area.

The prevalence of the common mental disorders such as anxiety, affective and substance disorders are of a magnitude to warrant our immediate attention.

These figures come as no surprise to INTRA as I mentioned earlier many clients attending other programs identify as having affective disorders. From data collected at assessment, 40% of all clients identify as having a history of mental illness.

If we turn to the severe mental disorders, the National Survey of Mental Health and Wellbeing report titled *People Living with Psychotic Illness: An Australian Study 1997-98*, it appears that:

- 4.7 persons per 1000 adults contact mental health services in any month because of symptoms of a psychotic disorder;
- Schizophrenia and schizoaffective disorder accounts for over 60% of the prevalence of psychotic disorders;
- A dual disorder was found in every fourth person (25%); and
- Fewer than (1%) reported having used services for alcohol and drug detoxification, counselling or rehabilitation. But 60% had used outpatient care of some sort.

A further source from which we can draw local data is Corrective Services and in particular The Probation and Parole Service Special Needs Survey of May 1999.

The Survey examined and identified the issues pertaining to probationers and parolees from ten district offices, of which Lismore was one, and who met criteria for 'special needs'. The survey states;

The majority (57%) of offenders were classified as having a 'mental/psychiatric illness and/or drug/alcohol induced psychosis',...

The survey reports that Lismore has the highest percentage of special needs clients (20% of the total caseload) with 67% of these clients falling into the category with a mental illness and/or drug induced psychosis. This compares with an average of 7% of offenders under supervision meeting the criteria of "special needs".

So, in summary, we have a large rural area, with several townships experiencing significant growth. An area in which drug use is high and the prevalence of mental health problems at least equal to if not higher than other regional centers in NSW.

Where do all these facts lead us?

When faced with such high incidence of dual disorders, and in particular a group of clients that consistently report problematic substance use and at the same time do not use AOD services we are compelled to respond.

Historically in our area the mental health and drug and alcohol services have operated independently. They are separately managed and funded. Both the

government and non-government sectors provide either AOD treatment or Mental Health services.

INTRA is the only organisation providing a specific Dual Disorder Program as an integral component of its overall drug treatment service.

More recent developments under the Second National Mental Health Plan indicate a desire to change and we have seen several projects initiated. Unfortunately this does not guarantee the permanent inclusion of dual disorder treatment as organisations continue to receive non-recurrent grants.

Common complaints from workers in the field are the lack of services to which a client can be referred. Frequently workers from both sectors acknowledge a sense of frustration with identifying a client with a dual disorder and then feeling they must navigate a treatment path without access to or the support of the resources from the "other" side.

Burgeoning caseloads, increasing demands on services and little if any cross-sectoral contact creates a stalemate where clients are either caught in the ping pong of referral back and forth from Mental Health to AOD or they disappear until crisis time and a relapse in one or both disorders finds them readmitted to hospital.

This works for no-one. Clients not being well serviced and workers are left feeling dissatisfied with their own services that fail to address the issues a client presents.

We must ask ourselves, "Why?" What stops the mental health worker exploring substance dependence with the client? Why doesn't the drug and alcohol counsellor speak with the client about medication and psychiatric symptoms? Some of the answers to these questions have become evident through our experience of implementing the program and I would like to discuss this in more depth after I describe for you what we have been doing.

The Development of the Program

As INTRA set upon the search for how to change this impasse we were able to be guided by Reports from NSW Health such as the *Discussion Paper and later Service Delivery Guidelines for The Management of People with a co-existing Mental Health and Substance Use Disorder 2000*.

Perhaps one of the unique characteristics of INTRA's approach to the issue of Dual Disorders is that we are operating on two planes. The first is at the clinical level, providing direct treatment to clients whilst the second is at a systems level, by promoting organisational change. It is because of this two-pronged approach to the issue that we have been able to not only experience the satisfaction from working with clients in a productive manner, but also maintain our optimism that the time has arrived for the literature reviews to cease and the action to occur.

There are a number of underlying principles that are fundamental to INTRA's model of service delivery. These can also be seen at the clinical and organisational level.

Clinical principles

- Concurrent treatment of both disorders;
- Assertive engagement and follow-up; and
- Adoption of a harm minimisation approach.

Organisational principles

- Integrated care – coordination of treatment plan; and
- Education and training – exchange of knowledge.

When we translate these principles into treatment it becomes evident that shared care is the most appropriate model for INTRA to adopt.

“Shared Care” means bringing together the mental health and the drug and alcohol clinicians in providing a streamlined treatment program that addresses both mental health and substance use disorders.

To address these principles INTRA has employed the following strategies:

- Treatment groups for clients;
- Co-facilitation of groups for workers from mental health agencies;
- The development of partnerships with other agencies; and
- Training for community, including workers, volunteers.

The Treatment Groups

- The groups are run in 8 week modules;
- The group program utilises the stages of change model developed by Prochaska and DiClemente.(1986) and when applied to both disorders, this guides us through treatment; and
- The program consists of five phases. Each phase can be identified by distinct client characteristics that relate to their stage of change. With the objective of the program being to move through the phases, the goal of each phase must address the primary characteristics of the stage of change.

1. Engagement Phase

- A pre-group interview is conducted before the group sessions begin. This provides both the facilitators and the participants an opportunity to begin the engagement process.
- In this phase the client may be in the pre-contemplative stage.
- The goal of this phase is to build rapport with the client and consolidate commitment to participation in the program.
- Accurate information about substances is provided to increase the individual's insight to his/her pattern of substance use.
- Clients are encouraged to openly discuss their experiences of having a mental illness.

Once participants begin to disclose more about their personal use of substances it is possible to move into the next phase. For some time, clients may move back and forth between the pre-contemplative and contemplative stages.

2. Engagement – Assessment Phase

- A gradual shift from the pre-contemplative to the contemplative stage begins to occur and prevails for longer periods.
- Engagement remains important, new members continue to join the group.
- Formal assessment of the client's real level of current drug use.
- Considerable discussion about medication and mental health.
- For those in the contemplative stage introduce elementary motivational interviewing strategies and goal setting.

3. Skills Development Phase

- Clients move through the determination-action stages of change.
- Not all participants progress to the action stage at the same pace.
- Participants with greater insight to their substance use and mental illness act as positive role models.
- Skills development to enhance the individual's effort to achieve personal goals. Emphasis is given to increasing the client's sense of self-efficacy.

These sessions may continue over a number of weeks dependent upon the needs of the client group. It is imperative that workers accept the need for patience.

4. Maintenance Phase

- This phase is characterised by a change in the behaviour of the client.
- Client may wish to re-negotiate his/her goal.
- The goal of this phase is to provide support and maintain the individuals commitment to the change.
- Reinforcement of the positive consequences and the individual's achievements is inherent to intervention at this time.

When stability is maintained, even for a short time frame, the concepts of the next phase may be introduced.

5. Relapse Prevention Phase

- The client may be stable in his/her use of substances however it is appropriate to introduce basic relapse prevention strategies.
- De-mystification of relapse is emphasised by introducing it as one of the stages of change.
- Individuals are encouraged to identify high-risk situations and to establish a network for support if relapse becomes a problem.
- Emphasise the relationship between relapse in mental illness and substance use.

As you will be aware treatment with this client group needs to be long term. In order to translate that into a manageable form, we run eight-week modules and encourage participants to continue through modules. A discrete number of sessions provide participants with a sense of completion which can be denied them if the program is endless.

The introduction of new clients to the group adds a dimension to the program that is both challenging and exciting. It requires good facilitation skills to maintain the group structure and progress through the phases. However older members may act as positive role models. The repetition of educative sessions is never a lost opportunity and the chance to practice skills in the skills phase is always important.

The Outcomes

The work we have done has not been undertaken as a research project. We don't have control groups to compare individuals, nor are we in a position to conduct extensive pre and post-tests. What we do have however is the qualitative data that we collect from the clients and clinicians with whom we have worked. We collect this in the form of self-reporting feedback sheets, completed at the end of each group program. I believe this data to be of significance and will now share this with you.

Since commencement of the program in September 1999:

- 53 clients have been involved with the service.

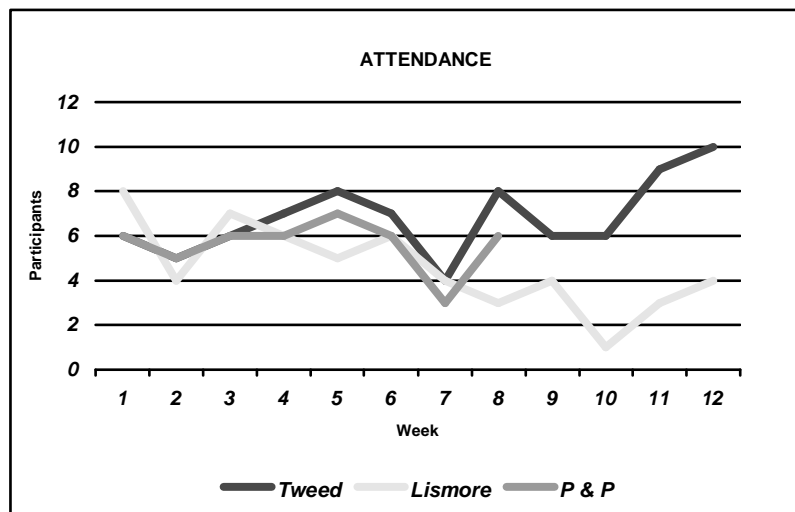
- One third of clients have reentered treatment after completing one program.

A non-confrontational approach with lots of emphasis on the engagement of clients is a major factor in success.

Frequently clients are seeking to re-engage. Unfortunately, in some instances, due to the constraints of our resourcing, the continuity of treatment is broken.

Number of people attending each week for Tweed/Lismore/PP:

- Attendance rates vary however trends are noted with peaks in the middle weeks (4,5,6)
- The average number of consultations per client is 6



Interestingly Tweed had higher attendance rates than either Lismore group. Most likely explanation is the benefit gained from working closely together with the MH NGO in referral, follow-up, support and co-facilitation.

Our experience has not been that clients are difficult to hold in groups. The style of the group and the approach taken by the workers has a lot to do with this.

Self report reduction in the harm caused by drug use:

- Clients complete an evaluation questionnaire at the end of the eight weeks. On a simple likert scale clients are asked if they have made any changes to their drug use and secondly if they intend to make any changes.
- From the Tweed pilot 100% indicated a change 100% indicated a definite intention to continue change
- From Lismore 75% indicated making a change 100% would like to continue change
- From P&P group 83% indicated making a change with 50% indicating a definite intention to change, the other 50% stating a possible intention for change.

Increased knowledge about harm:

- From the questionnaires it becomes obvious that what most impresses individuals is their heightened awareness of the interaction effects between using and becoming unwell. Most common answers are the using drugs can heighten the less desirable emotional states, lead to “losing the plot” “spinning out” “not coping”.

- The link is less often drawn between using and readmission to hospital.

What have we achieved with other agencies:

- Developed a formal working partnership with P&P;
- Increased the profile of the issues faced by dual disordered clients;
- Assisted in broadening the skills base of workers in relation to AOD issues;
- Normalised and encouraged the practice of working with dual disorder clients;
- Started to close this cultural divide; and
- Alleviating some of the pressure MH workers experience when they know a client is at risk by providing a forum for clients to address substance use issues.

What have we achieved in the community:

- Providing information and education about the nature of the relationship between using and mental illness;
- Assisted in demystifying the issues of drug use and drug treatment; and
- Challenged personal values around explanations for the high prevalence of use.

As mentioned earlier, in the course of implementing the program we have become aware of some of the reasons why an integrated dual disorder program has not previously been sustained in the Northern Rivers.

The difficulties we have faced can be categorized in three groupings:

1. Cultural

- There is a perception that this is Health core business and it needs to be dealt with "in-house" This tends to exclude rather than include NGOs;
- As a new NGO not readily included in the referral scheme;
- Being recognised as a credible service provider is taking time; and
- Gaining meaningful support from Health managers is difficult-little evidence of genuine commitment to change through resource allocation.

2. Organisational

2.1 Resourcing

- Limitations to what can be done due to our own resource issues;
- When there are constraints on resourcing this can stifle service development. For example, funding a multitude of short term pilots without a view to recurrent funding; and
- The difficulty in making staff available from both the government and non-government sector in participating in the program.

2.2 Policy

- The ambiguity of demarcation between services for responsibility for coordination of care. Examples need policy to support the actualisation; and
- Policy needs to reflect achievable expectations.

2.3 Professional

- Separation of professional ideology: Mental health and drug and alcohol were separated in the 70s and now there is a reluctance to rejoin these areas; and
- Need to remove the perception that the "work" is so different.

Bridging the Divide

What needs to happen for change to occur?

1. These are complex clients with complex needs who should not be served by one agency or worker alone. These clients benefit from the input of a variety of services however the service delivery needs to be coordinated if it is to stop the current experience where this client group remains disenfranchised from the health services we expect to be offered in an equitable and accessible form. We cannot continue to expect existing systems to somehow adapt just because we know it's a good idea and it has been said again and again and again.
2. Whilst it is essential that policy within agencies reflect a commitment to providing care to individuals with dual disorders, we need to acknowledge that it is not enough to direct change through documents, we have enough of those, but to support change through enabling staff to engage in the new ways. That is, support them in forming the partnerships and actualising the sharing of care.
3. To do this there needs to be recognition of the current situation that staff from all sectors are operating in an environment of high demand for their services. To expect staff to accommodate the types of changes to their work practice that are necessary for integrated treatment such as put forward by NSW Health in the Service Delivery Guidelines, whilst maintaining existing resourcing levels, is at best unreasonable and at worst setting workers up for failure. Resources need to be made available to those willing to initiate change
4. We need acceptance that change, for both individuals and organisations, comes about by doing not just stating intention.
5. The experience we have at INTRA is that the NGO sector can be utilised as the catalyst to change.

We are willing to initiate change
We are capable of initiating change
The challenge is, support us in realising change