"No Wrong Door"

A Mid-West Integrated, Community, Recovery and Evidence Based Treatment Resource For Those Struggling With Co-Occurring Conditions

July 2015

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Contributors

The current proposal has been established following a yearlong process of research, design and development by the following HSE personnel from the Mid West region:

Gearoid Prendergast

Gearoid Prendergast is the Co-ordinator of the Mid West Regional Drugs & Alcohol Forum

Marie Oppebøen

Marie Oppebøen is a Senior Registrar in General Adult Psychiatry HSE Mid-West, and holds the qualifications MB BCh BAO MRCPsych (Membership of the Royal College of Psychiatrists)

Donal Ryan

Donal Ryan is an addiction counsellor in North Tipperary Mental Health Service and is a registered addiction counsellor and psychotherapist (MACI, MIACP)

Colin O'Driscoll

Colin O'Driscoll is a registered Psychologist (PSI, BPS, HCPC), associate fellow of the PSI, and holds the position of Clinical Lead for the HSE Mid-West Drug and Alcohol Service

Table of Contents

Executive Summary

Introduction

The presentation of co-occurring disorders (substance misuse and mental health problems) is now considered to be more the norm than the exception. It presents many challenges for health care professionals and services, is difficult to treat and also has poorer outcomes such as increased risk of suicide and self-harm, higher rates of hospitalisation, longer duration of admission and increased risk of violence and offending.

According to Irish and International literature, there is a clear consensus that integration between mental health and addiction services is sorely needed and long overdue. Over the last two decades there has been a shift towards person-centred recovery-oriented mental health and addiction services, and there is an equally pressing need for transformation to recovery-oriented care in both systems.

It is clear from national protocols and policy informing documents governing both services (such as A Vision for Change, National Strategy for Action on Suicide Prevention, National Substance Misuse Strategy and HSE Primary Care/Mental Health Division Operational Plans 2015) that working in accordance with the concept of recovery, empathy and engaging in evidence based practice with the service user at the centre, is critical to effective treatment. There is a great emphasis on working together across sectors of care and integrating services to better meet the needs of the individuals with complex clinical presentations.

Efforts have already been made through a pilot project in North Tipperary in attempts to improve access to addiction services for people with mental health problems, and to deliver integrated and recovery based treatments with good results so far.

Philosophy and Mission Statement

We propose to develop a fully integrated and recovery focused community service for adults with co-occurring disorders and complex needs in the Mid-West. It is envisaged that such a service could serve as a bridge between primary and secondary care, work under a shared care model and help improve access to and engagement in treatment as well as outcomes for people with co-occurring conditions. The service would aim to provide person-centred, motivational and harm-minimisation treatment approaches, with continuity of care throughout the recovery process in keeping with evidence based and best practice guidelines. It also aims to promote knowledge of and help reduce stigma around co-occurring conditions. The ultimate goal of this service is to represent a solution for agencies in both mental health and addiction services that find it difficult to treat such conditions in isolation.

Proposed Strategy

1) Develop a Co-Occurring Conditions Team with staff from both MH and addiction services
2) Establish a Co-Occurring Conditions Service using a phased approach
3) Provide Integrated & Recovery-focused treatments
4) Interagency Working, Collaboration and Co-Ordination
5) Promote & Provide Education and Training on all issues related to mental health & addiction
6) Engage in Research on integrated and recovery oriented service delivery and outcomes
7) Continuous evaluation, and presentation of results

Background

Definition

*Co-occurring Conditions (*commonly referred to as "dual diagnosis" and "co-morbidity") broadly relate to the presentation of two or more conditions including substance misuse (abuse or dependence) and mental disorders.

Prevalence

The experience of co-occurring issues may be considered to be more the norm than the exception. The literature indicates high rates of co-occurring disorders that are increasing steadily over time (Jackson-Koku, 2001). Substance misuse treatment programmes typically report that 50 to 75 percent of clients have co-occurring mental disorders, while clinicians in mental health settings report that between 20 and 50 percent of their clients had co-occurring substance use disorders. (See Sacks et al. 1997*b* for a summary of studies).

Although prevalence research in Ireland is more modest, similar rates are found (e.g. Condren et al, 2001; Kamali et al 2000). In 2011, the Mental Health Commission identified that dual diagnosis (co-occurring conditions) rates among people in Ireland are reported between 30% and 80%. According to the HRB activities report on Irish psychiatric units and hospitals, 2,360 individuals were admitted with a primary diagnosis of alcohol or other drug disorder to an inpatient unit in 2013, representing 12.8% of all admissions (HRB *Activities of Psychiatric Units and Hospitals 2013,* Table 2.6a).

Implications

The treatment of clients with co-occurring conditions presents many challenges for health care professionals and services. As a group, this combination of presenting issues is more difficult to treat and to manage because of higher levels of physical, social and psychological impairment, increasing costs for patients, carers, health care systems and society at large. These clients often have poorer outcomes as outlined in Table 1

Table 1: Poorer Outcomes

- Increased risk of DSH and suicide: (*Arensman, NSRF 2013;Schneider, 2009; Drake & Wallach, 1989; Lysaker et al., 1994; Heila et al., 1997; O'Boyle & Brandon, 1998)*
- Increased relapse rates and severity : (*Holland 1998)*
- Higher rates of hospitalisation: (*Coffey et al 2001:* more than 20 times the rate for substance abuse-only clients, and 5 times the rate for mental disorder - only clients. *Salloum et al., 1991; Bartles et al., 1993; Haywood et al., 1995; Gupta et al., 1996)*
- Longer duration of admission*: (Menezes et al 1996)*
- Increased risk of violence and offending : (Swanson et al., 1990; Cuffel, 1994; Tardiff et al.,1997 Scott et al. 1998)
- Higher incidence of homelessness : (Odell & Commander (2000); *Susser et al. (1991)*

Despite a range of long-standing historical, political, ideological, professional, structural, and practical barriers, there has been, and continues to be, a clear consensus among experts that integration between mental health and addiction services is sorely needed and long overdue. The provision of integrated, coordinated care is essential to enable the delivery of effective treatment for people with co-occurring conditions. For further details on service provision models, see Appendix 4.

Over the last decade or two, there has been a shift towards person-centred recovery-oriented mental health and addiction services in Ireland and internationally and there is an equally pressing need for transformation to recovery-oriented care in both systems. The similarities and shared values between addiction and mental health recovery are striking, and literature suggesting the use of the recovery concept as an organising principle for bridging the divide between the two domains is now growing and gaining an evidence base.

Evidence Based Approaches

Several principles and responsibilities based on evidence- and consensus-based research and clinical practices for people with co-occurring conditions have been articulated and validated across the mental health and addiction treatment fields (Sacks, Ries, SAMHSA 2006; COCE, 2006; CCISC-model: Curie et.al 2005; Minkoff and Cline 2004; Minkoff, 2001). They are outlined in table 2.

Table 2: Evidence Based Principles and Responsibilities

1) **Effective Collaborative Partnerships** between mental health and addiction services and with professionals in primary care, social services, housing, criminal justice, education and related fields are required to meet the complex needs of people with co-occurring conditions.

2) **An Integrated Care Approach** that ensures continuity and quality between MH and addiction services.

3) **Integrated Service Provision** involves a **Biopsychosocial Approach** comprising an array of physical, psychological and social service interventions in the provision of engagement, assessment, treatment and care. These interventions are outlined in an **Integrated and Comprehensive Care-Plan.**

4) **A "No Wrong Door" Approach** is used that provides people with, or links them to, appropriate services regardless of where they enter the system of care.

5) The development and maintenance of a **Therapeutic Alliance,** or quality treatment relationship based on mutual respect, is an essential component of effective treatment for individuals with co-occurring conditions. Empathy, respect and belief in the individual's capacity for recovery are fundamental service provider attitudes and values.

6) **A Harm Minimisation Approach** which recognises that people with substance use and mental health problems have a wide range of treatment goals.

7) **A Holistic, Recovery-Based Approach** and effective linkage with the broader social service network

8) **Service User Involvement and active participation of primary carers, family or significant others**

9) **Peer support and Community involvement** must be explicitly recognised and supported in treatment planning and consumer advocacy

Policy Context

The national framework for working towards valid and targeted treatment of conditions and concerns relating to mental health and addiction issues are covered in documents and policies such as the following:

- A Vision For Change (2006)
- A Recovery Approach within the Irish Mental Health Services – A Framework for Development (MHC 2008)
- *Reach Out* National Strategy for Action on Suicide Prevention 2005-2014 (HSE 2005): Second report of the Suicide Support and Information System 2013 (NSRF,NOSP)
- *Connecting for Life* Ireland's National Strategy to Reduce Suicide 2015-2020 (NOSP, HSE)
- HSE Mental Health Division – Operational Plan (2015)
- HSE Primary Care Division – Operational Plan (2015)
- National Substance Misuse Strategy - Steering Group Report (Feb 2012)
- National Drugs Rehabilitation Framework - And the National Protocols and Common Assessment Guidelines document

It is clear in these protocols and policy informing documents that working in accordance with the concept of recovery, empathy and engaging in evidence based practice with the service user at the centre, is critical to effective treatment. The necessities of services to be driven by good practice and integrated care, especially in the context of multi-faceted problem presentations and co-occurring conditions, has never been so clearly articulated. There is a great emphasis on working together across sectors of care to better meet the needs of the individuals with complex clinical presentations.

Commitments from Government and higher HSE management level to tackle the issue of co-occurring conditions are finally starting to emerge. Recent publications such as *Connecting for Life* Ireland's Strategy for Action on Suicide Prevention 2015-2020 and *HSE Primary Care Division- Operational Plan 2015*, have both outlined strategic goals and action plans related to co-occurring mental health and substance misuse.

More detail pertaining to the relevance in a national policy context can be found in Appendix 5.

North Tipperary Pilot Project

Efforts have already been made in North Tipperary in attempts to improve access to addiction services for people with mental health problems, and to deliver integrated and recovery based treatments.

During 2013/2014, the addiction counsellor and psychiatric registrar in Nenagh community mental health service ran a pilot project for service users referred to addiction counselling in the CMHT. The project included screening/triaging, assessment, motivational and recovery based group programme led by counsellor and registrar, psychiatric reviews, group evaluations and a peer support aftercare group. They utilised strategies and techniques from motivational interviewing, cognitive behavioural therapy and community reinforcement approach, in keeping with evidence based and best practice guidelines for management of co-occurring conditions.

Results:

1) Waiting list for addiction counselling was significantly reduced
2) Access to and engagement in treatment improved
3) Further integration of mental health and addiction treatment established with positive results
4) Service Users got involved in planning and decision making
5) Good outcomes were identified in areas such as motivation to change, alcohol and/or drug use, overall well-being, self-esteem/confidence, social isolation and anxiety, sense of purpose and managing difficult emotions.

Table 3: Group Evaluation/Feedback

Best parts of group programme
- "Meeting new people without having drink and being able to talk to people who are going through the same difficulties"
- "Openness, feeling of safety, non-judgmental, good people in group"
- "It felt safe and understanding and I looked forward to it every week. The doctor and addiction counsellor were easy to talk to and it made me happy"
- "You weren't made feel like an outsider. I was involved and everyone could relate to each other. No one brushed over you making you feel like you shouldn't be there, I was accepted for who I was"
- "Made me feel normal, like I deserved to be there. The other group members helped my confidence and self-esteem"
- "The help that I have received to cope with triggers that have pushed me to abuse in the past, and the trust and security within the group"

Other relevant efforts locally:

- Subsequent groups ran by addiction counsellor in the CMHS offering more choice and services tailored to individuals' stages of change and needs such as Women's Group, Young Men's group and Group for more severe enduring mental illness.
- Strong links/collaboration established between Addiction Counsellor and Community Detox Team through joint assessments.
- Multidisciplinary Team Presentations on Co-occurring conditions, Integrated Treatment and Motivational Enhancement techniques (by addiction counsellor and registrar)
- Addiction Counsellor and Psychiatric registrar's involvement with MWRDAF's Drug and Alcohol Awareness Week 2014, providing public talk on Drugs, Alcohol and Mental Health
- Involvement in the North Tipperary Community Cluster Meetings
- Established close links with Peer Support Centre Aras Follain where Peer Support Aftercare group was established
- Existing close working relationship between addiction counsellor in Nenagh and other services such as TUSLA, Probation and Reparation Services

Aims and Objectives

- To develop a fully integrated and recovery focused community service for adults with co-occurring conditions and complex needs in the Mid-West, as recommended in *A Vision for Change* Recommendations 15.3.4 and 15.3.5. The aim of this service is to support and represent a solution for agencies in both mental health and addiction services that find it difficult to treat such conditions in isolation.

- In accordance with a Vision for Change 15.3.3., HSE Primary Care Division - Operational Plan 2015 and Ireland's National Strategy to Reduce Suicide 2015-2020 we wish to formalise care-pathways and establish collaborative partnerships between the mental health service and addiction services, and also with other primary care services, department of justice, TUSLA, housing, education and other related agencies.

- To enhance knowledge of and promote training in co-occurring conditions within the above services, and ultimately develop a "No Wrong Door" approach in the Mid-West aiming to improve engagement, access to treatment, quality of care and outcomes for people with co-occurring conditions.

- To help reduce stigmatisation and improve social inclusion of people with mental health and substance misuse problems

- To reintegrate clients into the community and help them pursue dignified and gratifying lives in the presence or absence of active mental health/addiction symptoms

Vision and Philosophy

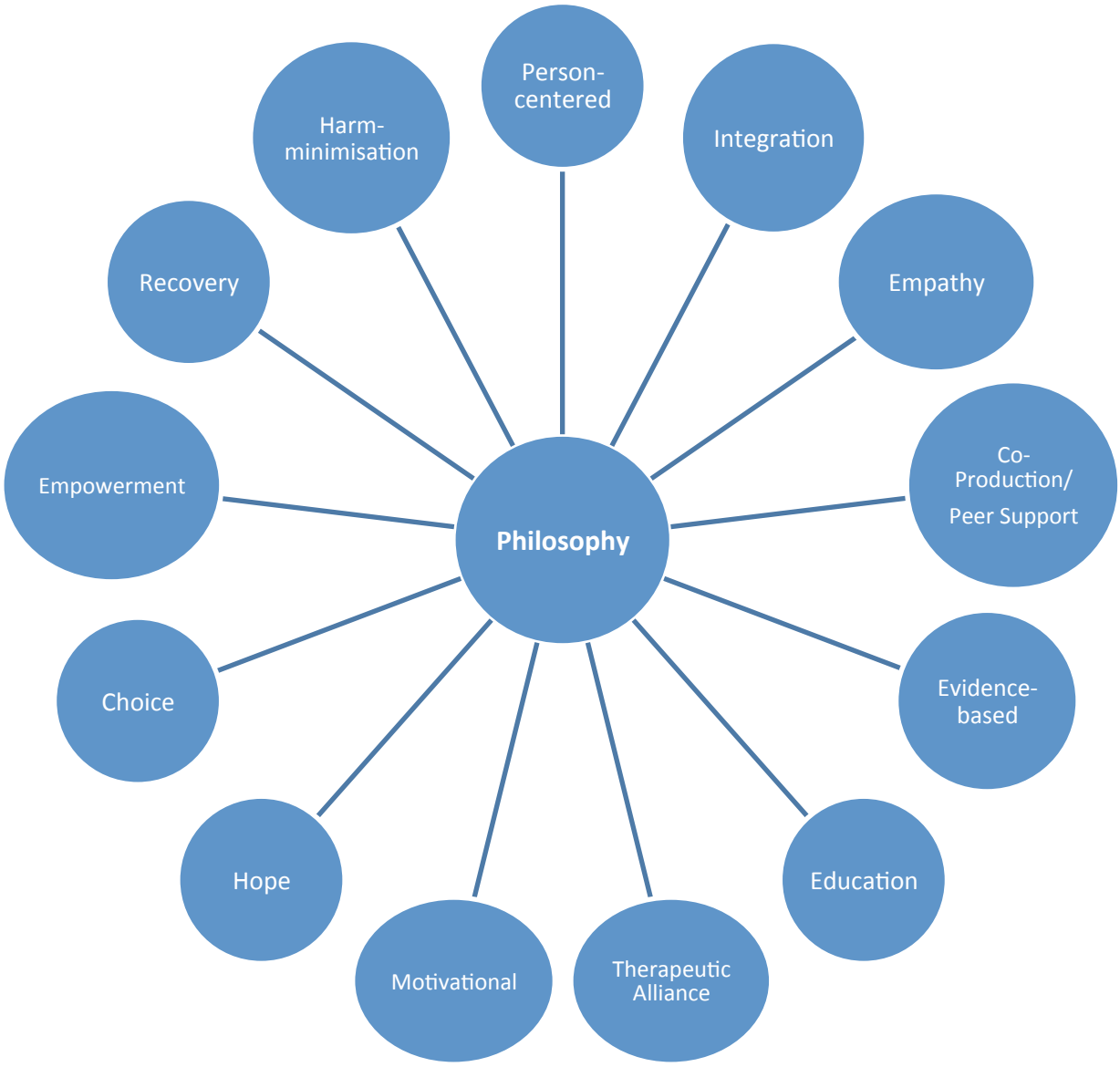


Figure 1: Philosophy

- Our vision is to provide an integrated service for people with co-occurring disorders, which involves a person-centred, harm minimisation and recovery-based approach.

- We envisage that such a service may serve as a bridge between primary and secondary care, and work under a shared care model.

- The *No Wrong Door* Philosophy is such that when an individual with addiction or mental health problems presents for assistance of any kind, they have arrived at the

right place. We hope that in the future, through the work of the "No Wrong Door" – project, the philosophy of No Wrong Door will apply to any door within the health service delivery system.

- We want to offer hope, choice, promote growth, empowerment and build on strengths

- Our treatment approaches will be largely motivational in nature and use evidence based principles from motivational interviewing, community reinforcement approach and cognitive behavioural therapy

- Development and maintenance of a therapeutic alliance is vital and continuity of care essential.

- Empathy, respect and belief in the individual's capacity for recovery are fundamental service provider attitudes and values

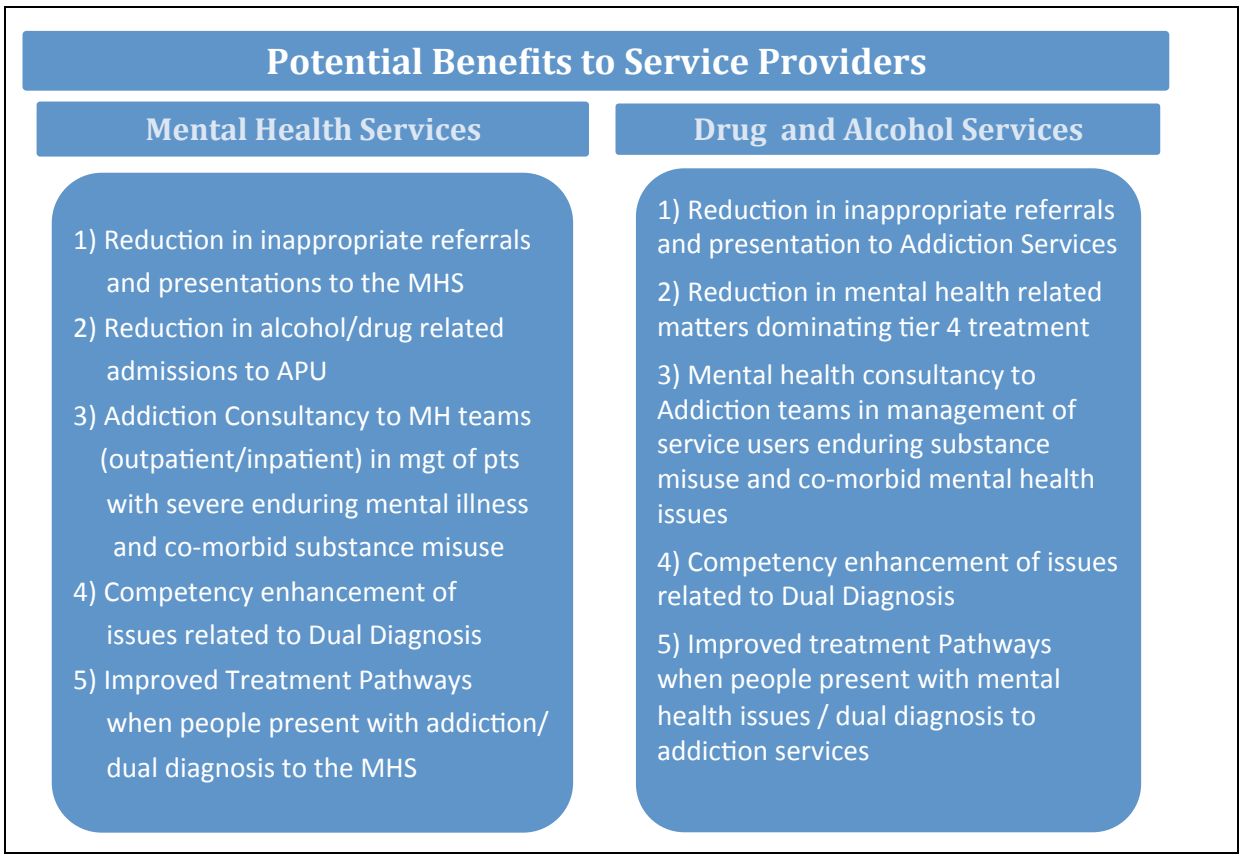
- Service user involvement, co-production and active participation of primary carers, family or significant others in the treatment and care

- Peer support and community involvement in treatment planning and consumer advocacy

- We envisage that by up-skilling and educating staff working in various relevant services, defining and standardising screening, assessments and referral pathways, and establishing close partnerships and communication between services, we can improve access to treatment for people with co-occurring conditions, prevent this population group from falling between the cracks, improve clinical outcomes and also reduce the amount of inappropriate referrals and presentations to the mental health service.

- We believe that the above philosophy could serve to reduce the stigma around mental health and addiction within services and in the community as a whole, which would further improve the quality of life of this often doubly stigmatised client group.

Table 4: Potential Benefits to Service Providers



Proposed Strategy

1. Establish a co-occurring conditions team as per example in Appendix 2

2. Team to provide integrated treatment of mental health and addiction problems (Services provided as outlined in Appendix 1)

3. Interagency Working/Collaboration and Co-Ordination
    - Through NDRIC and interagency network meetings
    - Mental Health Services (general and specialist)
    - Psychology/Counselling Services
    - Community Addiction Services (Statutory/Voluntary)
    - Housing
    - Probation/Dept. of Justice
    - TUSLA
    - Education Providers
    - Other relevant services

4. Education and Training on all issues related to mental health and addiction (for staff in relevant services as named above)
    - Raising competencies associated with co-occurring problem presentations and learning assessment strategies in their opposite disciplines and elsewhere

5. Engage in Research on integrated and recovery oriented service delivery and outcomes

6. Evaluation and presentation of results

See Appendix 1 for a full programme outline

Clinical Governance

The clinical governance structure of *No Wrong Door* has multi layers and considerations. The service is committed to best practice principles governing mental health and addiction service provision. The design is to draw from and implement a treatment based on demonstrated evidence. All staff will be managed and supervised appropriate to their needs, registration and discipline requirements to ensure safe and efficacious practice.

Quality management systems governing the project:

- A Vision for Change
- Mental Health Commission's Quality Framework
- QuADS (Quality in Alcohol and Drug Services – Organisational Standards)
- NDRIC publications (e.g. National Protocols and Common Assessment Guidelines)

More detail on these considerations can be found in Appendix 3

References

Arensman E., Wall A., McAuliffe C., Corcoran P., Williamson E., McCarthy J., Duggan A., Perry I.J. (2013)*Second Report of the Suicide Support and Information System* . 6-7. National Suicide Research Foundation 2013. HSE.

A Recovery Approach within the Irish Mental Health Services – A Framework for Development (MHC 2008)

A Vision for Change. Report of the Expert Group on Mental Health Policy. Government Publications Office (2006). 146 – 148.

Bartles, S.J., Teague, G.B., Drake, R.E., et al. (1993). Substance Abuse in Schizophrenia: Service utilization and Cost. *Journal of Nervous and Mental Disease,* 181, 227-232.

Caton, C.L.M., Gralinick, A., Bender, S., et al. (1989). *Young chronic patients and substance abuse. Hospital and Community Psychiatry*, 40, 1037-1040.

COCE (2006). Overarching principles to address the needs of persons with co-occurring disorders, Overview Paper 3, Cooccurring Center for Excellence, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services. *www.coce.samhsa.gov*

Coffey, R., Graver, L., Schroeder, D., Busch, J., Dilonardo, J., Chalk, M., and Buck, J. (2001). *Mental Health and Substance Abuse Treatment: Results from a Study Integrating Data from State Mental Health, Substance Abuse, and Medicaid Agencies*. DHHS Publication No. (SMA) 01-3528. Rockville, MD: Substance Abuse and Mental HealthServices Administration.

Condren, R.M., O'Conner, J., Browne, R. (2001). *Prevalence and patterns of substance misuse in schizophrenia: A catchment area case-control study*. Psychiatric Bulletin, 25, 17-20.

Connecting for Life Ireland's National Strategy to reduce Suicide 2015-2020.(June 2015) National Office for Suicide Prevention, HSE, Department of Health. 41-47.

Cuffel, B.J. (1994). Violent and destructive behaviour among the severely mentally ill in rural areas: evidence from Arkansas' community mental health system. *Community Mental Health Journal,* 30,495-504.

Curie C.G., Minkoff K, Hutchings GP, Cline C. (2005) *Strategic Implementation of Systems Change for Individuals with Mental Health and Substance Use Disorders* . Journal of Dual Diagnosis, Vol. 1(4)

Dixon, L., Haas, G., Weiden, P.J., Sweeney, J., et al. (1991). *Drug Abuse in Schizophrenic Patients: Clinical Correlates and Reasons for Use. American* Journal of Psychiatry, 148, 224-230.

Davidson, L & White, W. (2007). The concept of recovery as an organizing principle for integrating mental health and addiction services. *Journal of Behavioral Health Services and Research, Journal of Behavioral Health Services and Research,* 34(2), 1094-3412.

Dept. of Health UK (2007)*; Recommendations for Best Practice in managing risk.* Prepared for the National Mental Health Risk Management Programme.

Doyle J, Ivanovic J (2010) National Drugs Rehabilitation Framework Document. National Drugs Rehabilitation Implementation Committee. Dublin: Health Services Executive.

Drake RE, Essock SM, Shaner A, Carey KB, Minkoff K, et al. (2001). *Implementing Dual Diagnosis Services for Clients with Severe Mental Illness*. Psychiatric Services, 52:469-76,.

Drake RE, Mueser KT, Brunette MF, et al. (2004). A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. *Psychiatric Rehabilitation Journal*; 27(4):360-374.

Drake, R.E., Wallach, M.A. (1989). Substance abuse among the chronic mentally ill. *Hospital and Community Psychiatry,* 40, 1041-1046.

Elangovan, N., Berman, S., Meinzer, A., et al. (1993). *Substance abuse among patients presenting at an inner-city psychiatric emergency room*.

Gupta, S., Hendricks, S., Kenkel, A.M., et al. (1996). Relapse in schizophrenia: Is there a relationship to substance abuse? *Schizophrenia Research 20,* 153-156.

Haywood, T.W., Kravitz, H.M., Grossman, L.S., et al. (1995). Predicting the "revolving door" phenomenon among patients with schizophrenic, schizoaffective, and affective disorders. American *Journal of Psychiatry,* 152, 856-861.

Health Service Executive Primary Care and Mental Health Group (2012) Advancing the Shared Care Approach between Primary Care & Specialist Mental Health Services: A Guidance Paper, Naas: Office of the Assistant National Director Mental Health, HSE, p.11.

Heila, H., Isometsa, E.T., Henriksson, M.M., et al. (1997). Suicide and schizophrenia: a nationwide psychological autopsy study on age- and sex-specific clinical characteristics of 92 suicide victims with schizophrenia. *American Journal of Psychiatry,* 154, 1235-1242.

Holland, M. (1998). Substance use and mental health problems: meeting the challenge. *British Journal of Nursing,* 7, 896-900.

HRB *Activities of Psychiatric Units and Hospitals 2013,* Table 2.6a

HSE, Clinical Indemnity Scheme. *Risk Management in Mental Health Services – Guidance Document.* HSE 2009

HSE Mental Health Division – Operational Plan (2015) p.16-26

HSE Primary Care Division – Operational Plan (2015) p. 41

Jackson-Koku, G. (2001). *Mental Illness and substance misuse: a nursing challenge*. British Journal of Nursing, 10, 242-246.

Kamali, M., Kelly, L., Gervin, M., et al. (2000). *The prevalence of co-morbid substance misuse and its influence on suicidal ideation among inpatients with schizophrenia*. Acta Psychiatrica Scandinavica, 101, 452-456.

Keane, Mc Aleenan and Barry, 2014. *Addiction Recovery: A contagious paradigm! A case for the re-orientation of drug treatment services and rehabilitation services in Ireland.* Published by Soilse, Dublin 2014.

Kessler, R.C. (1995). *The epidemiology of psychiatric co-morbidity. In Textbook of Psychiatric Epidemiology* (eds. M. Tsuang, M. Tohen & G. Zahner), pp.179-197. New York: John Wiley.

Kessler, R.C., Nelson, C.B., McGonagle, K.A., et al.(1996). *The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization.* American Journal of Orthopsychiatry, 66, 17-31.

Kingdon D & Turkingdon D (1994), *Cognitive-Behavioural Therapy for Schizophrenia*, Hove: Lawrence Erlbaum, UK.

Lysaker, P., Bell, M., Beam-Goulet, J., Milstein, R. (1994). Relationship of positive and negative symptoms to cocaine abuse in schizophrenia. *Journal of Nervous and Mental Disease,* 182, 109-112.

MacGabhann, Liam and Scheele, Alexandra and Dunne, Triona and Gallagher, Pamela and MacNeela, Padraig and Moore, Gerard and Philbin, Mark National Advisory Committee on Drugs. (2004) *Mental health and addiction services and the management of dual diagnosis in Ireland*. Stationery Office, Dublin .

Menezes, PR., Johnson, S., Thornicroft, G., et al. (1996). Drug and alcohol problems among individuals with severe mental illness in South London. *British Journal of Psychiatry,* 168, 612-619.

Mental Health Reform (June 2015). A Vision for Change Nine Years on: A Coalition Evaluation of Progress. P. 45.

Miller, W.R. & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd edition). New York: Guilford Press.

Minkoff K. (2001). *Developing Standards of Care for Individuals with Co-occurring Psychiatric and Substance Disorders* .Psychiatric Services, 52:597-99.

Minkoff, K. (2001) *Behavioural health recovery management service planning guidelines co-occurring psychiatric and substance use disorders*. Illinois Department of Human Services' Office of Alcoholism and Substance Abuse.

Minkoff K, Cline CA. (2004). *Changing the World: The Design and Implementation of Comprehensive Continuous Integrated Systems of care for Individuals with co-occurring disorders.* Psychiatric Clinics of North America, 27 (4): 727 – 43. 2004

National Substance Misuse Strategy - Steering Group Report (Feb 2012)

O'Boyle, M., Brandon, E.A.A. (1998). Suicide attempts, substance abuse and personality. *Journal of Substance Abuse Treatment,* 15, 353-356.

Odell, S.M., Commander, M.J. (2000). Risk factors for homelessness among people with psychotic disorders. *Social Psychiatry and Psychiatric Epidemiology,* 35, 394-401

Piazza, N.J. (1996). *Dual Diagnosis and Adolescent Psychiatric Inpatients. Substance Use and Misuse,* 31, 215-223.

Prochaska JO and DiClemente CC (1984) *The Transtheoretical Approach: Towards a Systematic Eclectic Framework* . Dow Jones Irwin , Homewood, IL, USA

Reach Out National Strategy for Action on Suicide Prevention 2005-2014 (HSE 2005): Second report of the Suicide Support and Information System 2013 (NSRF,NOSP)

Regier, D., Farmer, N., Rae, D. (1990). *Co-morbidity of mental disorders with alcohol and other drugs of abuse: results from epidemiological catchment area* (ECA). Journal of the American Medical Association, 264, 2511-2518.

Rosenthal, R.N., Hellerstein, D.J., Miner, C.R. (1992). *Integrated services for treatment of schizophrenic substance abusers: Demographics, symptoms and substance abuse patterns*. Psychiatry Quarterly,

63, 3-26.

Royal College of Psychiatrists. (2008). *Rethinking Risk to others in Mental Health Services, College Report 150.*

Salloum, I,M., Moss, H.B., Daley, D.C. (1991). Substance abuse and schizophrenia: Impediments to optimal care. *American Journal of Drug and Alcohol Abuse,* 17, 321-336

Sacks S, Ries R, SAMHSA, US Dept of Health and Human Services (2006). *TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders*.

Sacks, S., Sacks, J., De Leon, G., Bernhardt, A.I., and Staines, G.L. (1997b). Modified therapeutic community for mentally ill chemical "abusers": Background; influences; program description; preliminary findings. *Substance Use and Misuse* 32(9):1217–1259.

Sciacca, K., 1991. "An Integrated Treatment Approach for Severely Mentally Ill Individuals with Substance Disorders" New Directions for Mental Health Services, Dual Diagnosis of Major Mental Illness and Substance Disorders, Eds., Minkoff, K. and Drake, R., Jossey-Bass, publishers, summer 1991, #50.

Scott, H., Johnson, P., Menezes, G., et al. (1998). Substance misuse and risk of aggression and offending among the severely mentally ill. *British Journal of Psychiatry,* 172, 345-350

Shaner, A., Khalsa, M., Roberts, L., et al. (1993). *Unrecognised cocaine use among schizophrenic patients*. American Journal of Psychiatry, 150, 758-762.

Smith, J., Hucker, S. (1993). *Dual diagnosis patients: substance abuse by severely mentally ill.* British Journal of Hospital Medicine, 50, 650-654.

Susser, E.S., Lin, S.P., Conover, S.A. (1991). Risk factors for homelessness among patients admitted to a State Mental Hospital. *American Journal of Psychiatry,* 148, 1659-1664.

Swanson, J.W., Holzer, C.E., Ganju, V.K., Tsutomu Jono, R. (1990). Violence and psychiatric disorder in the community: evidence from the Epidemiological Catchment Area Surveys. *Hospital and Community Psychiatry,* 41; 761-770.

Tardiff, K., Marzuk, P.M., Leon, A.C., Portera, L., Weiner, C. (1997). Violence by patients admitted to a private psychiatric hospital. *American Journal of Psychiatry,* 154, 88-93.

The National Protocols and Common Assessment Guidelines document. NDRIC. HSE, 2011

The UK Drug Policy Commission Recovery Consensus Group *A vision of recovery* **Policy Report** July, 2008

White W, Boyle M, Loveland D. (2004). Recovery from addiction and recovery from mental illness: Shared and contrasting lessons. In Ralph R, Corrigan P (eds). *Recovery and Mental Illness: Consumer Visions and Research Paradigms*. Washington, D.C.: American Psychological Association. pp. 233-258.

White, W., Boyle, M. And Loveland, D. (*2002).* Addiction as chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly*. 3/4:107-130.

Ziedonis, D.M., Rayford, B.S., Bryant, K.J., et al. (1994). *Psychiatric co-morbidity in white and African-American cocaine addicts seeking substance abuse treatment*. Hospital and Community Psychiatry, 45, 43-49.

Appendix 1 Treatment Programme Illustration

Services Provided

No Wrong Door will provide a variety of services across a continuum from minimum engagement to intense therapeutic engagement. A list of services provided is outlined in table 5.

Table 5 Services Provided

- Screening and Triage
- Dual Assessment (Mental Health/Addiction) and Care Planning
- Groups:
  - Therapeutic Groups (Motivational, Women's, Wellness/Relapse Prevention, Various Topic Related Group work)
  - Creative/Activity Groups
  - Social Groups
- Individual Counselling
- Psychiatric Assessment/Review/Medication prescribing
- Key working
- Case Management/Multidisciplinary Working
  - Psychology, Social Work, Mental Health Nurse, OT
- Drop-in centre
- Mindfulness
- Peer Support
- Family/Carer Involvement
- Continuing care
- Outreach
- In-Reach/Peripatetic outreach

Additional to the therapeutic services provided directly to the individual *No Wrong Door* will provide training and consultancy to mental health services and addiction services in raising competencies associated with co-occurring problem presentation and learning assessment strategies in their opposite disciplines.

Target Group

No Wrong Door is a service for individuals aged 18 years and over with complex mental health, complex substance misuse needs and multiple vulnerabilities which require an integrated treatment approach. Individuals can be referred by addiction or mental health services, GP's or self-referral.

Case Example

Joe Bloggs (aged 26) had a long history of attending the mental health service especially in crisis due to low mood, social anxiety, insomnia and intermittent suicidal ideation including two serious suicide attempts. His life was chaotic with multiple psychosocial stressors, forensic problems, binge drinking and polysubstance misuse. Furthermore, he was also left with a significant physical disability following one of his suicide attempts.

He would have frequently been seen by out of hours, crisis nurses, doctors and social workers within the community mental health team, as well as having required two hospital admissions to the acute psychiatric unit in crisis. Management of his multiple and complex problems was especially difficult because of his substance misuse. He would frequently be told by the mental health service that he would need to address his addiction issues before anything else could be addressed, yet the community drug and alcohol services were not willing to see him due to his mental health symptoms and presentations.

The CMHS did not have access to an addiction counsellor within their team. His non-attendance and disengagement from the mental health service further complicated management and his chance of recovery.

Treatment process

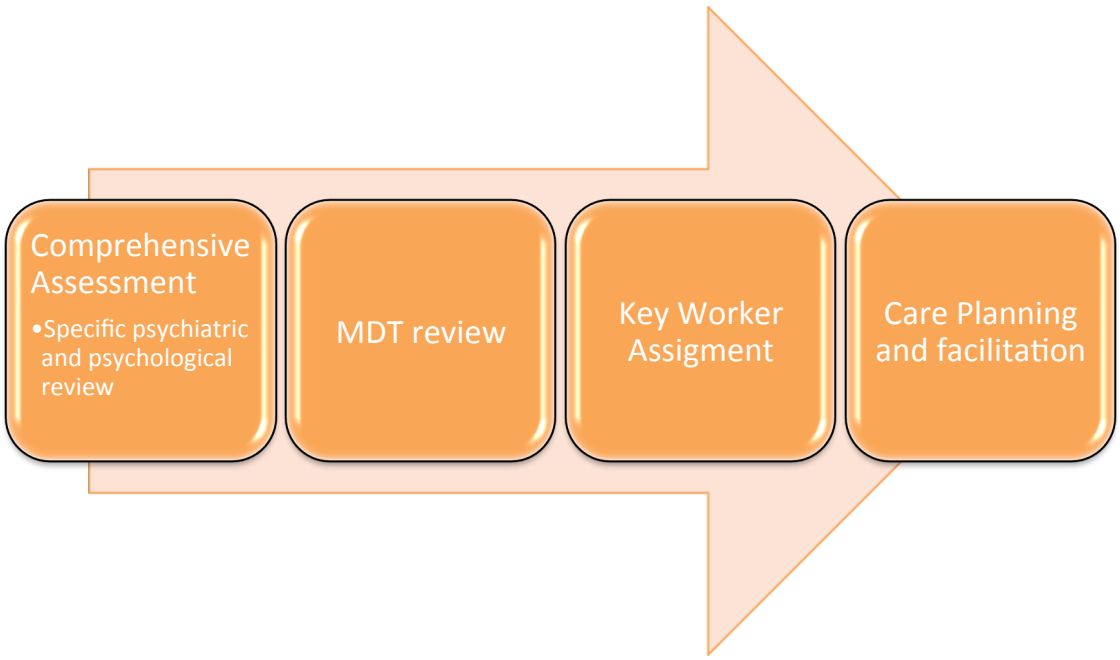


Figure 2.

When an individual presents for treatment, for example via mental health referral, they will be welcomed and undergo a comprehensive assessment. Following this the assessor will discuss the individual presentation profile in the clinical meeting with clinical leads. A recommended programme outline will be developed and presented to the individual for

consideration and negotiation. A care plan will be drawn up and a key worker assigned. Treatment will begin involving in-house programme facilitation (e.g. table 6 below) and off-site community support (e.g. table 7 below), following the process outlined in figure 2 above.

Engagement Process

The process of engagement within the service is as follows:

1. **Brief initial engagement**
    a. Review of presenting concerns
    b. Ascertaining goals for engagement
2. **Assessment**
    a. More comprehensive assessment of needs
        i. Mental health needs
        ii. Addiction needs
3. **Clinical team review (chaired by clinical leads)**
    a. Review of each screening
    b. Review of assessment process
    c. Review of all cases
4. **Feedback to individual**
    a. Presentation of options
        i. Including those outside of No Wrong Door
    b. Articulation of recommendations from the clinical team
    c. Review and initial treatment planning
        i. Commencement of care plan
    d. Nomination of key worker
5. **Implementation of therapy programme**
    a. In accordance with the treatment and care plan

A **Keyworker** from *No Wrong Door* will be responsible for the following:

- Ensure active engagement with all mental health and addiction services involved (including GP)
- Proactive referral to agencies that may be of benefit
- Support of mental health and addiction services (where involved) to manage treatment
- Feedback to clinical team within *No Wrong Door*

The preference and desire of the service user in terms of which treatment options they wish to avail of will be considered centrally and fundamentally.

Programme

The programme at *No Wrong Door* is multi-faceted. Individuals may attend to engage in low-level drop-in services, to be in the vicinity in a supportive context; to perhaps have a cup of tea and a listening ear, or indeed to sit in quietness.

No Wrong Door provides a space for anything between a recovery based full programme and low threshold harm reduction, which may be outlined as follows:

No Wrong Door full programme example:

Client: Joe Bloggs (see Case Example above)
Assessment: 07/01/15 (Mental health nurse)
Programme review : 12/01/15 (Clinical review meeting)

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Mindfulness	Individual homework style activities	Mindfulness	Therapeutic activity	Mindfulness
	Appt. Psychiatrist		One-to one therapy		Appt. OT
	Outdoor activity		Informal engagement		One-to-one therapy
	Group therapy		Group therapy		
Afternoon	Informal engagement		Appt. Social Worker		Informal engagement
			Informal engagement		Group therapy

Table 6.

At all these times staff will be available to manage less structured drop-in for those not engaged in the full programme, or not wishing to engage on that specific day. There will also be overlap between sessions (the above is an example of a complete programme for one individual).

Additional to the psychosocial programme and support will be full and on-going psychiatric review with staff psychiatrist (Clinical co-lead), including medication review.

The treatment programme outlined in table 6 will predominantly take place within the premises of No Wrong Door. However this will represent approximately half of the work of No Wrong Door. The other half will take place off premises and may include activities such as outlined in table 7 below:

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning		Meeting with FAS		Addiction counsellor assessment meeting	
	Mindfulness in community centre		Travel to one-to one psychology		Three way meeting with mental health
	AA meeting				
Afternoon					
			Meeting with probation		NA Meeting

Table 7

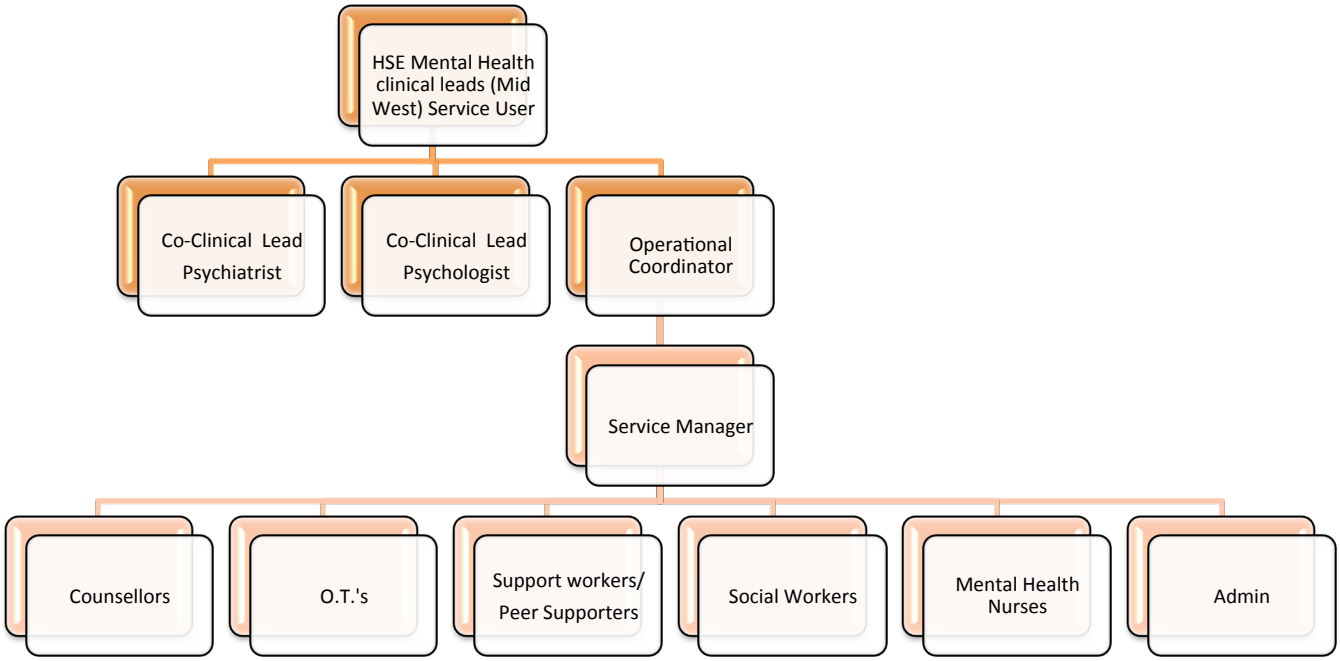
Treatment Ethos

The treatment in *No Wrong Door* is entirely voluntary. No element of the programme is mandated or mandatable. Any external forces mandating attendance is considered to be entirely separate from the programme itself. Engagement in any element of the programme is between the individual and the service provider. Environmental informal therapy is managed in this context by the staff team and all conversations that take place will be governed in accordance with evidence-based models of promoting support, empathy, compassion and positive change. All staff will hold training in these, including non-clinical staff.

It is the primary goal of *No Wrong Door* to be of value to the individual and to promote positive change emotionally and behaviourally. Engagement and treatment retention, being key factors to any successful intervention are considered the absolute primary goal, without which no treatment is likely to be of any benefit regardless of evidence base or model efficacy. Therefore the focus is on engaging and finding value in contact for the individual at whatever level makes sense to them. This becomes the platform then, from which treatment planning takes place.

The clinical team will engage in monthly supervision (all staff). There will be weekly clinical meetings. A comprehensive note keeping process will be central to the management of records and information and all clinical handovers will be recorded accordingly.

Appendix 2 Example Organisational Structure



(Service user involvement will also be central to this structure)

The clinical lead role in *No Wrong Door* is a role that is shared between the two key clinical professionals from each area of addiction and mental health. This clinical partnership of psychiatrist and psychologist underlines the nature of the approach to co-occurring conditions treatment, which represents not only issues that an individual can present with across two domains, but also the two domains that ordinarily underpin the treatment of each. It ensures two sectors are equally represented, and that two disciplines with differing approaches (psychiatric/medical and psycho-social) are also equally represented.

Appendix 3 Clinical Governance

The clinical governance structure of *No Wrong Door* has multi layers and considerations. The service is committed to best practice principles governing mental health and addiction service provision. The design is to draw from and implement a treatment based on demonstrated evidence. All staff will be managed and supervised appropriate to their needs, registration and discipline requirements to ensure safe and efficacious practice.

Evidence Based Care, Quality, Effectiveness and Research

- Quality management systems governing the project
    - A Vision for Change
    - Mental Health Commission's Quality Framework
    - QuADS (Quality in Alcohol and Drug Services – Organisational Standards)
    - NDRIC publications (e.g. National Protocols and Common Assessment Guidelines)

- The treatment approach governing the programme will draw from evidence emanating from research (e.g. trials and outcome research) associated with specific psychosocial interventions, such as:
    - Motivational Interviewing (e.g. Miller & Rollnick 2013)
    - CBT (e.g. Kingdon and Turkingdon 1994)
    - Transtheoretical model (Prochaska, DiClemente 1984)
    - Integrated Dual Diagnosis Treatment (e.g. SAMHSA 2005, Minkoff 2001, Sciaccia, 1991)

- Audits, Research and Evaluation of project using recovery-oriented outcome measures
    - Appreciation of the need to develop comprehensive evaluations using both qualitative and quantitative methodologies that include and move beyond traditional performance indicators
    - Aim to contribute to the development of a sound evidence base for recovery-oriented approaches for people with mental health and addiction issues.

Education, Training and Professional Development

- Qualification of staff:
  All staff will hold full qualifications specific to their respective disciplines and hold accreditation where relevant, such as:
    - Psychologists registered with the PSI

    - Psychiatrists registered with the Irish Medical Council, MRCPysch
    - Counsellors will be qualified and be accredited with the IAHIP, IACP or ACI
    - Nurses will be registered to practice with An Bord Altranais
    - Occupational therapists will be registered with CORU, AOTI
    - Social workers registered with SWRB, CORU
- All staff will be provided with training in assessment and treatment approaches relevant to co-occurring disorders, and also in the concept of recovery.
- Active supervision
    - All clinical staff will engage in clinical supervision externally relevant to maintaining their registrations
    - All clinical staff will additionally be supervised by the service clinical leads

Risk Management

- Clear lines of accountability
    - The clinical staff of *No Wrong Door* are immediately managed by the programme manager
    - The programme manager is in turn accountable to the clinical leads. The clinical leads have overall clinical oversight of the day to day practices and report monthly to the Governance Steering Group who assume overall accountability for the service
- Overall clinical and operational oversight will be framed within the Governance Steering Group
- Audits and Policy Development to manage risk to clients and staff
- Positive Risk-Taking/Management approach
    - Person-centred safety planning conducted in the spirit of collaboration
    - HSE, Clinical Indemnity Scheme. *Risk Management in Mental Health Services – Guidance Document.* HSE 2009
    - *Royal College of Psychiatrists, 2008; Rethinking Risks:* "Constructive and creative risk-taking is a vital part of a patient's rehabilitation and risk-aversive practice is detrimental to this process"
    - *Dept. of Health UK, 2007; Recommendations for Best Practice in managing risk:* "Positive risk management as part of a carefully constructed plan, is a required competence for all mental health practitioners".

Our aim is to develop a culture of trust, openness, respect and caring among all managers, clinicians, staff and patients working within the team.

Appendix 4 Service Provision Models

Treatment for people with co-occurring disorders is complicated from a clinical service provision point of view, due to the difficulty in ascertaining which diagnosis is primary, who takes responsibility, who holds the risk and who takes the lead in their care.

Moreover the responsibility of the service provider is to provide best practice evidence informed and clinically governed service.

Integrated Care

"Treatment in parallel and separate mental health and substance abuse treatment systems....is remarkably ineffective" – Drake and Colleagues (2004)

Despite a range of long-standing historical, political, ideological, professional, structural, and practical barriers, there has been, and continues to be, a clear consensus that integration between mental health and addiction services is sorely needed and long overdue. An integrated model proposes that an integrated team of practitioners from mental health and addiction services work on the same site with the same client, and is a means of coordinating substance abuse and mental health interventions to treat the whole person more effectively.

Traditionally, the psychiatric and addiction sectors have had different philosophies of practice that dictates how professionals respond to patient's needs. This has been reported as one of the major obstacles to integrating services both from a management and service delivery point of view.

The aspiration of *No Wrong Door* is to work with individuals in truly integrated ways. Therefore rather than care being provided by differing disciplines according to diagnostic groupings this service meets the person where they are, with dual expertise in order to assist in positive change according to the blended problem presentation.

The psychology of change is not so different relating to addiction and mental health. Treatment models are very similar and in fact demonstrate similar outcomes. Empathy, for example, is key to any successful therapeutic intervention in either presentation or setting. The theoretical approaches are the same. For instance CBT, MI, person-centred counselling, etc. have application and outcomes similar in both groupings.

Not only are the treatment principles similar, but also is the nature of the problem presentation and their aetiologies. From a psychological perspective mental health concerns and addictive behaviours may both be considered features of negative developmental experience, fear associated with separation in its many forms. This results in an array of safety seeking developmental processes, maladaptive coping to psychologically medicate

the experience of persistent negative emotional experience; the consequences for instance of poor or neglectful developmental contexts within which humans prosper, or in these instances, do not.

Integrated treatment of co-occurring conditions is not only appropriate but may be considered essential in the context of multiple problem presentations. At a time when treatment services increase in specialization and streamline focused clinical contexts with more sophisticated boundaries and specific criteria, clinical presentations are increasingly diverse and span beyond, and cut across, these very measured boundaries. Treatment services are literally moving in directions opposite to service need in this sense and those in most need of integrated treatment often do not fit these sophisticated criteria leaving the most vulnerable individuals further isolated and separated; festering and fastening the very nature of the separation that brought them to this place of vulnerability originally. This then infects the wound rather than treating it, albeit in attempt to help and heal problem presentations more accurately.

Recovery: Similarities and Shared Values in Mental Health and Addiction Services

Over the last decade or two there has been a **shift towards person-centred recovery-oriented mental health and addiction services** in Ireland and internationally, and there is an equally pressing need for transformation to recovery-oriented care in both systems. Literature suggesting the use of the recovery concept as an organising principle for bridging the divide between the two domains, as well as literature on chronic disease and recovery management approaches, is now growing and gaining an evidence base (Davidson et al.2007, White et al 2004, White et al 2002). This model of care may offer a strength based solution to achieving integration where pathology focused approaches have failed.

Reaching a consensus on the **definition** of recovery in mental health or addiction has been difficult, but the preferred definition in addiction is now much more closely related to mental health definition than before: “process of recovery is characterised by voluntary, sustained control over substance use which maximises health and well-being and participation in the rights, roles and responsibilities in society” (UK drug policy commission Consensus Group - A Vision of Recovery 2008).

The following two definitions of Recovery have been offered as having been helpful in distinguishing the process of recovery from the provision of recovery-oriented care within the overall context of behavioural health (i.e. across the mental health/addiction divide) (Davidson et al. 2007):

- *Recovery refers to the ways in which persons with or impacted by a mental illness and/or addiction experience and actively manage the disorders and their residual effects in the process of reclaiming full, meaningful lives in the community*

- *Recovery-oriented care is what psychiatric and addiction treatment practitioners offer in support of the person's/family's own long-term recovery efforts*

Shared Values Between Addiction and Mental Health Recovery:

(*Addiction Recovery; A Contagious Paradigm.* Keane, McAleenan, Barry 2014)

1) Sustained Health Care Partnership Model
2) Hope-based
3) Person and Family centred
4) Choice philosophy
5) Promoting Growth, Empowerment and Building on Strengths/Interests
6) Focus on overall life, wellness and health
7) Recovery Focused Outcome Measures

Further similarities exist in relation to addiction and mental health. The nature of the problem presentation and their aetiologies are similar, the psychology of change is not so different, the theoretical approaches are the same, treatment models are very similar and in fact demonstrate similar outcomes. For instance CBT, Motivational Interviewing, Person-Centred Counselling etc, have application and outcomes similar in both groupings.

Appendix 5 Policy Context

A Vision For Change (2006)

- *"Links between specialist mental health services, primary care services and voluntary groups that are supportive of mental health should be enhanced and formalized"*

- *"The majority of individuals with co-morbid substance abuse problems should be managed by their local general adult CMHT – They should provide whatever care is required to respond to a service user's mental health needs applying core best practice principles including:*
  1) User involvement
  2) Care planning
  3) Recovery orientation
  4) Attention to housing/employments needs and difficulties

- *"Reintegration in the community is an especially important feature of service with service users, and attention must be given to linking to community-based addiction services as a vital component of any comprehensive care plan."*

- *"Effective treatment will require that both mental health services and addiction services have a twin-pronged, coordinated approach"*

- *"It is recommended that a specialist team be established in each catchment area of 300 000 population, to care for people with severe mental disorder and long-standing complex co-morbidity – rehabilitation should be a strong feature of care provision*

HSE MHD – Operational Plan 2015

Priorities and Specific Developments

- *Ensure the views of service users, families and carers are central to the design and delivery of mental health services*

- *Design integrated, evidence based, recovery focused mental health services*

- *Promote the mental health of the population, in collaboration with other services and agencies, including reducing loss of life by suicide*

- *Progressing Mental Health Actions in partnerships with social exclusion arising from the All Ireland Traveller Health Study and the Substance Misuse Strategy*

- *The Introduction of peer support workers in mental health services*

HSE PC – Operational Plan 2015

- Social Inclusion Operational Plan Action (p 41)
    - Develop joint protocols between mental health and drug and alcohol services for patients with severe mental illness and substance misuse problems

Second report of the Suicide Support and Information System 2013

- Recommendations

  4. *Alcohol/drug abuse was identified as a major risk factor for suicide across the identified subgroups. It is therefore recommended that:*

  c) Active consultation and collaboration between the mental health services and addiction treatment services be arranged in the best interests of patients who present with dual diagnosis (psychiatric disorder and alcohol/drug abuse).

Connecting for Life Ireland's National Strategy to reduce Suicide 2015-2020

- The most common disorders associated with suicidal behaviour are depression and alcohol disorder.
- All substance use disorders increase the risk of suicide
- Risk Factors for suicide (among others)
    - Mental Health Problems
    - Alcohol or drug misuse
    - Hopelessness
    - Lack of social support
    - History of trauma or abuse
    - Barriers to accessing health care, mental health services and substance abuse treatment

- General Goals
    - Targeted approaches for those vulnerable to suicide (Goal 3)
    - Improved access, consistency and integration of services (Goal 4)

- Strategic Goal 3.1: Improve the implementation of effective approaches to reducing suicidal behaviour among priority groups.
  3.1.2 Develop and implement a range of agency and inter-agency operational protocols

- Strategic Goal 3.2: Support, in relation to suicide prevention, the substance Misuse Strategy, to address the high rate of alcohol and drug misuse

- **Strategic Goal 4.1**: Improve psychosocial and psychiatric assessment and care pathways for people vulnerable to suicidal behaviour

4.1.1 Provide a coordinated, uniform and quality assured 24/7 service and deliver pathways of care from primary to secondary mental health services for all those in need of specialist mental health services (Lead HSE MH)

4.1.2 Provide a coordinated, uniform and quality assured service and deliver pathways of care for those with co-morbid addiction and mental health difficulties (Lead HSE MH)

- Goal 4.2: Improve access to effective therapeutic interventions (e.g. counselling, CBT)for people vulnerable to suicide.

  4.2.1 Deliver accessible, uniform, evidence based psychological interventions, including counselling, for mental health problems at both primary and secondary care levels (Lead HSE: MH, PC)

Steering Group Report on a National Substance Misuse Strategy (2012)

- "Treatment & Rehabilitation Pillar - Action 10 - *Develop joint protocols between mental health services and drug and alcohol services with the objective of integrating care planning to improve the outcomes for people with co-morbid severe mental illness and substance misuse problems.*

- Treatment & Rehabilitation Pillar - Action 11 - *Establish a forum of stakeholders to progress the recommendations in A Vision for Change in relation to establishing clear linkages between the addiction services, primary care services, community mental health teams and specialist mental health teams to facilitate the required development of an integrated approach to service development."*

Advancing the Shared Care Approach between Primary Care and Specialist Mental Health Services

(Health Service Executive Primary Care and Mental Health Group, 2012)

E. Addiction Services – Care and Treatment

i. The effect and impact of alcohol and drug misuse on a person's mental health needs to be highlighted. The preventive role of the Primary Care Team in this area needs to be supported by training and resources from Specialist Services.

ii. Clarity needs to be provided on the organisation, delivery and alignment of substance misuse services to Primary Care and a national standardised model

iii. Strong links should be established with local addiction services as well as links with local addiction support groups such as AA & Narcotics Anonymous etc.