Co-occurring substance use disorders and other mental health disorders: policy position statement for Mental Health Alcohol and Other Drugs Services 2021

Queensland Health Guideline
QH-GDL-964:2021

1. Policy position statement

Co-occurring substance use disorders and other mental health disorders are common in consumers of mental health services and alcohol and other drug services, consistent with the multimorbidity increasingly recognised across all health services.

Consumers with co-occurring substance use disorders and other mental health disorders and their families have multiple, complex needs that require a high level of responsiveness across all services, levels of care and throughout all phases of recovery including engagement, screening, assessment, treatment, rehabilitation and transitions of care, including illness self-management with relapse prevention.

Comprehensive treatment and care for consumers with co-occurring substance use disorders and other mental health disorders is fundamental to Queensland Health Mental Health Alcohol and Other Drugs (MHAOD) Services.

2. Scope

This policy position statement applies to Queensland Health MHAOD services across all service settings and age groups. It outlines the policy position and principles that should be adopted by all MHAOD services when providing treatment and care for consumers with co-occurring substance use disorders and other mental health disorders. The policy position statement should be read in conjunction with relevant related documents, identified in section 9.

3. Key policy positions

3.1. Consumers with co-occurring substance use disorders and other mental health disorders are the expectation, not the exception, in MHAOD service systems.

3.2. MHAOD services integrate with primary care providers and other health providers to provide holistic person-centred care, using stepped care approaches.

3.3. MHAOD services assess and provide treatment and care for consumers using a comprehensive care approach, supported by the Queensland Health Comprehensive Care documents and resources, with care plans developed collaboratively between consumers, families, carers, and service providers.

3.4. MHAOD services use the quadrant model to guide decisions on treatment and care for consumers with co-occurring substance use and other mental health disorders (Appendix A).

3.5. MHAOD services routinely screen and assess health problems including substance use, mental health, and physical health, to develop care plans which consider multi-morbidity and to address identified needs.

3.6. A trauma informed care approach is considered at all stages of treatment and care for consumers.

3.7. Effective services require comprehensive, person and family-centred interventions and care, which should be undertaken within the primary treating team wherever possible, with collaborative transfers of care or shared care in selected individual situations.

3.8. MHAOD staff are appropriately skilled to identify and respond effectively to consumers with co-occurring substance use disorders and other mental health disorders and have access to relevant training and clinical supervision to enhance their capabilities. This includes an awareness of stigma and its association with substance use disorders and other mental health disorders and the effect stigma has on consumers accessing services, and access to relevant training.

3.9. Queensland Health staff are expected to provide services that are culturally appropriate to Aboriginal and Torres Strait Islander consumers and culturally and linguistically diverse consumers, guided by the relevant related documents (Section 9).

4. Terminology

Mental and behavioural disorders - mental health disorders

The term 'other mental health disorders' is used throughout the policy position statement (PPS) to describe mental and behavioural disorders and includes those substance use disorders which DSM-5[1] calls substance-induced mental disorders, but excludes other substance use disorders.

Separating out substance use disorders from other mental and behavioural disorders, particularly what have been called substance-induced disorders, is a complex classificatory and clinical challenge. Some of these difficulties are considered further in Appendix B.

Substance use and substance use disorder

The term 'substance use' is widely used internationally and includes the use of any psychoactive substances including alcohol, nicotine and prescription substances. Substance misuse is often used as an overarching term to describe both substance dependence and harmful use. The term 'substance abuse' has long been seen as inappropriate. Substance use disorder is used throughout this policy position statement as an abbreviation for disorders within the ICD-10 classification of Mental and behavioural disorders due to psychoactive substance use. [2]

Co-occurring substance use disorders and other mental health disorders

In the context of MHAOD service delivery, co-occurring substance use and other mental health disorders are generally understood as the co-occurrence of one or more substance use disorders and one or more other mental health disorders and are recognised as complex[3].

Co-occurring mental illness and problematic alcohol and other drug use or disorders was often referred to as dual diagnosis in earlier literature and this terminology has been common practice since. This term is now avoided in policy and academic literature due to its lack of conceptual coherence and specificity, with confusion with other co-occurring disorders such as intellectual impairment co-occurring with mental illness as well as a tendency to exclude other co-morbidities.

Other terms used can include co-morbidity, complex presentations and concurrent, co-morbid or co-occurring disorders. However, each raises similar conceptual and definitional problems. The term

[1] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.).*

[2] World Health Organisation (WHO). 1993. *The ICD-10 Classification of Mental and Behavioural Disorders*. World Health Organisation.

[3] National Mental Health Commission. Deady M et al, 2013, One person, diverse needs: living with mental health and alcohol and drug difficulties.

'co-occurring substance use disorders and other mental health disorders' will be used in this policy position statement as the standard term for the co-occurrence of one or more substance use disorders with one or more other mental health disorders.

This term has various limitations which may vary with perspective; they include its length and its focus on disorder, however it does emphasise the need for both more specificity about the types of disorders involved and for recognising substance use disorders as a specific group of mental health disorders with a significant impact upon mental health.

Where an abbreviation improves communication, the following terms may be used –

- Co-occurring disorder – in place of co-occurring substance use disorder and other mental health disorders, to be used when the types of co-occurring disorders have been established,
- Mental disorders – for 'other mental health disorders'

Often, multimorbidity may be a preferable term.

Multimorbidity

Multimorbidity is the co-existence of multiple chronic conditions in an individual.

Consumer

The term consumer refers to individuals receiving a service from either Queensland Health mental health (MH) services or alcohol and other drug (AOD) services. The term patient is only used in reference to medical treatment of this consumer group. While recognising the historical and continuing use of client in most AOD and many MH service settings, the term consumer is used throughout this document for consistency with the National Standards for Mental Health Services 2010 (NSMHS) guidance and CIMHA terminology.

Comprehensive care

Comprehensive care refers to integration across the essential elements of comprehensive care including assessment, formulation, diagnosis, care planning, clinically appropriate and effective treatment and care provision, care review and transitions of care. Each of these elements are underpinned by collaborative consumer and carer engagement and informed by social and cultural considerations.

5. Principles of care for co-occurring substance use disorders and other mental health disorders

5.1. Individuals with co-occurring substance use disorders and other mental health disorders are the expectation, not the exception. Systems planning, service operations and the delivery of treatment and care must address the need to provide appropriate services for people with co-occurring disorders.

5.2. MHAOD services should be experienced by the consumer as caring, accepting, respectful, and responsive to individual preferences and cultural values, providing treatment and care without bias or stigma.

5.3. A thorough, holistic approach is needed in assessment, treatment, and care of individuals with co-occurring substance use disorders and other mental health disorders. MHAOD services should support the seamless delivery of mental health and substance use treatment services, minimising discontinuity of care.

5.4. A 'no wrong door' approach provides people with appropriate services, which must be accessible from multiple points of entry. All services should respond to the individual's stated and assessed needs through direct service, whenever possible. Where linkage to alternative service providers is the most appropriate intervention, this should be through a "warm" handover (handover conducted in person, between two members of the treating team, with the consumer present) as much as possible, whereby the assessing team maintains clinical responsibility until the consumer is engaged with the new service provider.

5.5. Referral within MHAOD services from MH services to AOD services, and vice versa, should not be routine practice, though advice and opinion should be sought when appropriate, and referral may be needed in individual cases where a consumer's needs will be best addressed through care in a different service type.

5.6. MHAOD services incorporate the principles of trauma-informed care in the assessment, treatment, and care of individuals with co-occurring substance use disorders and other mental health disorders[4].

5.7. Effective collaborative partnerships across MHAOD services and with other health care providers, social services, housing, criminal justice, education, and related fields are required to support and sustain recovery.

5.8. MHAOD staff have a shared role in considering and responding to multimorbidity in consumers.

[4] Kezelmen, C., & Stavropolous, P. (2012). The Last Frontier: Practice guidelines for the treatment of complex trauma and trauma informed care and service delivery.

6. Queensland Health seeks the following actions:

MHAOD services provide evidence and consensus-based practices for people with co-occurring substance use disorders and other mental health disorders consistent with standard Queensland Health models of service, clinical governance, and the principles above. In relation to co-occurring disorders, this includes:

6.1. Local governance structures and processes that support effective engagement, screening, assessment, formulation, diagnosis, care planning, treatment and care, review of care, and transition, including a 'no wrong door' approach. This requires specialist MHAOD services to provide brief and specialised interventions and treatment for all co-occurring substance use disorders and other mental health disorders.

6.2. Systems planning, service operations and the delivery of treatment, care and service evaluation should address the need to provide appropriate services for people with co-occurring disorders.

6.3. MHAOD services provide interventions matched to a person's current needs including consideration of specific symptoms, behaviours, impairments, and disorders, using various perspectives including recovery and motivation for change. This should involve a 'stepwise' approach to treating substance use disorders (e.g. engagement, brief intervention, motivational enhancement, active treatment, relapse prevention) with individualised specific treatment within a service in addition to a stepped care approach both within and between services and service providers.

6.4. Consistent with the quadrant model (Appendix A), AOD services should facilitate treatment for their consumers with mild to moderate severity of mental disorders and arrange referral to MHS where the mental disorder is more severe and requires MH service care. For consumers with severe mental health conditions, MHS take primary responsibility for treatment. The reverse applies for MH services in relation to people with severe substance use disorders and mild to moderate mental disorders. Treatment may be via shared care with GPs/private providers/NGOs/community controlled health organisations with clear allocation of responsibilities, particularly for prescribing pharmacological treatment.

6.5. Proactive coordination and negotiation of services on behalf of a person with co-occurring substance use disorders and other mental health disorders to ensure continuity of treatment and care across services.

7. Implementation of this policy position statement

MHAOD services are responsible for building and monitoring service capability to work effectively with consumers with co-occurring disorders. This should be achieved through:

7.1. Leadership and governance

Policies and systems support comprehensive care for consumers with co-occurring disorders.

7.2. Education and training

Staff have the skills and knowledge to provide effective services for consumers with co-occurring disorders.

7.3. Supervision and support

Staff working with consumers with co-occurring disorders are supported.

7.4. Evaluation and improvement

The quality of care is measured and improved.

8. Legislation

- *Hospital and Health Boards Act 2011*
- *Mental Health Act 2016*
- *Human Rights Act 2019*

9. Related documents

- Chief Psychiatrist Policy – Treatment and Care of Patients
- Comprehensive Care – Partnerships in Care and Communication, Queensland Mental Health Alcohol and Other Drugs, Documentation Framework 2020
- Comprehensive Care – Partnerships in Care and Communication, Queensland Mental Health Alcohol and Other Drugs, Documentation Guide 2020
- Equally Well – Improving the physical health and wellbeing of people living with mental illness in Australia, Australian Government, National Mental Health Commission
- Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings, second edition, Australian Government, Department of Health, Centre of Research Excellence in Mental Health and Substance Use at the National Drug and Alcohol and Research Centre at UNSW Australia 2016
- Multicultural Clinical Support Resource Folder | Queensland Health

- Practice Guidelines for Clinical Treatment of Complex Trauma 2019, Blue Knot Foundation, National Centre of Excellence for Complex Trauma
- Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 - 2033
- Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016 – 2021
- Queensland Health Guidelines - Information Sharing - Between mental health staff, consumers, family, carers, nominated support persons and others
- Queensland Health response to the final report – When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services.
- Queensland Mental Health Commission: Changing attitudes, changing lives – options to reduce stigma and discrimination for people experiencing problematic alcohol and other drug use, March 2018
- Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018 – 2023
- The National Standards for Mental Health Services 2010, Australian Government Department of Health
- The National Safety and Quality Health Service Standards – Clinical Governance Standard, Comprehensive Care Standard
- Violence Risk Assessment and Management Framework – Mental Health Services – Queensland Health
- Working with parents: guidance for mental health alcohol and other drugs services

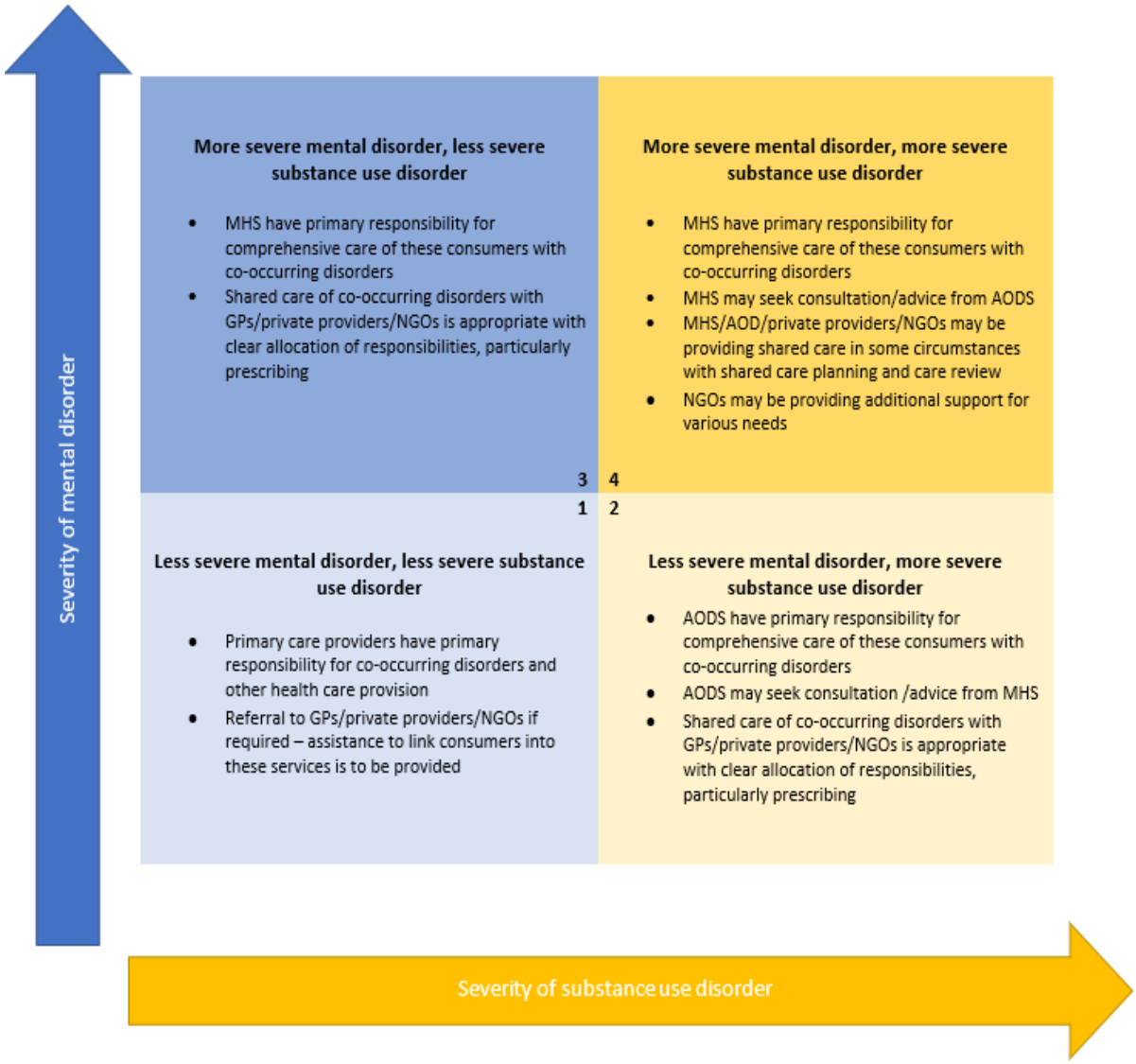
Version Control

Version	Date	Comments
0.1	Sept 21	*Final*

Appendix A

The Quadrant Model – a recommended guide for considering appropriate service for provision of treatment and care for consumers with co-occurring substance use disorders and other mental health disorders.

General Practitioners (GPs) are the primary care providers for consumers with co-occurring disorders in quadrant 1, please note GPs retain responsibility for providing primary care to consumers with co-occurring disorders in all other quadrants.



Appendix B

Classification issues for substance use disorders and other mental health disorders

The World Health Organization *International Statistical Classification of Diseases and Related Health Problems (ICD)* and the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders (DSM))* have varied over time in classifications of substance-related disorders and use of the term substance use disorders. ICD-10 uses the overarching category “mental and behavioural disorders due to psychoactive substance use” while ICD-11 uses the term “disorders due to substance use”. DSM-5 uses the term substance-related disorders to include two groups, substance use disorders and substance-induced disorders.

DSM-5 categorises as substance-induced disorders the following: intoxication, withdrawal, and other substance/medication-induced mental disorders (psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, sleep disorders, sexual dysfunctions, delirium, and neurocognitive disorders). It notes “In substance/medication-induced psychotic disorder, the psychotic symptoms are judged to be a physiological consequence of a drug of abuse, a medication, or toxin exposure and cease after removal of the agent” (DSM-5 Schizophrenia Spectrum and Other Psychotic Disorders). The diagnostic criteria for these disorders are considered with Schizophrenia Spectrum and Other Psychotic Disorders as substance/ medication-induced psychotic disorder.

ICD-11 classifies disorders due to substance use by the substance, with a qualifier of substance-induced for each substance where appropriate, so that caffeine and tobacco do not have induced psychotic disorders. DSM-5 core substance use disorder categories are broadly consistent with the ICD-11 categories of harmful pattern of use and dependence and the similar ICD-10 categories.

The diagnosis of substance-induced disorders with slow onset and resolution, such as some substance-induced psychoses, poses particular challenges in assessment and causative reasoning, requiring a particular long term perspective and a good understanding of the presence or absence of substance use. Diagnostic classifications require clinicians to make such causal decisions with limited and inconsistent guidance by evidence-based criteria. This is a particular problem in relation to co-occurring substance use disorders and other mental health disorders and highlights the importance of careful diagnostic practice in and clinical management of such disorders.