Comorbidity

towards evidence based practice in the ATOD sector

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# List of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Terms</td>
<td>iv</td>
</tr>
<tr>
<td>Preface</td>
<td>v</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>1</td>
</tr>
<tr>
<td>Introduction: The Complexities of Comorbidity</td>
<td>2</td>
</tr>
<tr>
<td>- What is Comorbidity?</td>
<td>2</td>
</tr>
<tr>
<td>- How Widespread is Comorbidity in Australia?</td>
<td>2</td>
</tr>
<tr>
<td>- The Complexities of Comorbidity</td>
<td>4</td>
</tr>
<tr>
<td>- Talking with Children and Young People about Parental Comorbidity</td>
<td>4</td>
</tr>
<tr>
<td>- Prioritising Safety: The Necessity of Risk Assessment and Management</td>
<td>5</td>
</tr>
<tr>
<td>What Doesn’t Work: Challenges and Barriers to Best Practice Services</td>
<td>7</td>
</tr>
<tr>
<td>What Does Work: Towards Evidence Based Practice</td>
<td>10</td>
</tr>
<tr>
<td>- What is Evidence Based Practice?</td>
<td>10</td>
</tr>
<tr>
<td>- Effective Interventions</td>
<td>11</td>
</tr>
<tr>
<td>- Integrated Care</td>
<td>17</td>
</tr>
<tr>
<td>- Re-framing Recovery</td>
<td>18</td>
</tr>
<tr>
<td>Emerging Issues and Future Directions</td>
<td>21</td>
</tr>
<tr>
<td>- Not Just Crisis Management</td>
<td>21</td>
</tr>
<tr>
<td>- Advocacy, Consumer Participation and Empowerment</td>
<td>21</td>
</tr>
<tr>
<td>- Broadening Support Networks: Carer Input and Family Sensitive Practice</td>
<td>24</td>
</tr>
<tr>
<td>- Comorbidity as a Priority for Future Social Research Agendas</td>
<td>25</td>
</tr>
<tr>
<td>- The Necessity of Principles-Driven Practice</td>
<td>26</td>
</tr>
<tr>
<td>Conclusion</td>
<td>27</td>
</tr>
<tr>
<td>- Towards Evidence Based Practice – Comorbidity Guidelines</td>
<td>27</td>
</tr>
<tr>
<td>Appendices</td>
<td>29</td>
</tr>
<tr>
<td>- References</td>
<td></td>
</tr>
<tr>
<td>- Information Resources</td>
<td></td>
</tr>
</tbody>
</table>
List of Tables and Boxes

Table 1: Type of Mental Illness and Most Common Type of Co-Occurring Substance Misuse 3
Table 2: ATOD Practitioner Evidence Checklist Tool 10
Table 3: Useful Questions and Statements for Motivational Interviewing 12
Table 4: Communication Examples in Motivational Interviewing 12
Table 5: A Hierarchical Illustration of Levels of Client Participation 22
Table 6: Strategies for Consumer Participation – Matching Purpose with Method 23

Box A: Case Study: Integrated Treatment Example 18
Box B: Key Competencies for Practitioners 20

KEY TERMS

- **Comorbidity** – a medical term for the co-existence of more than one problem, in this case, the co-existence of substance misuse and mental illness.

- **Substance Use** – the act of taking a drug, where there may be the presence of some risk, but this does not necessarily infer it is wrong, harmful or illegal.

- **Substance Misuse** – implies use outside of medical use and which is harmful or done in a wrong way. It refers to drug use that is dependent or part of a problematic or harmful behaviour.

- **Dual Diagnosis** – the diagnosis of both a substance use disorder and a psychiatric disorder in the individual, often used interchangeably with the term ‘comorbidity’.

- **Consumer** – a person with a mental illness and/or other complex needs who is a service user or participant. The term is an affirmation of their rights and capacity to receive a service, rather than being seen as passive.

- **Evidence Based Practice** – a term describing practice, theories, tools or interventions that are supported by an evidence base containing credible research and verified practice; practice that has been evaluated. Evidence based practice involves integrating individual expertise and the conscientious and discerning use of the best available research evidence.
Preface

Evidence based practice is an increasing focus in the alcohol, tobacco and other drugs [ATOD] sector. Yet a feature of work in this field is that practitioners usually do not have much time to read widely across the research literature. Upon consultation with staff at The Salvation Army Bridge Program, it was decided that the format of this resource should be as practical and user-friendly as possible. The literature review, therefore, has been designed in report format to enhance accessibility and relevance to practitioners across the alcohol, tobacco and other drugs sector. Case studies, boxes, tables, and dot points have been used to emphasise key pieces of information to inform everyday practice and work situations.

Although no data collection was undertaken in the compilation of this report, the ‘voices from the field’ coloured verbatim quotes have been chosen from various sources to highlight real life first-person perspectives. It is from both a philosophical and practical viewpoint that this is the case because the overall objective of this report is to inform and enhance the knowledge of practitioners to better support people with co-existing mental illness and substance misuse. The report would not be complete without hearing the voices of all parties concerned, especially being inclusive of those who experience comorbidity.

Throughout the document, there are various terms that can be used interchangeably. The ‘key terms’ box of definitions is located earlier in the document, and it contains specific definitions and explanations. It is acknowledged that the preferred choice in this report is to refer to people with a mental illness and people with a co-existing mental illness and substance misuse as ‘consumers’. This term is commonly used in countries such as Australia and New Zealand, and has arisen out of the broader health movement towards affirming the active participation and agency of people who choose to receive or participate in services. Past terminology carried stigma or portrayed this group in a passive manner, whether directly or indirectly. However, ‘consumer’ is not a global term. In other countries, there are different terms used instead to describe the same movement towards empowerment. For example, in the United Kingdom (and UK publications that are quoted in this report) it is more common to refer to ‘service users’ or ‘users’, and another term is ‘participants’. Some authors and publications cited in this report choose to refer to ‘clients’ because they are writing strictly from a services and practitioner-specific perspective. Use of the term ‘patient’ has been, overall, avoided because of its perceived strong medical inference and connotations in light of deinstitutionalisation. In summary, it is important to acknowledge these distinctions because different terms carry different connotations for different people. These issues are further highlighted in introductory discussions around how to define comorbidity.

The report is also available online at the Criminology Research Unit website, under the heading of ‘Comorbidity Improved Services Capacity Building Project’. Go to http://www.utas.edu.au/sociology/CRU/cru.html

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Executive Summary

The co-existence of mental illness and substance misuse – commonly known as ‘comorbidity’ or ‘dual diagnosis’ – is a pressing issue on a number of fronts. The impact is most profound for consumers and their families. Yet there are also significant implications for the practitioners who seek to engage them in services by offering therapeutic support and interventions, which, in turn, have a broader bearing on the communities in which they live.

Comorbidity is quite common, in fact, some commentators argue that it should be the expectation and not the exception. In Australia, rates of comorbidity are between 40-60%, with variation dependent on where and how the rates were counted. These percentages represent complex challenges for agencies who support this group in one of the two areas, highlighting the importance of equipping practitioners who work with this group to have adequate ‘tools’ in the toolbox to effectively engage them. Common tools also aid collaborative service provision between agencies and across sectors.

In the literature, several psychosocial interventions emerge as effective in the treatment and support of people with comorbid substance misuse and mental illness. These include (but are not limited to):

- Motivational Interviewing
- Cognitive Behavioural Therapy
- Anger Management
- Relaxation Techniques
- Relapse Prevention
- Skills Training and Strengths Based Rehabilitation
- Short term residential rehabilitation with integrated treatment

The majority of the above techniques are discussed in more detail in the ‘Effective Interventions’ section of the report.

The development of evidence based practice is emerging as increasingly important in the alcohol and other drugs sector because of its contribution to sustainable good practice and workforce development.
Introduction: The Complexities of Comorbidity

What is Comorbidity?

The term ‘comorbidity’ is a clinical word referring to the co-existence of more than one problem or disorder (physical and/or psychological); however, it is most commonly used to refer to the co-existence of mental illness and substance misuse. It is often interchanged with the term ‘dual diagnosis’. In both definitions, substance misuse includes licit or illicit drugs.

“Dual diagnosis is a label they give you, but even at my most buoyant I think I’ve got more than two problems.”
(Comorbid Consumer, in Hawkings & Gilburt 2004: 2)

Another term that is used frequently to complement comorbidity is ‘complex needs’, stemming from the recognition that individuals may have a constellation of needs in multiple domains. In fact, dual diagnosis has been labelled as ‘a generic index of complexity’ (Rasool, 2002: 134).

Despite commonality of terminology, there are different perspectives on dual diagnosis, posing some methodological issues for the various disciplines involved (Todd, Green, Harrison, Ikuesan, Self, Baldacchino, & Sherwood, 2004).

How Widespread is Comorbidity in Australia?

In relation to rates of mental illness, one in five Australians will experience mental illness in their lifetime (Australian Bureau of Statistics [ABS], 2005). In terms of illicit drug use, a quarter of the Australian population over the age of 14 have reported use of illicit drugs in the 12 months prior to the survey (ABS, 2002). However, there is less available data measuring the specific prevalence of the co-existence of disorders in the Australian population.

Determining the prevalence of comorbidity is difficult because of a lack of integration between the mental health and the alcohol and other drug sector (Gournay & Johnson, 1997; Department of Health & Ageing, 2003). There are significant issues with realistically ascertaining its incidence and prevalence (both at a state level and nationally) because this data is gathered at a service level. Overall under-reporting occurs due to factors such as ‘poor identification of dual diagnosis, a narrow service focus on either mental health problems or drug and alcohol problems’, poor data compliance, and different ‘rules for the recording of substance use and disorder’ (Department of Human Services Victoria, 2007: 6).

However, from the relatively limited amount of research and statistics available in the public domain, it is possible to denote that rates of comorbidity are high and are rising. The lifetime cross-over between substance misuse and mental illness is generally between 40-60%
(Daley & Moss, 2002; Andrews, Issakidis, & Slade, 2003; Mueser, Noordsy, Drake, & Fox, 2003). In a census of registered mental health clients in Victoria in 2002, it was found that 45% of clients were reported to have comorbidity of mental health and substance use disorders (Department of Human Services Victoria, 2007). These rates are thought to be increasing in populations that engage with institutions, i.e. groups of people which are accessed for research through their use of or contact with support agencies and community services, or specialist populations. Various effects are associated with different types of substance misuse in combination with specific mental illnesses; see Table 1 for more detail.
Table 1: Type of Mental Illness and Most Common Type of Co-Occurring Substance Misuse

| Depression | **Alcohol**: Even moderate use of alcohol can increase symptoms of depression. Alcohol worsens the sedative effects of benzodiazepines and some anti-depressants, and can reduce the effects of some prescription medication.  
**Cannabis**: The sedative effects of cannabis can increase depression. Cannabis increases the sedative effects of benzodiazepines and some anti-depressants.  
**Amphetamines**: People with depression may use stimulants to help them cope with lack of energy or low moods. Stimulants can also inhibit some anti-depressants.  
**Benzodiazepines**: These can be useful for short-term management of agitation, anxiety and insomnia associated with depression but tolerance occurs in weeks. |
| ----------- | --------------------------------------------------------------- |
| Psychosis  | **Cannabis**: Cannabis and other hallucinogens can cause acute psychotic episodes in most people who have an existing psychotic disorder. It can exacerbate hallucinations, delusions and thought disorder. It shortens relapse times and increases rates of hospitalisation.  
**Alcohol**: The long-term impact of alcohol use in people with a psychotic disorder is unknown. Alcohol can cause a lack of energy and motivation; and it can cause problems with blood pressure and balance. People with bipolar disorder often find that the use of alcohol makes their moods swing more rapidly between manic and depressive states.  
**Stimulants**: Psychotic symptoms are very common in people who are dependant on stimulants. Stimulants can trigger feelings of paranoia. In people with bipolar disorder, they can trigger mania, and the ‘crash’ that follows can cause depression.  
**Opioids**: Opioids have a sedative effect and can combine with anti-psychotic medications to cause high levels of dysfunction. Opioids can exacerbate symptoms of psychosis. |
| Anxiety    | **Cannabis**: Cannabis and other hallucinogens can induce anxiety in susceptible people. This occurs during intoxication and when high doses have been used. Cannabis interacts with a number of prescription medications. It can cause symptoms of mania, confusion, depersonalisation (a feeling of unreality concerning oneself and your immediate environment) and psychosis, when used with some of the newer anti-depressants.  
**Alcohol**: People who suffer from anxiety often use alcohol as a way of self medicating to cope with symptoms. However, alcohol actually increases anxiety symptoms.  
**Stimulants**: Stimulants generally make symptoms of anxiety worse. Chronic amphetamine or cocaine use can cause anxiety states and panic attacks. Some prescription medications can also increase the effects of ecstasy and cocaine, increasing the risk of overdose.  
**Benzodiazepines**: These can be very effective for the short-term treatment of anxiety. However, users develop tolerance and can become dependant quickly. If benzodiazepines and opioids are used together, the risk of fatal overdose is increased. People taking methadone may also experience increased sedation if they combine it with benzodiazepines.  
**Opioids**: Opioid use can have a positive effect on some anxiety symptoms through sleep-inducing effects, sedation and euphoria. However, withdrawal effects can increase anxiety. |
| Personality Disorders | **Cannabis**: Little evidence exists on how cannabis affects people with personality disorders.  
**Alcohol**: Alcohol use and intoxication impair judgment and affect impulse control which can lead to disinhibition, violence and self-harm attempts in people with personality disorders.  
**Opioids**: Opioids are generally used to relieve distress associated with behavioural and interpersonal problems of personality disorders. Opioids are often part of poly-substance use  
**Stimulants**: People who have borderline personality disorder and anti-social personality disorders may find that stimulants increase their impulsive behaviours. Stimulants interact with prescription medications used to treat some of the symptoms of personality disorders. |

Source: Adapted from NSW Department of Community Services [DoCS] (2005: 10-17)
The Complexities of Comorbidity

There is extensive consensus across the literature that people with comorbid substance misuse and mental illness face challenges compounded across several domains. The complexities of negotiating everyday life, as well as treatment and service engagement between agencies and across sectors can be quite complex.

Predictive factors of comorbidity include ‘male gender, young age, lower educational level, and single (or divorced) marital status’ (Burns & Teeson, 2002 cited in Kavanagh, Mueser, & Baker, 2003: 78). These sociodemographic factors highlight issues of accessibility to this group of people in the community, as they have problematic and lower levels of sustained engagement with services and research. However, there are significant rates of comorbidity found in populations that engage with institutions. For example, research about rates of comorbidity in a forensic psychiatric institution in Victoria found that 74% of inpatients were comorbid (Ogloff, Lemphers, & Dwyer, 2004). Rates in specialist populations such as offenders or homeless people are high and thought to be increasing.

When compared to people with only one disorder, people with comorbidity:

- Often experience more severe and chronic medical, social and emotional problems
- Increased rates of hospitalisation with longer admissions, shorter remissions and higher rates of sectioning.
- Increased rates of housing instability, homelessness and unemployment
- Increased rates of violence
- Increased rates of criminal behaviour and imprisonment
- Increased rates of non-compliance with treatment
- Poorer treatment access
- Poorer comes in both psychiatric and AOD treatment
- Increased service use, especially acute care services
- Increased rates of suicidal behaviour
- Require longer treatment and progress more gradually in treatment
- Experience more crises

> Are more vulnerable than people with only one disorder to AOD relapse and a worsening of the psychiatric disorder


An additional point to note is that people with personality disorders are the most likely to have acute comorbidity and to engage in chronic poly-substance use. People with personality disorders are likely to have experienced stress, trauma or abuse as children, and there is little evidence as to nature of the interactive and compounding effects of comorbid poly-substance use on personality disorders (NSW DoCS, 2005).

Talking with Children and Young People about Parental Comorbidity

The above section demonstrates that comorbidity has an acute impact in the life of the individual. Yet its affects are felt acutely by those dependant on comorbid adults, such as children and young people. Practitioners should engage in detailed planning with comorbid parents around relapse management, care of children, and planning around what to do in the case of hospitalisation.
The New South Wales Department of Community Services (2005: 8-9) offer guidance to practitioners on how to explain parental comorbidity to children and young people:

- As a worker, you may think that talking to children and young people about these issues may confuse or upset them, make them feel different or turn them against their parents. Or you may feel concerned that the parent’s don’t want their children to know what’s happening to them. The ‘secrecy’ caused by not talking about a parent’s mental illness or substance misuse can make it worse and result in children or young people feeling more ashamed or alone.

- Children and young people will have their own feelings and beliefs about their parent’s mental illness and substance misuse. They will have their own explanations and questions. Some children and young people may have had bad experiences of talking with adults, and may be wary, uncertain or frightened. Others may welcome the opportunity to talk openly.

- One of the best things you can do is listen. Give them the opportunity to tell their story in their own words. Understand that this may take some time. Allow them to express feelings or reactions they have had. Acknowledge their feelings and beliefs – they are very real for them. Helpful statements might include: “I imagine other kids must feel like that sometimes too.”

- Some may feel sad or depressed, others may feel angry or frustrated, some may blame themselves or feel guilty whilst others may even pretend that nothing’s going on or that they don’t care.

- If a child or young person asks questions, be sensitive but honest in your response. Provide details at an age-appropriate level and use language they understand. Check that they have understood what you have told them.

- Some questions can’t be answered straight away. For example: “When is daddy coming home from hospital?” This can sometimes be difficult to predict and it may be helpful to say: “Daddy is in hospital because he is not well. When he feels better, he will be able to come home. Maybe we can ring him, or write a letter, or visit when he is a bit better.”

- It is important that you as a worker seek support by talking about any issues with a supervisor.

Source: Adapted from NSW Department of Community Services (2005: 8-9)

Especially if the comorbid parent is a primary care-giver, it is clear that intensive support will need to take on a holistic approach to ensure that dependant children and young people are supported through what can be traumatic, chaotic or difficult life experiences.

Prioritising Safety: The Necessity of Risk Assessment and Management

‘Risk’ can be seen in a positive or a negative light, depending on the perspective taken. On one hand, it can be perceived as problematic by consumers and practitioners with agendas to overcome issues of stigma and what seems like an obsessive focus on risk. For comorbid consumers, there is validity in not wanting to constantly be perceived as a risk or a problem, with assessments serving as a constant reminder of vigilant checking.

On the other hand, the assessment and management of risk can be instrumental in emphasising and protecting safety and wellbeing – for all concerned (NSW Department of Health, 2007). The real issues lie in the manner and methods through which these processes and activities are carried out. If done well, risk assessment can uncover some important therapeutic issues and concerns which can then be supported by practitioners, as well as adding...
to the awareness of significant others such as family and carers of what to look out for. For example, through a supportive assessment that takes into account medical as well as psychosocial factors, problematic or risky behaviour is found to be linked to issues of anger, trauma, or the absence of communication strategies for self-expression, this can be addressed through the course of their treatment. It takes skilled and aware practitioners to have insight into deeper contributing factors that underlie symptomatic behaviour typified by aggression or crisis. Hawkings and Gilburt (2004) have some valuable tips for frontline practitioners working in a therapeutic environment with comorbid consumers:

**Specialist considerations in risk assessment and management**

- Comorbid consumers are more likely to pose risk to themselves than to others. Practitioners need to be aware of the risk of self-harm and attempted suicide.
  - Practitioners may fear that asking about ‘risky behaviours’ or suicidal feelings might encourage the individual to engage in them. In fact, this is unlikely. Instead, by acknowledging people’s thoughts, practitioners can work with them using techniques such as anger management programs, individual therapy and group work.
  - For those with mental health problems, misuse of drugs or alcohol can contribute significantly to the risk of violence and disturbed behaviour.
  - It is important the risk assessment looks at individual rather than generalised factors.
  - It is helpful for services to work together to develop shared protocols and approach the assessment and management of risk.
  - If yours is a referral only service, you may need to complete a full assessment before the client can use the service.
  - Include as part of the assessment process, a contingency plan for deterioration in the client’s substance misuse or a mental health crisis.
  - When clear expectations and boundaries are established and communicated, this benefits all team members, including the client.

**Comprehensive assessments**

Assessment should be systematic and thorough, and may therefore take more than one appointment. It is important to consider past history as well as the client’s current situation. The assessment should consider four main elements:

- Suicidal or self-harming ideas, plans and intentions
  - Ideas, thoughts and actions of harming other people
  - Self neglect
  - Risks from others, including exploitation


The subsection on the four elements required in a comprehensive risk assessment emphasises protecting the safety of the comorbid consumer, as three of these elements are focused on their wellbeing and security. There is wide scope for the assessment and management of risk to exemplify a holistic perspective on the needs and wellbeing of the consumer, as well as considering others who are involved in their care. The rationale and benefits of assessment should be communicated to consumers, and asking for their feedback – being inclusive – rather than a bureaucratic or coercive intervention undertaken by risk-averse agencies, partially motivated by a fear of litigation.
What Doesn’t Work?
Challenges and Barriers to Best Practice Services

“How have different services put the policy into practice? What works best in different areas? And, importantly, what hasn’t worked? I often wish we had more courage to be honest about what doesn’t work, and then we could learn from that.”
(Mental health worker, cited in Hawkings & Gilburt, 2004: 60)

People with comorbidity are perceived to be one of the most challenging client groups due to their often difficult and aggressive behaviour (when unwell), instability, and social isolation. A study of 338 mental health staff in Sydney found that 82% reported that working with this client group was ‘moderately’ or ‘very difficult’ (Kavenagh et al., 2000 cited in Allen & Davis, 2007). People with comorbidity can be seen by inpatient services as ‘the bed blockers – no one will take them after hospital. Services like housing and day centres shy away, they want people who are drug free’ (Mental health nurse, cited in Hawkings & Gilburt, 2004: 58). As highlighted by this quote, there are some perceptions and attitudes across agencies and practitioners about people with co-existing disorders that are of concern. There is a sense of ‘too hard’, of which the consequences of this attitude are quite problematic. The existence of these perspectives may, at times, contribute as a barrier to the service engagement and retention of comorbid consumers.

What are the Barriers to Service Engagement that Comorbid Consumers Experience?

One of the leading Australian studies into comorbidity is contained in the report Barriers and incentives to treatment for illicit drug users with mental health comorbidities and complex vulnerabilities (Department of Health & Ageing, 2007). Seventy seven service users and eighteen service providers, as well as key informants/experts, participated in giving feedback through interviews and workshops. The findings are listed below.

**Barriers to effective treatment engagement as outlined by comorbid consumers:**

- The stigma associated with both drug use and mental health, resulting in service users denying symptoms or feeling unable to seek treatment
- The impact of service user anxiety and depression symptoms on self-motivation and help-seeking behaviour
- The lack of holistic or comprehensive services, forcing service users to access and work with many different services and providers, often in a variety of locations
- Complex vulnerabilities such as physical health problems, family issues, relationship breakdown, debt, criminal justice problems, and unstable accommodation impacting on treatment success
- Lack of resources within drug treatment settings, particularly for access to mental health services
- Overly restrictive entry requirements for drug treatment programs for service users with co-occurring drug and mental health problems.
- The extensive use of clinical language, and subsequent differences in definition of comorbidity. Some of the clinical language is confusing for both clients and practitioners.
Barriers to good service provision, as outlined by practitioners:

- Difficulties in the diagnosis of mental health disorders, such as anxiety and depression, within a drug treatment setting
- Lack of confidence in the management of anxiety and depression within drug treatment services
- Acknowledgement that people with drug and mental health disorders continue to ‘fall between the cracks’ of mental health and drug treatment services
- The need to foster a culture of willingness to work together between drug and mental health services
- The absence or limited provision of training for health professionals in dealing with co-occurring problems
- The lack of feedback from other services after referrals, making follow up and review of service user progress difficult
- The challenge of developing well-coordinated care to attract service users into treatment
- A lack of resources and restrictions on the way that funding is allocated

Source: Department of Health & Ageing (2007: 6-7)

A key finding in the research was the tensions, difficulties and also opportunities in the therapeutic relationship between comorbid consumers and practitioners. Comorbid consumers described ‘feeling as though they were in a vulnerable position in their dealings with staff, and this led to the belief that it was safer to be unforthcoming and to keep unnecessary interactions with staff to a minimum. Treatment centre staff occupy positions of power as gatekeepers to the program. Many participants described the role of staff at treatment centres as more like those of prison wardens than healthcare professionals’ (Department of Health & Ageing, 2007: 60). Practitioners, especially at pharmacotherapy treatment centres, were seen overall as lacking in the ability to cope with service users’ frustration, distress or anger, responding in an inadequate manner to already volatile situations (Department of Health & Ageing, 2007). However, on the other hand, practitioners who showed empathy through acts of compassion and humanity were praised as exceptional by consumers because of their non-judgmental and kind approach.

A prominent study in the international literature is from Scotland titled Comorbid Mental Health and Substance Misuse in Scotland (Hodges, Paterson, Talkaito, McGarrol, Crome, & Baldacchino, 2006). Problems with treatment engagement for comorbid consumers included:

**Accessibility and availability**
- Poor signposting – a lack of information, details, and advertising of services.
- Structural obstacles – the structure of existing services and their service philosophies were seen as barriers for comorbid consumers who might need multi-agency support. Therefore, client centred thinking had not yet translated into structural change.
- Issues of eligibility and exclusion – management of mild to moderate mental health problems in substance misusers was problematic, as was the management of mild to moderate substance misuse problems in those with a mental illness.

**Service characteristics**
- Lack of flexibility and consistency – there was a stark contrast between the inflexibility of services and the chaotic characteristics of comorbid consumers lives.
Lack of responsiveness and continuity – waiting lists were seen as an isolating factor because both service providers and comorbid consumers identified a strong impetus for services and help being available when asked for or needed.

Acute need for strengthening of psychotherapeutic approaches – comorbid consumers identified a deficiency in opportunities to receive this type of intervention within the context of a warm therapeutic relationship with a practitioner.

Lack of holistic care – sequential styles still exist and are a cause for isolation.

Service organisation

- Lack of dedicated comorbidity specialists
- Few opportunities for specific comorbidity training to support service provision
- Different assessment protocols and patchy joint working arrangements – the design of care pathways or individual case plans were often hindered by lack of uniformity and streamlining across collaborative agencies, especially in the area of assessment.
- Bureaucratic quagmire – structural and procedural elements acted as inhibiting factors to developing functional and successful collaborative efforts in care.
- Exclusion – comorbid consumers experienced exclusion from active and meaningful participation in decisions about their care, and expressed the desire to be more involved and empowered throughout different processes.
- Stigma and the need for acknowledgement of wider cultural and social problems

Source: Hodges et al. (2006: 2-5).

On top of the organisational constraints and bureaucratic/structural issues discussed, comorbid individuals can experience high complexity of need and acute social disadvantage and disconnection, accompanied by feelings of loneliness, stigma and marginalisation (Todd et al., 2004).
What is Evidence Based Practice?

Evidence based practice is a term describing practice, theories, tools or interventions that are supported by an evidence base containing credible research and verified practice. Peer review or evaluation is part of this. Evidence based practice involves integrating individual expertise and the discerning use of the best available research evidence. It originated from medical research, but remains an emerging area in the ATOD sector; a high standard of evidence to work towards.

The Alcohol and other Drugs Council of Australia (2007: 11) have designed the following evidence based practice research tool specifically for use by ATOD practitioners.

Table 2: ATOD Practitioner Evidence Checklist Tool

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<td><strong>Clarity</strong></td>
<td>Is the purpose/query/objective/intervention clearly stated?</td>
<td></td>
</tr>
<tr>
<td><strong>Relevancy – accurate reflection of my scenario/situation</strong></td>
<td>Is my specific query/situation addressed? Consider client/population’s age, sex, race, social background/situation.</td>
<td></td>
</tr>
<tr>
<td><strong>Size</strong></td>
<td>Significant number of participants in the study</td>
<td></td>
</tr>
<tr>
<td><strong>Setting – accurate reflection of my setting</strong></td>
<td>Rural/Metro? Is the setting Australian or a country with a similar social setting?</td>
<td></td>
</tr>
<tr>
<td><strong>Trustworthiness</strong></td>
<td>Is the study design used appropriate?</td>
<td></td>
</tr>
<tr>
<td><strong>The recommendation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Results</strong></td>
<td>Were the results clearly stated? Were full explanations given?</td>
<td></td>
</tr>
<tr>
<td><strong>Ability to Replicate</strong></td>
<td>Has the study already been replicated or could it be replicated in my own situation? Consider costs, appropriateness and additional resources required</td>
<td></td>
</tr>
<tr>
<td><strong>Credibility</strong></td>
<td>Is the action or recommendation in line with your current practice? Is it logical and reasonable?</td>
<td></td>
</tr>
<tr>
<td><strong>Impact</strong></td>
<td>Were the negative and/or positive impacts and/or unexpected outcomes of following this course fully explained?</td>
<td></td>
</tr>
<tr>
<td><strong>General considerations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Currency</strong></td>
<td>Is the date when the evidence was produced relevant? Is currency an impact factor?</td>
<td></td>
</tr>
<tr>
<td><strong>Organisation associated with evidence</strong></td>
<td>Is this a known organisation? Do they have a particular bias or affiliation?</td>
<td></td>
</tr>
<tr>
<td><strong>Author</strong></td>
<td>Is the author known? Does he/she have a particular bias or affiliation?</td>
<td></td>
</tr>
<tr>
<td><strong>Journal</strong></td>
<td>Is this a well known and respected journal? Consider criteria for article inclusion.</td>
<td></td>
</tr>
<tr>
<td><strong>Ethics</strong></td>
<td>Was any ethics approval sought or is there any ethics statement made?</td>
<td></td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>Has the source of funding been disclosed?</td>
<td></td>
</tr>
</tbody>
</table>

Source: The Alcohol and other Drugs Council of Australia (2007: 11)
Effective Interventions

There are many therapeutic interventions and techniques, as well as biomedical interventions or pharmacology, which can assist with the amelioration of substance misuse or mental illness. However, the co-existence of the two presents heightened complexity and interactive factors. The following subsections outline which psychosocial interventions and techniques have been proven to be effective in supporting and treating people who live with co-existing disorders or problems. However, for details on the methodologies used and to assess of each study’s validity and generalisability of results, see each individual reference.

Motivational Interviewing

The aim of motivational interviewing is, as its name suggests, enhancing motivation to change behaviour. Presentation of factual information in a non-judgmental way by the practitioner is followed by asking the consumer for their views, and reflective listening helps the consumer to identify aspects of their life or behaviour that are problematic (Hawkings & Gilburt, 2004). There are five general principles of motivational interviewing:

1. **Express empathy** – acceptance facilitates change; skilful reflective listening is essential; and ambivalence is normal.
2. **Develop discrepancy** – A discrepancy between present behaviour and important goals will motivate change, and awareness of consequences is important. The consumer should present the arguments for change.
3. **Avoid arguments** – arguments are counterproductive and defending breeds defensiveness. Resistance is a signal to change strategies and take a different angle or approach. Labelling and judgmental phrases are not appropriate.
4. **Roll with resistance** – momentum can be used to good advantage, perceptions can be shifted. New perspectives are invited but not imposed because the consumer is a valuable resource in finding solutions to problems.
5. **Support self-efficacy** – belief in the possibility of change is an important motivator, and the consumer is responsible for choosing and carrying out personal change. There is hope in the range of alternative approaches available.


Motivational interviewing is a therapeutic technique designed to elicit intentions to change and optimism about future possibilities and lifestyles that do not include the problematic behaviour or issue of concern. The focus is around increasing readiness to achieve goals. Motivational interviewing has been found to be particularly effective with comorbid consumers who have depression or an anxiety disorder (Proudfoot, Teeson, Brewin, & Gournay, 2003; Drake, Mueser, Brunette, & McHugo, 2004; NSW Department of Health, 2007).

The following tables contain practical information about the ‘how to’ aspect of motivational interviewing. However, it should be noted that they are outlined in the literature to act as guides, not as a substitute for appropriate training.
Table 3: Useful Questions and Statements for Motivational Interviewing

<table>
<thead>
<tr>
<th>Useful Questions and Statements for Motivational Interviewing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Here are some things that we need to talk about (provide a short list). Which of these would you like to talk about first?</td>
</tr>
<tr>
<td>What concerns do you (or your partner) have?</td>
</tr>
<tr>
<td>How has …. caused trouble for you?</td>
</tr>
<tr>
<td>What are some good things about ….? What are some not-so-good things about ….?</td>
</tr>
<tr>
<td>How would things be better for you if you made that change?</td>
</tr>
<tr>
<td>What do you think will happen if you don’t ….?</td>
</tr>
<tr>
<td>So the thing that most concerns you is…</td>
</tr>
<tr>
<td>How can you make that happen?</td>
</tr>
<tr>
<td>When would be a good time to start?</td>
</tr>
<tr>
<td>If you look forward to, say, a year from now, how would you want your life to be different?</td>
</tr>
<tr>
<td>What worked for you in the past?</td>
</tr>
<tr>
<td>I think that will work for you.</td>
</tr>
<tr>
<td>Thanks for your honesty.</td>
</tr>
<tr>
<td>Thanks for talking with me.</td>
</tr>
</tbody>
</table>


The questions and statements in the table above are similar in their emphasis on the restatement or reflective feedback of any comments that indicate concern about present behaviour or interest in change (Walters et al., 2007).

Following on from this, Table 4 is a practical illustration of how some statements and forms of questioning are more beneficial and professional than others because they will have a positive influence on the chance that the person being interviewed will communicate more productively about change (Walters, Clark, Gingerich, & Meltzer, 2007).

Table 4: Communication Examples in Motivational Interviewing

<table>
<thead>
<tr>
<th>Trap</th>
<th>What NOT to Say</th>
<th>What TO Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Playing the Expert</td>
<td>You don’t have a job because you’re not putting in enough applications.</td>
<td>What ideas do you have as to how you might get a job?</td>
</tr>
<tr>
<td>Arguing the Positive Side</td>
<td>You need to stop making excuses and find a job.</td>
<td>How would things be better for you if you found a job?</td>
</tr>
<tr>
<td>Giving Unsolicited Advice</td>
<td>You need to get up first thing in the morning, get a cup of coffee, and go in and fill out that application.</td>
<td>If you decided you wanted to put in a job application, how would you go about that?</td>
</tr>
<tr>
<td>Premature Focus on Change</td>
<td>We’ve been talking a lot about how important it is to get a job, and this week I’d like you to submit five job applications.</td>
<td>Ultimately, you’re the one who has to decide whether you want to put in the hard work to finding a job. What do you think is a reasonable number of applications to put in this week?</td>
</tr>
<tr>
<td>Asking Backward-Focused Questions</td>
<td>Why did you go to that party when you knew it would get you in trouble? Why haven’t you been able to get a job?</td>
<td>It sounds like that situation really got you in trouble. What can you do this week to move this forward?</td>
</tr>
</tbody>
</table>

Source: Walters, Clark, Gingerich, & Meltzer (2007: 68)
Cognitive Behavioural Therapy

Cognitive behavioural therapy [CBT] is widely proven to be effective as a form of treatment for people with comorbidity (Drake et al., 2004; Kay-Lambkin, Baker & Lewin, 2004; Baker et al., 2006; NSW Department of Health, 2007; Baker, 2008).

Cognitive restructuring strategies are used to identify a client’s negative thinking and to challenge it, in order to regain control and resilience in overcoming difficulties. According to the NSW Department of Health (2007: 60), a typical CBT approach contains the following elements:

1. **Identifying triggers** – careful assessment identifying what triggers unhelpful thinking or interpretations of the situation.

2. **Become aware of unhelpful thinking patterns** – connected to the person’s triggers are their negative thinking patterns of self-talk. Self-talk is an internal monologue that is often automatic and subtle, and anticipates the worst before it happens. This can manifest as catastrophising, overgeneralisation, unrealistic expectations, mind reading and labelling. Clinicians work closely with clients to identify negative thinking patterns and how these thinking patterns cause problems in their lives.

3. **Thought stopping** – once clients have identified when they use negative self-talk, they are encouraged to use thought stopping. This consists of mentally saying “Stop, slow down!” and taking time out to analyse what is going on in the situation. Some people picture a stop sign or traffic lights as they do this.

4. **Challenging thoughts** – clients are then encouraged to talk back to their negative thinking. They are given techniques to challenge their way of thinking, including looking at their thoughts more objectively and realistically.

5. **Replacing negative thoughts** – clients are assisted to replace negative thoughts with more helpful thoughts.

6. **Behavioural modification** – behaviour modification aims to identify and change aspects of behaviour that cause or exacerbate anxiety or depression. This is often done by exposing clients to the thing they fear, or teaching them new strategies to deal with their thoughts and feelings. All behaviour modification techniques need to be practiced regularly and require significant time and effort to master, depending on the degree of reaction the client experiences. There is also some evidence that if alcohol use continues during behaviour modification treatment, the use of alcohol retards the treatment process.

Source: NSW Department of Health (2007: 60)

Cognitive behavioural therapy is preferable to medication in the treatment of comorbid anxiety and substance use disorders because of the potential for misuse of common medications used to treat anxiety, for example, benzodiazepines (Proudfoot, Teeson, Brewin, & Gournay, 2003). Yet it is also effective as part of a multi-method combination approach.

**Anger Management**

Anger management therapeutic interventions have been shown to be beneficial for people with co-existing mental illness and substance misuse (Beck & Fernandez, 1998; Reilly & Shopshire, 2002; Reilly, Shopshire, Durazzo, & Campbell, 2002). Research on cognitive behavioural therapy [CBT] based anger management found it was 76 per cent more effective, compared to the outcomes for the control group who did not receive it (Beck & Fernandez, 1998; Reilly & Shopshire, 2002). There are four types of CBT interventions,
‘theoretically unified by principles of social learning theory, that are most often used when treating anger disorders:

1. **Relaxation interventions** which target emotional and physiological components of anger
2. **Cognitive interventions** which target cognitive processes such as hostile appraisals and attributions, irrational beliefs, and inflammatory thinking.
3. **Communication skills interventions** which target deficits in assertiveness and conflict resolution skills
4. **Combined interventions** which integrate two or more CBT interventions and target multiple response domains

Source: Reilly & Shopshire (2002: 1)

Anger management CBT manuals for practitioners and workbooks for participants have been designed as a publicly available resource for professionals, including 12 structured sessions.

**Resources:** See Reilly & Shopshire (2002); Reilly, Shopshire, Durazzo, & Campbell (2002).

### Relaxation Techniques

Relaxation techniques can be instrumental in reducing symptoms and anxiety that may arise from stressful or negative life experiences. The New South Wales Department of Health (2007: 59) recommends the following activities for use with people with comorbidity, especially in cases where the person has anxiety or depression:

1. **Calming response:** The calming response is a quick coping skill developed by Montgomery and Morris (2000). It is helpful when strong feelings rise up quickly and is most effective if used as soon as uncomfortable feelings arise. It is best practiced regularly, a couple of minutes each day. The steps are for clients to mentally detach from the situation and “smile inwardly at yourself”. They then think “clear head, calm body” and take in one slow, deep breath. As they breathe out, they relax.

2. **Abdominal breathing:** Breathing reflects the level of tension in our bodies. Under tension, breathing becomes shallow and rapid, high in the chest sometimes causing hyperventilation. When relaxed we breathe more fully, deeply and from the abdomen. Encouraging clients to practise abdominal breathing exercises can lead to deep relaxation and reduce the symptoms of anxiety.

3. **Progressive muscle relaxation:** Progressive muscle relaxation involves tensing and relaxing, in succession, the different muscle groups of the body. Although it is easier to do this exercise when lying down, it can be adapted to sitting up. It needs to be practised for 20 minutes a day, although twice a day is better. It is good to do this at the same time each day and on an empty stomach. The idea of this exercise is to tense each muscle group separately working from the hands, through the neck, and then down to the feet. Tensing needs to be hard without straining for 7-10 seconds concluded by suddenly letting go or relaxing. After tensing each muscle, it is important to take a 15-20 second break to notice how the muscle group feels when relaxed. If one group of muscles is not sufficiently relaxed, they should be tensed a second time after a twenty second break. All other muscles should be relaxed while working on a particular muscle group.

4. **Reducing hyperventilation:** When people become anxious, they set off an emergency or alarm reaction which may lead to an increase in the speed and decrease in the depth of breathing called ‘hyperventilation’. When people hyperventilate, they get rid of too much carbon dioxide.
This worsens the light-headedness and breathlessness and may lead to choking or a sense of smothering, blurred vision, tingling sensations, or numbness in the hands, arms or feet and cold, clammy hands. As over-breathing is hard physical work, it can lead to clients being tired and feeling hot, flushed and sweaty. Mild hyperventilation can cause an individual to remain in a state of perpetual apprehension and anxiety. For many clients, worry and anxiety are due to an inability to solve their problems.

Source: NSW Department of Health (2007: 59)

In addition to relaxation techniques, another common problem area for individuals in this group is sleeping problems. People with depression or anxiety disorders may ‘experience difficulty getting to sleep or staying asleep, may sleep for too long, have abrupt awakening or sleep walk. Assisting clients to develop regular sleep patterns and to address insomnia are important strategies to help manage depression and anxiety. These include: not taking naps during the day, maintaining regular routines and avoiding using bed for other activities, for example watching TV’ (NSW Department of Health, 2007: 60).

**Appropriate Management of an Acute Psychotic Episode**

In the support of people living with a psychotic disorder, such as schizophrenia or drug induced psychosis, practitioners from other fields may be the first on hand during the onset of an acute episode. Psychotic symptoms need to be assessed and supported by professionals who are adequately qualified to do so. However, there are some practical tips available as to how ATOD practitioners without these qualifications can manage an acute episode until more specialist support is available (NSW Department of Health, 2007: 63-64):

- During an acute episode of psychosis, a person’s behaviour is likely to be disruptive. It is important to ask questions of the client to clarify and understand the severity and degree of their symptoms such as their experience of delusions and hallucinations.
- As psychotic clients may experience thought disturbance, it is important to speak clearly and remain calm. When asking someone to do something, it is best not to give choices and to be clear and direct.
- There are several do’s and don’ts about interacting with someone with psychosis, such as
  - Do point out the consequences/effects of the other person’s behaviour. Be specific.
  - Don’t be vague.
  - Do try to express your feelings. It is best to do this when not upset, angry or overwhelmed.
  - Do distract the person if you can. You could offer them something to look at or involve them in doing something meaningful.
  - Don’t try to figure out what the person is talking to or about.
  - Don’t laugh (or let others laugh) at the person
  - Don’t act horrified or panic
  - Do ignore strange or embarrassing behaviour if you can, especially if it is not serious.
  - Maximise and assess the client’s safety
  - Organise Treatment and support


Contact details of mental health crisis assessment teams, triage systems, or crisis hotlines should be readily available for use if an emergency or an acute episode of psychosis arises. Planning for this event with the comorbid consumer is important in allowing them to have input into their care. Protocols of protecting safety and lists of contact people can be pre-arranged so the person has the choice about what will happen if they become unwell. The
use of therapeutic ‘contracts’ to cover issues such as psychosis, violence, suicidality, or self-harm may be appropriate in some circumstances.

Resources: See the ‘Mental Wellbeing Plan’ in the Appendices; Streetwize Communications, 2007; Black Dog Institute, 2007).

Appropriate Strategies for Working with People with Personality Disorders

The category of disorders with the highest cross-over with substance misuse is personality disorders. However, ‘treatment’ of people with personality disorders is not usually within the scope of alcohol and other drug practitioners, without more specialised training such as Dialectical Behaviour Therapy [DBT] which is a relatively new treatment for borderline personality disorder (NSW Department of Health, 2007). However, for ATOD practitioners who have to work with a comorbid client with a personality disorder (without necessarily addressing the disorder itself) it is necessary to be aware of some appropriate strategies:

- Develop a therapeutic relationship with clear boundaries and a limit setting approach
- Listen to and evaluate the client’s concerns
- Accept but do not confirm the client’s beliefs
- Do not reward inappropriate behaviour (such as demanding, aggressive, suicidal, chaotic or seductive behaviour)
- Plan clear and mutual goals while maintaining clear limits
- Explain everything clearly and concretely to the client
- Take careful notes
- Establish a team approach
- Help with the ‘here and now’ problems the client presents with rather than trying to establish causes or exploring past problems
- Unless the client has a high level of self-awareness, avoid referral into group programs unless the programs are specifically designed for clients with personality disorders
- Address any worker personal reactions to the client (including frustration, anger, dislike, attraction or enmeshment) by organising clinical supervision


Comorbid personality disorders and substance misuse is a challenging area for professionals, requiring specialist expertise if they are to be addressed concurrently.

Other effective psychosocial strategies not otherwise discussed here:

- **Relapse prevention** (Drake et al., 2004; Streetwize Communications, 2007)
- **Skills training and strengths based rehabilitation** (Heinssen, Liberman, & Kopelowicz, 2000; Cloitre et al., 2002)
- **Brief motivational interventions** (Drake et al., 2004)
- **Short term residential rehabilitation with integrated treatment** (Aguilera et al., 1999; Anderson, 1999; Drake et al., 2004)

However, this list is not included with the intention of being full or complete, there may be other effective strategies and approaches to comorbidity that are not listed in this report.
Integrated Care

There is a line of reasoning called ‘the primacy argument’ that has lead to assertions that treatment should focus on substance misuse (if practice guidelines were written by ATOD service providers) and mental illness (if mental health providers authored the guidelines) (Corrigan, McCracken, & McNeilly, 2004). This perspective sees ‘the problem in a manner consistent with guidelines written by experts on dual disorders: namely, what came first – the mental illness of the substance abuse disorder – is largely a red herring. People with dual disorders are best served when common etiology, risk factors, and treatments are assumed’ for the combined comorbidity or co-existence of both or multiple disorders (Corrigan et al., 2004: 154). Integrated care is being successfully implemented for use in supporting individuals with comorbidity across Australia, as well as internationally in places such as Scotland and England (New South Wales Department of Health, 2000; Department of Health [UK], 2002; Hodges et al., 2006).

Strengths and Opportunities:

The benefits of the integration of service provision are multiple for agencies and consumers:

- Improved client outcomes
- Improved adherence to treatment plans where both substance misuse and mental illness interventions are supported
- Improved efficiency because consumers do not have to shuffle between providers and clinicians do not have to make referrals

Additional benefits to consumers include:

- Better integrated information rather than conflicting advice from several sources
- Improved access to services through “one-stop-shopping”

Additional benefits to programs and clinicians include:

- Opportunities for agency and professional growth
- Workforce development
- Less frustration and increased job satisfaction

Difficulties and Challenges:

The consumer may experience mainly positive encounters when receiving integrated care. Yet from the perspective of practitioners and agencies, the challenges of the integration of service provision can be multi-faceted. There may be a need to:

- Identify and respond to gaps in workforce competencies, certifications and licensures
- Proactively address staff concerns in relation to changes in roles and responsibilities
- Institute changes in record keeping to accommodate comorbidity
- Modify facilities to meet additional needs (e.g. space for individual or group counselling)
- Revise staff patterns and work schedules
- Reconcile differences in confidentiality regulations, policies, and practices between substance misuse and mental health
- Revise policies and practices regarding dispensing of medications

Source: Centre for Substance Abuse Treatment (2007: 3)
Comorbid people generally do not like being passed to and fro between services. Because of the complex needs and vulnerability of this population, integrated care does help towards preventing them ‘falling between the cracks’.

Box A: Case Study

CASE STUDY: INTEGRATED TREATMENT EXAMPLE

The following case study is by Croton (2007: 17) and in the context of presenting to an ATOD agency in Victoria for screening, assessment and treatment planning.

**Client:** Eve 22 years old, single unemployed female, self-referred for assistance with methamphetamine abuse.

**Mental Health Screening** (using PsyCheck) indicated:
- Sporadic episodes of treatment for anxiety since 17 yrs old (by GP & private psychologist)
- Moderate suicide risk
- Marked symptoms of depression and anxiety

**Further Assessment** indicated:
- Eve presents as irritable and suspicious with concerns that others can read her thoughts.

**Multi-Agency Integrated Treatment**

The AOD worker initiated a telephone consult with local Clinical Mental Health Service triage with the outcome that Eve agreed to an immediate joint appointment with the mental health worker and AOD worker. At that appointment, a safety plan was negotiated, involving support from Eve’s parents and daily contact with a mental health worker. At a subsequent joint appointment, an Individual Service Plan (signed off by both services and the client) was developed which involved
- The mental health worker/service monitoring and managing Eve’s suicidality
- The AOD worker providing counselling around Eve’s amphetamine use (Motivational Interviewing, Goal Setting, Relapse Prevention)
- Both workers communicating with the other after contact with Eve and her family (consent forms signed by Eve)
- Further joint session when either service was planning discharge.

This case study is one example of how integrated treatment can work in practice. There are opportunities for integrated care to be even more involved and collaborative than the case study above, but this is asserted with an emphasis on tailoring integrated services around individual need and context. Furthermore, there is an acute need for further research to provide a sound longitudinal evidence base about the efficacy and specific outcomes of integrated service provision.

**Re-framing Recovery**

When considering ‘what is recovery?’, the presence of dual or multiple co-existing disorders in the individual highlights the need for an expanded perspective. The milestones, emotions, symptoms, achievements and expectations associated with one disorder or problem are not
necessarily relevant or transferable across domains. Substance abuse literature, diagnostic criteria and terminology is quite different to that of the mental health field.

Recovery is not mentioned extensively in substance misuse literature. It has been recognised that there are different perspectives across the sector. A definition from the United Kingdom, the ‘process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society’ (UK Drug Policy Commission Recovery Consensus Group, 2008)

Recovery is a common concept in mental health literature. In Australia, recovery is defined in the National Mental Health Plan 2003-2008 (Australian Health Ministers, 2003: 11) as ‘a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic events of psychiatric disability’. Rickwood (2004) suggests caution though in assuming that the use of the term recovery implies full recovery to a state of wellness, because of problematic connotations about the course of some mental illnesses. She admits that ‘there is a long way to go, change is slow, and the barriers at times can be considerable, but Australia is slowly but surely moving toward a mental health service system that empowers and promotes the wellbeing of people with a mental illness’ (Rickwood, 2004: 3).

From a consumer perspective, there has been criticism of those who have a narrow view of recovery that simply focuses on reduction in symptoms as the desired outcome. The emphasis on the medical model and medication has been criticised too, with one consumer stating that ‘there is too big a comfort zone around the medications and we have to break out of the traditional mould’ (Manns, 2003: 146).

In New Zealand, the Mental Health Commission authored a ‘Blueprint’ for mental health services in 1998, in which recovery was a central concept. It was defined as ‘living well in the presence or absence of one’s mental illness. It mentions the importance of hope and personal and social responsibility. It states that families, communities and people with mental health problems themselves need to be as actively involved in recovery as mental health services’ (cited in O’Hagan, 2004: 1). Central to this understanding of recovery is a philosophical underpinning of egalitarianism and collective responsibility, emphasising that it is important for all stakeholders (consumers, families, practitioners, governments) to break down stigma and discrimination in order to support recovery (O’Hagan, 2004: 2). Some of the answers put forward to seeing this definition become a reality included:

- A consumer focused values base as a key driver of recovery.
- An acknowledgement of the shattering impact of mental illness, and focus on not just overcoming symptoms but also developing personal resourcefulness and receiving support from others.
- Engaging wider support networks such as family and friends in recovery.
- The development of a national approach that signals there are many ways of understanding and responding to mental health problems, and that no one way should dominate at the expense of others.
Moving beyond a monocultural and individualistic perspective to emphasise social, economic, political and cultural processes and connection to one’s culture as beneficial to recovery.

An emphasis and spotlight on human rights, advocacy and on service user partnerships with professionals at all levels and phases of service planning, delivery and evaluation.

Key competencies and benchmarks for practitioners that support recovery.

Source: O’Hagan (2004: 2)

New Zealand’s approach to recovery reflects a broader understanding of the context in which a mental health consumer lives. It emphasises social responsibility, citizenship and partnership, whereas the Australian definition is more individualistic.

Box B:

**KEY COMPETENCIES FOR PRACTITIONERS**

In New Zealand, there are ten key competencies that act as general standards for practitioners in mental health services supporting consumers towards recovery:

> A competent mental health worker understands recovery principles and experiences, supports service users’ personal resourcefulness, accommodates diverse views on mental health issues, has self-awareness and respectful communication skills, protects service users’ rights, understands discrimination and how to reduce it, can work in diverse cultures, understands and supports the user/survivor movement, and understands and supports family perspectives (cited in O’Hagan, 2004: 2).

These general competencies are essential in the position description of practitioners who support people with co-occurring disorders and complex needs. Skilful practitioners are those who also possess the skills to operationalise these competencies in practice on a daily basis in diffuse and complex situations throughout their work activities.

Arguably, with development, the strategies listed in Box B are relevant enough to be beneficial in informing efforts to define recovery in relation to comorbidity. The ten key competencies upheld in New Zealand are also of wider relevance to comorbidity.

Therefore, ‘recovery from mental illness is a process and not an event. Long-term support and monitoring is the best way to detect and reduce severity and duration of lapses’ (Streetwize Communications, 2007: 1).
Emerging Issues and Future Directions

Not Just Crisis Management

There is a clear need to extend the identification, management and treatment of people with comorbidity beyond a narrow focus of crisis management (Manns, 2003; Hodges et al., 2006). In Australia, a common conception amongst ATOD service providers is the feeling of needing to ‘act as gatekeepers to mental health services because of limited resources’ (Department of Health & Ageing, 2007). In practice, this means that only the most acute clients with co-occurring problems are referred on, because practitioners perceive that, otherwise, mental health services may have extensive workloads and may or may not adequately treat and/or admit people with less chronic immediate issues.

Comorbid consumers may also feel that they need to be in crisis – and possibly a threat to self or others – before their needs will be appropriately responded to by services. Treatment at the crisis level ‘is not efficient; true recovery involves both psychological and social wellbeing’ (Manns, 2003: 146).

Prioritisation of cases is a valid practice, however, there is a need for both the mental health and ATOD sectors to engage in forward planning within individual services, as well as broader workforce development, to ensure there is adequate resources and capacity to respond to any comorbid consumer – acute or not.

Advocacy, Consumer Participation and Empowerment

The ‘involvement of consumers and carers in our response to comorbidity is both feasible and crucial to the achievement of good outcomes’ (Manns, 2003: 146). Agencies may encourage consumer participation informally, or may seek input periodically. However, there is a strong need (especially in the alcohol and other drug sector) for consumer participation to be supported by policy and integral to practice.

Consumers’ knowledge is increasingly valued as ‘especially valid… They cannot escape the dominant discourse of psychiatry – it surrounds them. But they also have access to their own knowledge, often collectively produced. Being able to “speak two languages” means that consumers have a better developed understanding of services than those speaking from only one position (Tew et al., 2006: 9). Involvement of the consumer perspective is vital to encouraging a wider ‘partnership’ approach that is not patronising or interventionist, and may aid the translation of strategic planning recommendations and consultation into everyday practice (Bassman, 2001; Bland, Laragy, Giles, & Scott, 2006; Bland & Epstein, 2007; Olsen & Epstein, 2001). A significant imperative is for the consultation process to exemplify and be integrated with the desired outcomes of the findings; in this case, benefits for consumers as
stakeholders, such as empowerment through inclusion, integrated advocacy through reciprocity, and contributions to knowledge about a diverse population with specialist needs.

Progress can be made from wherever along the continuum an organisation is current at (see the next table). For example, an organisation may provide information to its clients regularly, as well as get them to fill in exit surveys. However, measures can be built in to ensure that the comorbid consumer voice and perspective is consulted, along with advocacy bodies, across key areas of service planning to result in meaningful contributions and input into decision-making. Organisations can assess the level of consumer participation occurring by using the following illustration, which adopts a general community stance but is still applicable in the case of comorbidity.

Table 5: A Hierarchical Illustration of Levels of Client Participation

<table>
<thead>
<tr>
<th>Degree of control</th>
<th>Participant’s action</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Has control</td>
<td>Organisation asks community to identify the problem and to make all the key decisions on goals and means. Willing to help community at each step to accomplish goals.</td>
</tr>
<tr>
<td></td>
<td>Has delegated control</td>
<td>Organisation identifies and presents a problem to the community, defines the limits and asks community to make a set of decisions, which can be embodied in a plan it can accept.</td>
</tr>
<tr>
<td></td>
<td>Plans jointly</td>
<td>Organisation presents tentative plan subject to change and open to change from those affected. Expects to change plan at least slightly and perhaps more subsequently.</td>
</tr>
<tr>
<td></td>
<td>Advises organisation</td>
<td>Organisation presents a plan and invites questions. Prepared to modify plan only if necessary.</td>
</tr>
<tr>
<td></td>
<td>Is consulted</td>
<td>Organisation tries to promote a plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so that administrative compliance can be expected.</td>
</tr>
<tr>
<td></td>
<td>Receives information</td>
<td>Organisation makes a plan and announces it. Community is convened for information purposes. Compliance is expected.</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>Community not involved.</td>
</tr>
</tbody>
</table>

Source: National Resource Centre for Consumer Participation in Health (2003f: 2)

In replacement of the word ‘community’ in the table above, the word ‘comorbid consumer’ could take its place to describe the different levels of participation.

In Australia, there is an acute need for further support and resourcing of consumer advocacy and participation groups, especially for substance users (Department of Health & Ageing, 2007). Presently, Tasmania does not have such a group, and hence a professional peer advocacy voice is missing in contribution to practice and policy debates in the public domain. However, the peak body the Alcohol, Tobacco & other Drugs Council of Tasmania has been active in highlighting need in this area and publicly emphasising the vital need for progress and development.
Core principles underpinning the consultation and involvement of comorbid consumers are:

- Ensuring that relevant information is accessible and provided in user friendly formats and languages
- Providing access to independent advocacy where appropriate. This should ensure that people understand their treatment and available options and are able to express opinions and preferences
- Making adequate resources available to support service users. This could include both “human resources” such as facilitators or translators, and finance to cover transport and other expenses
- Giving regular feedback on actions suggested by service users so that they know their views are taken seriously
- Encouraging service users to participate. It is important that consumers are clear about why and how they will be involved and how this may affect outcomes
- Developing a culture that recognises and encourages the rights of service users to participate as fully as possible in decisions about their care and evaluate the services they receive

Source: Hawkings & Gilburt (2004: 49)

It is necessary to complement this with more specific details to guide practitioners and organisations on the ‘how to’ of comorbid consumer participation.

Table 6: Strategies for Consumer Participation – Matching Purpose with Method

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Possible Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify risks or problems</td>
<td>Complaints, hotlines, phone-ins, focus groups, workshops, submissions, forums, surveys</td>
</tr>
<tr>
<td>Engage culturally diverse consumers</td>
<td>Consult with local organisations, support groups, telephone surveys, phone-ins. Use consumer advocates, consumer representatives, bilingual workers, culturally appropriate venues. Prepare charters (translated), promotions, and information to consumers (in appropriate languages).</td>
</tr>
<tr>
<td>Identify priorities or needs of/for community</td>
<td>Surveys, project groups, in-depth consumer interviews, focus groups, submissions, complaints, patient forums, nominal group techniques</td>
</tr>
<tr>
<td>Provide information and seek dialogue about a new service</td>
<td>Promotion and campaigns, round tables, publications, public meetings, seminars</td>
</tr>
<tr>
<td>Measure acceptability of new service</td>
<td>Surveys, research, evaluation of service, in-depth interviews, focus groups, phone-ins, support groups</td>
</tr>
<tr>
<td>Plan health services</td>
<td>Submissions, consumer councils, consumer representatives, policy round tables, consultative committees, consumer participation policies, consumer input into organisation policies</td>
</tr>
<tr>
<td>Facilitate individual care</td>
<td>Question lists, care plans, assessment tools, education classes, one-on-one coaching, tailored information, skills training, evidence-based health and treatment information</td>
</tr>
</tbody>
</table>

Source: National Resource Centre for Consumer Participation in Health (2003f: 3)
Central to these strategies is the matching of purpose to method, in other words, choosing what fits best after analysing consumer and organisational needs.

Combinations of several of these strategies may be used to as part of a stakeholder or partnership approach to formal organisational quality improvement activities.


Broadening Support Networks: Carer Input and Family Sensitive Practice

“The involvement of comorbid consumers and their carers in their treatment and service development ‘is not an optional extra. The expert knowledge which they bring is a vital part of the resources which any service planners must have at their disposal’ (Treated as People, 2004 cited in Hawkings & Gilburt, 2004: 49). Fundamentally central to the participation and empowerment of consumers’ families and carers is that it be meaningful. This will help to overcome histories where participation, if allowed at all, has been asked for and organised (by practitioners or agencies) in a piecemeal or, worse, a tokenistic way. It is time that practitioners and agencies across the sector work towards overcoming the suspicions and misgivings of families and carers that have been widely ignored and disadvantaged voices in the system.

In a Canadian report examining the contributions and needs of families and caregivers to comorbid family members, the following areas of need were highlighted:

1. Services for Families: Educating, Supporting and Caring for the Caregivers – although families take on significant care-giving roles, they are often ill-prepared for the challenges associated with this role. They may lack information regarding the problem(s), treatment, available resources, and the system itself.

2. Peer Support: Families Helping Families – families have needs that often go unrecognised. Their loved one’s illness can lead to substantial financial burden, careers can be interrupted, social networks may desert them due to stigma and discrimination, and they may be blamed for their loved one’s mental illness or addiction. People who have “been there” understand all this and, in the context of self-help and mutual aid groups, providing a caring atmosphere where families can speak freely, exchange coping strategies and educate themselves about their loved one’s illness or substance use problem – and about their own needs for support.

3. Recognition as Partners in Care, Rehabilitation and Recovery – families report that their perspectives, their observations and opinions are rarely sought, and often discounted, by service providers. Their efforts to be actively involved, and to advocate on behalf of their ill relative, may be met with disinterest or suspicion. Families want to be an integral part of treatment and community rehabilitation teams as they are deeply concerned about the recovery of their loved one.
4. **Families as System Partners** – family members and family organisations are poised to be active participations in system planning. Families have seen first hand how the system works and know better than anyone there is room for improvement. Families often act as advocates for their loved one at the point of care (crises, hospitalisation, referral to community services, social assistance and legal issues), and this advocacy equips them for participation in system planning, program development, implementation and evaluation, legislation critique, and mental health reform activities.

Source: Family Mental Health Alliance (2006: 8-11)

These points highlight the need for further workforce development, training and planning around advocacy and the rights and responsibilities of families and carers.

There are various resources and practitioner manuals available to assist with the inclusion and support of families/carers of comorbid consumers.

**Resources:** See Chairn et al. (2003); Patterson & Clapp (2004); National Consumer & Carer Forum of Australia (2004); NSW Department of Community Services (2005); Family Mental Health Alliance (2006); O’Grady & Skinner (2007a, 2007b)

**Comorbidity as a Priority for Future Social Research Agendas**

Repeated emphasis in existing literature reiterates the need for more social research into the complex issues involved with the co-existence of mental illness and substance use, especially into the areas of disadvantage and social problems experienced by this group and the context of their engagement with agencies, institutions and systems (Rachbeisel, Scott & Dixon, 1999; Alverson, Alverson, & Drake, 2000; Manns, 2003; Brunette, Mueser, & Drake, 2004; Chandler, Peters, Field, & Juliano-Bult, 2004; Department of Human Services VIC, 2007; ADCA, 2008).

An optimal ‘mix’ for future research should involve different perspectives to ensure that well rounded and insightful data is generated. Tew and colleagues (2006) speak of the benefits of research that collaboratively uses information from the three perspectives of academic researchers, consumers, and practitioners to both corroborate and challenge the knowledge that is perpetuated:

> Some framework that allows space for thinking and reflection is essential. Raw experience does not immediately turn itself into useful knowledge: there is a need to stand back in order to analyse and interpret… Such approaches to engaging with, and triangulating between, different sources of evidence may not be conducted on the basis of any assumptions of ‘neutrality’ or ‘objectivity’; questions of evaluation and significance can only be worked through on the basis of standpoints that are declared and out in the open. In many instances, rigour may perhaps best be judged by how faithful the outputs of the research process are in their representation and conceptualisation of people’s lived experience’ (Tew *et al.* 2006: 11)

This describes the need for a conceptual framework that draws upon different sources of knowledge (a form of triangulation) to produce a rigorous and balanced view of the issues surrounding comorbidity. The quote also highlights the need for research outcomes to be
measured against a few benchmarks, one of priority being the benefits and applicability to the lives of comorbid consumers.

The Necessity of Principles-driven Practice

Principles and ethics are upheld as fundamentally important, but there is often little consensus about what this looks like in practice. Yet an ethical approach based on sound foundational principles is imperative when liaising with and supporting people with complex needs (Graham & White, 2008a, 2008b).

The Alcohol and other Drugs Council of Australia [ADCA] peak body recently designed a new code of ethics for the ATOD sector about making values and ethics explicit. The list of core practitioner values is of relevance here (Fry, 2007: 7):

<table>
<thead>
<tr>
<th>Access</th>
<th>Autonomy</th>
<th>Beneficence</th>
<th>Compassion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competence</td>
<td>Community</td>
<td>Conscientious Refusal</td>
<td>Diligence</td>
</tr>
<tr>
<td>Discretion</td>
<td>Equity</td>
<td>Fidelity</td>
<td>Gratitude</td>
</tr>
<tr>
<td>Health</td>
<td>Honesty</td>
<td>Loyalty</td>
<td>Justice</td>
</tr>
<tr>
<td>Non-Maleficence</td>
<td>Obedience</td>
<td>Reciprocity</td>
<td>Respect</td>
</tr>
<tr>
<td>Restitution</td>
<td>Self-Improvement</td>
<td>Self-Interest</td>
<td>Stewardship</td>
</tr>
<tr>
<td>Transparency</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In a similar vein, ten principles for a residential context have been outlined by Graham and White (2008b): Dignity and respect; fairness; difference; empowerment; safety and wellbeing; confidentiality; multi-tasking; collaboration; accountability; and integrity. These have been designed to account for context and individual differences, and form a values base for interaction applicable to all parties involved, not just the consumer or not just the practitioner (Graham & White, 2008b).

Principle driven practice involves valuing those we work with, and it serves as a reminder of their dignity and worth; those who are our richest resource; those who may rarely be offered opportunities of social inclusion and citizenship-like participation; those who we seek to increase understanding of and support for – the very people to whom we serve to make their world a better place. Rather than inflicting harms through unethical practice, the driving force of our work should seek to overcome the very harms and social problems that have been a formative and sometimes detrimental part of a consumers’ life experience. The operationalisation of ethics from principle to practice involves offering comorbid consumers the opportunity to participate in planning and development with the goal of services and meaningful advocacy opportunities that promote their wellbeing and benefit; whilst acknowledging the potential for fallibility and risk within services, doing everything in our power to offer the utmost protection to mitigate potential for harm.
Conclusion

Comorbidity is an increasingly complex challenge intersecting across agencies and sectors, and requiring increased communication and collaboration between all involves.

In response to the barriers to treatment engagement, highlighted earlier in the report, a list of recommendations were put forward by the Australian Government to improve services for comorbid consumers across the country. The findings of the study suggested an urgent need for a national, conjoint mental health, alcohol and drug health system to be developed with the following characteristics:

- Integrate treatment with the public health model using a range of strategies
- Recognition that illicit drug users, as service users, have the same rights as any other consumer within the Australian health system
- Instigating low threshold, easy access for service users with complex needs
- Integrating and co-locating a range of treatment options within services
- Adequately resourcing and training staff in co-occurring drug and mental health problems
- Encouraging and appropriately resourcing drug user organisations and consumer advocacy/participation within treatment services.

Source: Department of Health & Ageing (2007)

In Tasmania, the Alcohol and Other Drugs Services have now merged or come under the umbrella of Mental Health Services, within the Department of Health and Human Services. It is hoped that the integration of these two areas into one overall stream will support best practice in integration of care.

Towards Evidence Based Practice – Comorbidity Guidelines

As this report did not undertake any research data collection, it falls to the literature to provide recommendations of future directions and standards against which to measure practice. A report by Minkoff (2001, cited in Corrigan et al., 2004: 156-157) summarises eight recommendations to guide quality service delivery for people with comorbidity:

1. **Comorbidity should be expected; people with these disorders are not exceptions.** Hence, the system of care should be set up and ready for the difficult treatment needs posed by people with these disorders. They should not be pieced together in an ad hoc manner from mental health and substance abuse services that traditionally only work with one disorder.

2. **When co-existing disorders are observed, both psychiatric and substance abuse disorders should be considered as primary.** All aspects of service need to target both aspects of the duality aggressively from the beginning of care.

3. **Individuals within the population of treatment consumers currently served by any single program are likely to be in all the various stages of change.** Hence, the program needs to provide treatments that address the various stages.

4. **When possible, services for people with dual disorders should be provided by individuals, teams, and programs who are expert in treating both mental illness**
and substance abuse. Piecing together a dual disorders program from the practice of individual mental health and substance abuse centres is likely to be less effective.

5. **Services should be longitudinal and continuous.** Teams and programs should expect that services for people with dual disorders will require months and years of continuous interventions. Long-term intervention is more likely to be successful when the person with dual disorders builds lasting relationships with the same set of providers.

6. **Beware admission criteria that exclude people from participating in a program.** Teams and programs should expect people with dual disorders to have multiple and significant problems including serious physical health problems, homelessness, involvement with the criminal justice system, continued drug abuse, and family physical abuse. None of these issues should be grounds for excluding people from a dual disorders program or for dismissing them from treatment if they recur.

7. **There should be no formal boundaries to dual disorders treatment beyond which services do not occur.** The traditional model of 50-minute hours in the therapist’s office is not suitable to address the multi-layered problems of people with dual disorders. Teams and programs must seek and serve people with dual disorders in sites that are most convenient and timely to the consumer. Seeing the person in the locale in which problems recur helps the service provider better understand the problem as well as makes interventions more potent.

8. **Fiscal and administrative operations of the program need to yield integrated and effective programs.** The evolution of most public systems has produced independently functioning mental health and substance abuse treatment programs. As a result, people with dual disorders have been served poorly by both.


This literature review report has highlighted multiple issues for consideration, emphasising the need for planning and workforce development around coping with the challenges of comorbidity into the future.

“I know how very difficult it is to hang on to some hope, but hope is important. The other thing is to keep trying.”
(Kathy McMahon, consumer & practitioner in Cowan, 2007: 57)
APPENDICES:
Comorbidity References & Information Resources

The Appendices includes:
- References
- Comorbidity Resources
- Mental Wellbeing Plan Template
- ‘Privacy Laws, Client Protection and Practitioners’ Information Sheet


New South Wales Department of Community Services [DoCS] (2005) *Dual Diagnosis: A Resource for Case Workers* New South Wales Department of Community Services: Ashfield, NSW.


Streetwize Communications (2007) Comorbidity Worker Support Kit Streetwize Communications, Ted Noffs Institute and Beyond Blue: Redfern, NSW.


Comorbidity Resources

- Beyond Blue, Australia [www.beyondblue.org.au](http://www.beyondblue.org.au)
- Centre for Addiction and Mental Health, Canada [http://www.camh.net/](http://www.camh.net/)
Mental Wellbeing Plan

Name: ____________________________________________

My mental health condition/symptoms
__________________________________________________________________________
__________________________________________________________________________

My treating health practitioners
__________________________________________________________________________
__________________________________________________________________________

Looking after myself: what I can do to stay well
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

My triggers and early warning signs
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

My plan: what I agree to do to avoid these triggers so I can stay well
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

My support: people I agree can be contacted if I show early warning signs
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

What I’d like these people to do if I become unwell and refuse to take agreed actions
__________________________________________________________________________
__________________________________________________________________________

- I agree that a copy of my Mental Wellbeing Plan can, where necessary, be given to other treating health practitioners involved in my care YES  NO

- I am aware that I can change or update this Plan.

Signature: ________________________________ Date: ________________________________
In December 2001, the Privacy Act (Commonwealth) was adjusted, involving changes to the responsibilities of practitioners and agencies in the private and non-government health and human services sector who receive federal funding. This two page flyer provides a snapshot of information and advice on how to achieve best practice in protecting client privacy.

Handy Hints: Complying with the Law & Ethical Best Practice

- Only collect information that is necessary, and only for an appropriate timeframe.
- Provide each client with details of how they can contact someone in the agency about their information, who to ask, and how they can access it if they wish. For example, tell them verbally, at the start of forms, put up posters, as well as put it in client charters.
- If you wish to deny a client access to personal information collected about them, you should provide reasons, consistent with the Privacy Act, as soon as possible. Agencies should be mindful of their obligations under the Freedom of Information Act 1988 (Commonwealth) which also provides some grounds for denying access.
- Keep personal information secure. For example, if case notes are entered electronically into a pro forma on a computer, a copy of these should also be printed out, dated and signed, and kept in secure storage. Restrict access to this storage.
- Keep personal client information safe from unauthorised access, modification, or disclosure and also against misuse and loss. Methods could include: removing all information before computers are sold or disposed of, installing firewalls and security software, cookie removers and anti-virus scanners, training staff in privacy procedures, and regularly reviewing confidentiality policies and protocols.
- Consider the methods of how personal information about a client is shared with other practitioners and agencies. For example, if information is to be faxed, consider who may view the faxed document once it is sent through to another agency. If it is not appropriate for this information to be potentially accessed, then consider other methods.
- Always be aware of which documents are in eye-sight of other people (e.g. on your desk, notice board, computer screen) when different people enter your office.
- As part of induction, brief all new staff on privacy and confidentiality policy and practice, as well as provide them with a copy of the National Privacy Principles (2006).
- Ensure strict and thorough information sharing protocols are in place for all information exchanges between internal staff and other external practitioners or agencies.
- If quality improvement, monitoring or evaluation activities require examination of client information or files, ensure that this is either conducted by a qualified practitioner who is bound by organisational confidentiality policy, or that information is de-identified if it is to be viewed by an external professional or agency subcontracted to do these duties.

- Consider the level of detail of information that is discussed at staff meetings or as part of informal staff discussions. Only disclose what is necessary and appropriate.

- When clients ask you about other clients, be careful about what you tell them. Also use caution when communicating with family, friends and significant others.

- Where necessary, encourage collaborative partners or regular visitors to sign confidentiality agreements indicating they will respect the privacy of clients.

- If participating in research activities for an education institution or professional body, ensure that they have obtained Human Research Ethics approval and maintain privacy.

- Document any incidents or privacy/confidentiality breaches, and make a concerted effort to rectify the situation as well as put plans in place to prevent future breaches.

Source: Don’t leave privacy to chance, take steps to protect personal information – 10 steps for organisations and agencies to protecting other people’s information (2002)

### Client Privacy Rights, Data Collection and Information Sharing

Under the 2001 Federal privacy laws in Australia, clients have the right to:

- Be clearly informed why their personal information is being collected and how it will be used;
- Request access to their records, including their health information;
- Know which organisations will be given their personal information;
- Ensure organisations only use their information for the purposes they have been informed of and would reasonably expect;
- Find out what information an organisation holds about them and how it is managed, as well as to correct any inaccurate information.


### References, and for further information on privacy laws:

- ‘Private Sector Information Sheet 18 (2003) Taking reasonable steps to make individuals aware that personal information about them is being collected’
- ‘Private Sector Information Sheet 25 (2008) Sharing health information to provide a health service’
- ‘Don’t leave privacy to chance, take steps to protect personal information (2002) 10 steps for organisations and agencies to protecting other people’s information’

Office of the Privacy Commissioner:
www.privacy.gov.au    1300 363 992