Implementing integrated treatment for dual disorders in The Netherlands: lessons learned

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Who are we? LEDD

- 4 Mental health care institutions and Trimbos Institute
- Goal: central base of knowledge and experience
- Activities
  - Website: [www.ledd.nl](http://www.ledd.nl), downloads, information, literature
  - Bi-annual conferences
  - Platform meetings
  - Advice and training
  - Implementation projects
  - Products: books, implementation guides, psycho-educational booklets etc.
  - Field standard integrated treatment

NEW!
Programme

• Organization of Dutch care system
• Drug policy
• Integrated treatment model
• Implementation in The Netherlands
• Results
• What works?
• Discussion
Dutch care system

• Developments relevant for integrated treatment:
  
  Scaling up
  Drug policy
Scaling up

• Broad, integrated psychiatric institutions
• Offering:
  – Ambulatory (outpatient) help
  – Clinical facilities
  – Residential facilities (sheltering living)
  – Vocational and daytime activity services
  – Prevention and general services
absolute values

- Integrated institutions
- Ambulatory mental health
- Addiction care
- General hospital psych ward
Our image abroad...
Key notions in Dutch drug policy

• **Realism**: drugs / drug use endemic phenomenon
• **Pragmatic** rather than principle-based: do what works best
• **Personal freedom**: reluctance to infringe on individuals' rights
• **Health protection and harm reduction**: don’t make problems bigger than they already are
• **Separate markets** for hard and soft drugs: coffeeshops
Dutch (mental) healthcare

• Developments relevant for integrated treatment:
  
  – Scaling up: addiction care and mental health within one organisation, integration easier?
  
  – Drug policy: acceptance of drug use, acceptance of patients who are willing to change their behaviour (yet).
Dual disorders
Estimates Dual Disorders

- Mental health care clients: 20% to 50% has (at least one) co-occurring SUD

- Addiction care clients: 60% to 80% of clients has (at least one) co-occurring mental health problem
Treatment models

• Sequential

• Parallel
Consequences

- One disorder remains untreated
- Were to begin and when to stop?
- Limited or no communication
- Separate treatments, different views
- Client responsible for integration
- Differences in approach and vision

- Result:
Philosophy on dual disorders

- Comorbidity is the expectation, not the exception.
- Both disorders are chronic and biopsychosocial in nature.
- Both disorders are primary.

(Minkoff, 2001)
### Principles Integrated Treatment

<table>
<thead>
<tr>
<th>One multi-disciplinary team of dually trained professionals</th>
<th>Based and working from one location</th>
<th>Integrated treatment of both disorders</th>
<th>Treatment matches motivational stage of change of client</th>
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</thead>
</table>

**Principles Integrated Treatment**
Benefits integrated treatment

**Reduction in**
- Relapse of substance abuse and mental illness
- Hospitalization
- Arrest
- Incarceration
- Duplication of services
- Service costs
- Utilization of high-cost services

**Increase in**
- Continuity of care
- Consumer quality-of-life outcomes
- Stable housing
- Independent living
Stages of change model

Precontemplation → Contemplation → Action → Maintenance → Stable Lifestyle → Relapse → Precontemplation
A means to an end

<table>
<thead>
<tr>
<th>Stage of change</th>
<th>Stage of treatment</th>
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</thead>
<tbody>
<tr>
<td>• Precontemplation</td>
<td>• Engagement</td>
</tr>
<tr>
<td>• Contemplation</td>
<td>• Pursuasion/motivating</td>
</tr>
<tr>
<td>• Preparation</td>
<td>• Pursuasion/motivating</td>
</tr>
<tr>
<td>• Action</td>
<td>• Active treatment</td>
</tr>
<tr>
<td>• Consolidation</td>
<td>• Relapse prevention</td>
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</table>
Implementing integrated treatment
First Wave
Implementing IDDT

2004-2006 pilot study

High fidelity implementation of IDDT in 5 outpatient mental health teams

Deciding whether integrated treatment can be implemented in the Netherlands
Second wave: ‘breakthrough’

• Implementing IDDT

• 2007-2008 Breakthrough project Dual disorders

• Since then:
What changed?

• Attitude
• Sense of urgency
• Working with stages of change model
• Start with motivational interviewing
• Level of expertise on drugs and addiction
• Contemplation groups
What remains difficult?

- Comprehensive treatment (both disorders in all stages)
- Group treatment
- Selfhelp
- Family participation
- Screening, assessment and monitoring
- Safety, rules and vision
- Integrated treatment plans
Recommendations

• Ask the right questions!

• Why do we want this?
• Who will benefit?
• Is this the right time?
• Can we do this?
• Who can help us?
Final recommendations

• No shortcuts: complex implementation proces
• Internal motivation of teams
• Top down and bottom up
• Make adjustments to match teams specific characteristics
Current situation

• Growth in integrated clinical and outpatient services
• Integrated care for youth and adolescents
• Triple disorder: including (mild) intellectual disability
• Integrated forensic care

• But: still not high on the national agenda…
Thank you for your attention

Anneke van Wamel,
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Discussion

- The national drug policy has a great influence on the way integrated DD treatment is implemented.

- Specialised DD facilities are an organisational weakness: care for DD clients should be integrated in regular mental health & addiction care

- Integrated care is not always the ideal, under certain circumstances sequential treatment is preferable.

- The benefits of a thorough assessment is outweighed by the time it takes.