Capabilities for handling complex substance abuse problems and its relationship to the treatment system: Using the DDCAT instrument to explore local treatment systems in Finland

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ABSTRACT
BACKGROUND – Mental health problems in Finland have been the responsibility of the health care, and substance abuse problems have been handled within social care. In 2009, a national reform aiming at integrating mental health and substance abuse treatment systems (SATS) was launched. The critics of integration were concerned that it implies a medicalization and a narrowing of the social care goals. AIM – This article analyses to what extent integration of mental health and SATS affect the capability to treat co-occurring substance abuse and mental health problems. A secondary aim is to assess the utility of the DDCAT (Dual Diagnosis Capability in Addiction Treatment) instrument in a Finnish context. DATA – The study is based on group interviews, using DDCAT, in six Finnish municipalities, three with integrated and three with separate mental health care and SATS. The assessment pertains to the main outpatient unit in the city. RESULTS – The dual diagnosis treatment capability did not depend on the system-level integration. Two municipalities where SATS was administratively separate from mental health care were able to achieve high dual diagnosis capability ratings while in one municipality with system level integration this capability was not very high. The DDCAT instrument puts an emphasis on medical staff and competence. CONCLUSIONS – Strong, separate local SATS may adapt to the integration demands or needs by strengthening their psychiatric competence. This solution can result in treatment that is equally competent in treating mental health and substance abuse problems as integrated systems. The DDCAT instrument can be useful in a Finnish context to measure medical competence to handle dual diagnoses, irrespective of system solutions. For a balanced measurement, the instrument should be complemented with a section mapping competence to handle co-occurring social problems.
KEYWORDS – substance abuse treatment, integrated treatment, treatment systems, dual diagnoses, DDCAT, medicalization, Finland

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Background
Substance abuse treatment systems are undergoing large reforms in many countries, with the search for more optimal and cost-efficient mixes and coordination of services to handle widespread and often complex and longstanding problems (Babor, Stenius & Romelsjö, 2008). Coordination within a system that addresses various and often complex problems has become a key part of the solution. For the individual, a coordinated system is supposed to give better help, with less risk of falling between the cracks. Coordinated or integrated systems can avoid costly duplications of services and are able to ensure availability, address complex problems in all phases, avoiding expensive in-patient treatment (see also Miller & Weisner, 2002; Humphreys & Tucker, 2002).

The concept of integrated treatment for substance abuse has been used in many ways. It was first launched in the USA (Mueser, Noordsy, Drake & Fox, 2003), where substance abuse treatment after the post-war period was established as a separate system, strongly influenced by the AA-ideology, but outside of and even in opposition to psychiatric care (Miller & Weisner, 2002; Room, 1978). In reference to the system level in the USA, Miller and Weisner (2002) have advocated the benefits of integrating specialist substance abuse treatment with primary health care, mental health care and social services.

In the Nordic countries, addiction treatment grew out of poor relief and has thus been mainly linked with social work (Aalto, 2007; Kaukonen, 2000; Edman & Stenius, 2007). In a Nordic framework, organizational integration between the medical services and substance abuse treatment that is based in social services has lately been seen as a priority (see for instance Storbjörk, 2014), but professionally and legislatively it remains a challenge.

From a clinical point of view, integrated substance abuse treatment has been used particularly in relation to dual diagnoses (Mueser et al., 2003; Aalto, 2007). From this perspective, integrated treatment means the simultaneous treatment of both substance abuse and mental health problems, which is thought to be a more appropriate and effective solution than parallel or sequential treatment (Mueser et al., 2003; Aalto, 2007), particularly if the mental health problems are severe.

The literature focusing on mental health/substance use disorders has drawn a distinction between system-level and service-level integration (Rush & Nadeau, 2011). System-level integration can refer to co-location of different treatment or service organizations, simply facilitated referral processes for parallel or sequential treatment, and usually common finances and administration for mental health and substance abuse treatment. Service-level integration refers to clinical integration, with teams of various specialists that offer simultaneous treatment of both substance abuse problems and concurring social, mental or health problems (see also Aalto, 2007).

Though many good arguments favour integrated treatment, the conceptual confusion may have a bearing on how surprisingly difficult it is to show its effectiveness. Handmaker and Anderson (2002) in a review concluded that comprehensive integrated systems improved treatment retention, which should be important for dual diagnoses patients, but that integrat-
ed treatment showed only slightly better results for substance abusers’ patterns of use. Aalto (2007), in his overview of more recent reviews, notes the many difficulties in generalising from earlier research: both abuse and mental health problems are defined in various ways in different studies, affecting the classification of patients. There may also be differences in outcome measures, for instance in how much they focus on diagnosed substance abuse and mental health problems and how much on criteria for rehabilitation.

In this article, we will look closer at the impact of the integration of mental health and substance abuse treatment systems on local and clinical realities in Finland.

The Finnish treatment system for alcohol and drug abuse can be characterised as extensive by international comparison. Since the 1930s it has grown into a separate, accessible, decentralised and multi-professional treatment system, based in social work traditions and a social legislation (Bruun, 1971; Takala & Lehto, 1992). The responsibility for providing the population (5.4 million) with sufficient treatment for substance abuse problems today lies with the 320 municipalities.

The establishment of a semi-separate drug treatment system at the turn of the millennium gave medicine a key role in one area of substance abuse treatment (Tammi, 2007). This medicalization implied a rise in public health and harm reduction approaches (rapidly increasing substitution treatment and needle exchange programs) rather than a psychiatrization or strengthening of the individual—curative aspects of medicine.

Currently a new change seems to be taking place in Finland in which the medical profession again has a key role. A national reform for integrating mental health and substance abuse treatment systems was launched in 2009 (Plan for mental health and substance use work, 2010).

One important motive for the Finnish reform was the fact that morbidity and mortality related to mental health and substance abuse problems constituted a major (and in the case of alcohol, an increasing) problem. In 2007 this led 106 MPs to sign an initiative to ask the government to address the issue. Against the backdrop of ongoing significant reforms in the country aimed at the administrative integration of health and social service sectors into larger municipalities or regional units, the actors moved nearer to a system integration proposal. Increasing comorbidity was presented as an additional argument in support of integration. System reforms were assessed, independently of the integration reform, as especially necessary in Finnish mental health care, as it suffers from an inadequate and expensive concentration on inpatient treatment and insufficiently regulated compulsory treatment. (Plan for..., 2010).

The national plan for mental health and substance abuse work (Plan for..., 2010) identifies four priorities and principles for development, up to 2015. 1) empowerment of service users, 2) increased emphasis on mental health promotion and prevention of problems, 3) the integration of diverse services into coordinated entities, with efficient basic and outpatient services for all age groups, and 4) the development of steering tools (training, guidelines, centralised coordination, development of resources and legislation) for integration. The proposal for a re-organization of men-
tal health and substance abuse services include: emphasis on a low threshold and “one-door” access to basic mental health and substance use services on a primary service level, and integration of specialised, outpatient addiction treatment and psychiatric services. It is also assumed that the need for inpatient services will decrease when outpatient services are developed. However, it is acknowledged that outpatient services must be developed before the inpatient services are cut.

Those critical of the integration attempts have raised concerns about how accessible treatment for alcohol and drug problems will be after the integration of substance abuse treatment and mental health services. Today, specialised outpatient substance abuse treatment services in so-called A-clinics require no referrals and treatment is free. Almost all the municipalities with more than 20 000 inhabitants and 2/3 of those with 10 000–20 000 inhabitants have an A-clinic or can purchase a similar kind of service (Kuussaari & Partanen, 2010). Access to specialised mental health services, on the other hand, is generally based on referral. If access to integrated specialised outpatient services is dependent on a referral from primary-level services, the low threshold principle for specialised outpatient substance abuse services will disappear. A further concern is that integration implies a medicalization of substance abuse problems and thus a narrowing of the rehabilitation goals. Special concern has been raised over how a more medicalized system will be able to meet the needs of marginalised substance abusers with social problems. For this group, integration with mental health care does not seem to be the most obvious solution (Stenius, Kekki, Kuussaari & Partanen, 2012).

The Finnish Mieli-reform is built on information steering, and has no strong economic incentives. The reform favours system-level integration, but is not clear about details or timetables. It opens itself up for various local interpretations of the concept of integration. In a national study from 2009 (Kokko et al., 2009) in which 313 Finnish municipalities (out of some 415 at the time) took part, the municipalities reported whether their services were integrated or not. To the question “Does your city/region have service units in which traditionally separately produced services (e.g. mental health and substance abuse services, psychosocial services for children and adolescents, or family service centres) are combined into a joint entity?” 56% of the municipalities answered that their substance abuse and mental health services had been combined. The positive replies from more than half the respondents could be interpreted either as referring to system-level or service-level integration, even if the former interpretation seems more likely.

In 2010, a new and more thorough analysis of 30 Finnish municipalities, 20 with more than 30 000 inhabitants and 10 with less, was performed. According to Kokko and colleagues (2009), half had reported the previous year that they had an integrated system and the other half not. The new analyses showed that 9 of the 30 municipalities had both service- and system-level integration, 10 had only system-level integration, 3 had only service-level integration and 8 had neither (Stenius et al., 2012). A reasonable conclusion is that local variations in treatment systems are
large. Further, the analysis indicated that system-level integration does not automatically mean service-level integration, and in fact service-level integration can take place without system-level integration.

Finally, thematic interviews and further data gathering in a smaller number of these municipalities pointed to a development where most or many local treatment systems had some elements of integration, to be found within mental health care or sometimes within substance abuse treatment. Our conclusion was that a thorough assessment of clinical practice is required to establish the extent to which local substance abuse treatment services are capable of treating co-occurring mental health and substance abuse disorders and whether this competence is related to treatment system integration.

Aims of this study
In this article we aim to study if system-level integration is related to the extent and nature of the clinical capability to treat substance abusing clients’ mental health problems in Finland. We do this by comparing the clinical practice in six Finnish municipalities, half of them integrated on the system level and half not.1

In the analyses we use the North-American instrument DDCAT (Dual Diagnosis Capability in Addiction Treatment). A secondary aim of this study is to assess the usefulness of this instrument in assessing the competence to treat complex problems in a Finnish setting.

Data and methods
Material
The main data came from structured interviews done with the DDCAT assessment tool, a tool developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), under the US government. We used this instrument to describe the work at the main outpatient unit in six geographical areas of Finland: Espoo, Jyväskylä, and Imatra (integrated) and Kotka, Vaasa and Vantaa (non-integrated). These areas are suitable as well as diverse representatives of both integrated and non-integrated systems in larger Finnish municipalities (see below for a description of the local services).

Figure 1 (below) shows the number of clients (per 1000 inhabitants) in outpatient treatment for substance abuse problems in each of these areas. With the exception of Kotka, which has a high rate of unemployment and related social problems, there are no large differences in the number of clients in substance abuse treatment between the areas.

In Espoo, substance abuse and mental health treatment services are integrated with health care at the system level. At the service level, treatment for both problems is provided at Emppu, a unit established in 2010. The stated motives for integrating the services are almost identical to the national Mieli plan (see above): Both epidemiological (overlapping of MH and SA problems) and clinical (more effective to treat two problems together) arguments were used (see Stenius et al., 2010). In Imatra, substance abuse and mental health treatment services were integrated already at the end of the 1990s, both at the system and services levels. For a long time, it was the only integrated municipal service system operating, and was also well-known as a model. The background to the integration was a financial crisis that led to a complete...
reform of local social and health care. As a result of the re-organizing of services, the city decided to stop buying mental health services from the area’s hospital and established its own services. Substance abuse treatment moved out from social services and was merged with mental health services. In Jyväskylä, treatment of substance abusers is the responsibility of the district hospital’s psychiatric division. In practice, however, substance abuse treatment has been contracted out and is bought from the local Sovatek Foundation. This foundation was established in 2002 by the district hospital, four municipalities of the region and both local and national-level NGOs. Sovatek can be said to have a monopolistic role in planning and organizing the treatment of substance abuse and co-occurring mental health problems in Jyväskylä.

In Kotka, Vantaa and Vaasa, the substance abuse treatment systems are clearly separate from mental health care, although the clinical work is multi-professional, involving social workers, therapists, nurses and physicians (also psychiatrists). In Kotka, where substance abuse treatment is outsourced and bought by the city’s social services from the A-Clinic Foundation, there have been projects and working groups for developing dual-diagnosis treatment within substance abuse treatment. In Vaasa there is an integrated treatment unit for youngsters but treatment for adults is separated. In Vantaa, the local A-clinic can be characterised as relatively well-resourced, and includes medical and psychiatric expertise; even though it is non-integrated and organizationally falls under social services, the A-clinic co-operates closely with the district hospital’s psychiatric polyclinic.
The DDCAT instrument

The DDCAT instrument was first created and field-tested in 2003. DDCAT is a commonly used measure in the USA and Canada, developed to assess the capacity for handling co-occurring mental health problems within substance abuse treatment systems (McGovern, Matzkin & Giard, 2007; see also Minkoff, 2008). DDCAT consists of 35 questions across seven domains (see Appendix 1). The domains are: 1) program structure (four questions), 2) program milieu (two questions), 3) clinical process – assessment (seven questions), 4) clinical process – treatment (five questions), 5) continuity of care (five questions), 6) staffing (five questions) and 7) training (two questions). The domains concerning treatment (domains 3, 4 and 5) comprise altogether 22 questions, i.e., the majority. It should also be noted that as domains 2 and 7 both have only two questions each, the weight of a single question is markedly higher here than in, for example, the treatment domains.

The questions are rated from 1 to 5 points on a continuum from Addiction Only Services (AOS) to Dual Diagnosis Capable (DDC) and to Dual Diagnosis Enhanced (DDE). Averages are then calculated for each subdomain and for an overall score. Within the context of our study, one question (6D)³ was not used as it was not considered applicable in the Finnish context, and thus the DDCAT we used comprised 34 questions.

The DDCAT instrument has its own website⁴ where the tool as well as its background have been described in detail.

Interview procedure

The DDCAT (version 3.2) interviews were conducted in each of the six cities in 2012–2013. The interviews were in all cases led by the first author, in some instances in the presence also of other members of the research team. Interviews took about two hours each (ranging from 1.5 to 2.5 hours). They were not recorded, but notes were taken in addition to completion of the assessment instrument. The six groups comprised 2–6 interviewees. The interviewees represented in all cases both the city (‘purchasers’ or administrators of services in three cities) and the managers and practitioners (nurses, social workers, medical doctors) from local clinics. The biggest groups (six persons) were in Kotka and Vaasa, whereas in Imatra, Vantaa and Espoo, the group consisted of three interviewees in each, and in Jyväskylä only two (the manager and medical director of the clinic). The assessments in the DDCAT instruments were consensus decisions. In some cases, two alternative (though close) figures were given. After the interview, the interviewees were given an opportunity to comment on their answers. They also discussed the overall results in a separate meeting (in spring 2013) where they were presented jointly to all municipalities participating in the project.

As the DDCAT instrument is designed to assess the dual-diagnosis capability of a treatment program (instead of the overall service system), the answers were given concerning the main outpatient clinic for drug and alcohol abusers in the city (in the case of Vantaa, jointly for the two branches of the A-clinic).

Results and discussion

The DDCAT ratings for each city are presented in Table 1. They are listed both for subdomains and as overall ratings.
Table 1. DDCAT ratings of six Finnish cities in 2012-2013, with integrated versus non-integrated systems

| Domain                        | Integrated SATS | Non-integrated SATS |
|-------------------------------|-----------------|---------------------|
|                               | JYVÄSKYLÄ      | IMATRA   | ESPOO | VANTAA | KOTKA | VAASA |
| 1. Program structure          | 3.8             | 2.5      | 4.2   | 4.0    | 3.3   | 2.5   |
| 2. Program milieu             | 4.5             | 3.3      | 4.0   | 3.3    | 3.5   | 3.5   |
| 3. Clinical process: assessment | 4.0             | 3.2      | 3.0   | 3.4    | 3.2   | 3.1   |
| 4. Clinical process: treatment | 3.8             | 3.6      | 2.6   | 3.2    | 3.2   | 2.5   |
| 5. Continuity of care         | 3.4             | 4.0      | 3.3   | 4.0    | 3.5   | 2.8   |
| 6. Staffing                   | 4.5             | 4.3      | 2.5   | 4.3    | 3.8   | 3.5   |
| 7. Training                   | 3.5             | 2.3      | 1.5   | 2.5    | 2.3   | 1.5   |
| **OVERALL SCORE:**            |                 |          |       |        |       |       |
| **DUAL DIAGNOSIS CAPABILITY** |                 |          |       |        |       |       |
| DDC/DDE                      | (3.5–4.49)      | (3.3–4.9) | (3.0–3.49) | (3.5–4.49) | (3.3–3.49) | (2.8–2.99) |
| DDC                          | (3.0–3.49)      | (3.3–4.9) | (3.0–3.49) | (3.5–4.49) | (3.3–3.49) | (2.8–2.99) |
| DDC/DDE                      | (3.5–4.49)      | (3.3–4.9) | (3.0–3.49) | (3.5–4.49) | (3.3–3.49) | (2.8–2.99) |
| DDE                          | (4.5–5.0)       | (3.5–4.9) | (3.0–3.49) | (3.5–4.49) | (3.3–3.49) | (2.8–2.99) |

Interestingly, as seen in Table 1, there are “dual-diagnosis capable” (DDC rating or higher) substance abuse treatment units in both the integrated and non-integrated categories. Also, in both categories some municipal outpatient units do not qualify as DDC based on the scorings. In other words, system-level integration does not seem automatically to imply a good (clinical) capability to treat co-occurring disorders, and vice versa, treatment units that are not integrated at the system level can have that capability. How is this to be explained?

Jyväskylä was ranked highest with regard to its dual-diagnosis capability. The clinic is operated by the Sovatek Foundation, from which the psychiatry division of the area’s hospital district purchases all its addiction treatment services. The clinic is officially mandated to treat independently also patients with psychiatric problems of high-severity (schizophrenia, psychosis, etc.). The senior physician of the clinic is a psychiatrist; she and other medical doctors working in the clinic are allowed to make diagnoses and start psychiatric medications at the clinic without referrals to the psychiatric clinic at the hospital. The majority of the clinical staff are health care professionals. The Sovatek clinic has also mental-health-related peer support; there are several questions on the availability and use of peer-support in DDCAT and the presence of such support increases the rating for capability.

At almost the same level in its DDC-ranking was Vantaa, which has a non-in-
tegrated treatment system. It was reported, however, already in our pre-study interviews, that the Vantaa A-clinic has “good and active cooperation” with the psychiatric clinic maintained by the area’s local hospital district: The clinical workers at both ends keep personal contacts with each other and make agreements on who has responsibility for patients with dual diagnoses and in which order they will be treated. Similarly as in Jyväskylä, psychiatric diagnoses are made and related medication initiated at the A-clinic. The clinic’s relatively good medical resources make this possible: There are altogether five physicians and, as in Jyväskylä, the senior physician is a psychiatrist.

Also Kotka, with its formally non-integrated substance abuse treatment system like Vantaa, succeeded in gaining the DDC rating. In Kotka, the local A-clinic reported having systematically developed its competence in psychiatric care, for which there had been a special need due to the city’s own difficulties in recruiting psychiatrists into the mental health care system. The district hospital’s psychiatric polyclinic tends to refer patients with a dual diagnosis to substance abuse treatment to address their substance abuse problems before they can be taken into psychiatric care. One possible interpretation of the overall situation in the town is that in practice – even if there is no official agreement on this – the relatively well-resourced substance abuse treatment system compensates for the lack of psychiatric services in Kotka. The relative weakness or strength of local mental health services and substance abuse treatment (in different combinations) is highly relevant from the viewpoint of service integration.

Espoo and Vaasa have the lowest DDCAT ratings. Of all six cities, Vaasa has the most clearly segregated services for substance abusers and mental health patients, and the rating was expected. On the other hand, the rating of Espoo was unexpected because, and as opposed to Vaasa, the outpatient treatment unit (Emppu) assessed should be, according to its official description, the most integrated of our six examples. According to its public mission statement, Emppu treats both substance abuse and mental health problems (although the latter only from low to medium severity). The key explanation for the relatively low DDCAT rating of Espoo is that the outpatient treatment unit does not have a medical doctor. In DDCAT there are several questions on activities that are possible only for physicians (diagnostics, prescriptions, psychiatric expertise); without an in-house physician, ratings for these items remain inevitably at a low level.

Conclusions
The aim of this article was to systematically describe the clinical competence in Finnish outpatient substance abuse treatment units and relate that competence to system-level integration. We applied the DDCAT measurement tool developed to assess an addiction-treatment-system’s capability to treat co-occurring psychiatric problems among drug and alcohol clients. Six carefully chosen Finnish geographical areas participated in the study; three of them were integrated, with the other three representing non-integrated addiction and mental health service systems.

The main finding was that dual diagnosis capability did not depend on the system-level integration of the local sub-
stance abuse treatment system. Two units that were administratively totally separate from mental health care were able to achieve a DDC rating, according to which they can be regarded as (clinically) “integrated”. Strong, separate local substance abuse treatment systems may adapt to the integration demands or needs of handling co-occurring problems by strengthening their medical (psychiatric) competence. This solution can result in treatment that is equally competent in treating complex mental health and substance abuse problems as integrated systems. In other words, the dual diagnosis treatment capability as measured by DDCAT did not seem to depend on the system-level integration of the local substance abuse treatment system with mental health treatment. We can conclude that system-level integration is not a necessary prerequisite for a dual-diagnosis treatment capability.

Even if social aspects have traditionally been strong in Finnish substance abuse treatment, health care professions have also had a stronger role in the Finnish system than in the US system, from where the DDCAT instrument originates. Despite the differences in DDCAT scorings and related ratings, it can generally be said that all of the assessed outpatient units for substance abusers in the six areas had some capability for treating their patients’ mental health problems. They all had to some extent clinically integrated services.

Overall, the interviewees were positive towards using the DDCAT instrument. This study shows that the DDCAT instrument seems suitable also in a Finnish context for measuring the readiness and possibilities to treat co-occurring mental health and substance abuse problems.

Strengths and limitations

It goes without saying that the ratings are not to be considered final; the local systems and their resources are in constant change. Further, we cannot preclude the possibility that the answers to some of the DDCAT questions could be somewhat different with a different composition of the groups. In DDCAT, there are certain factors that are stressed: to be able to achieve a higher rating a treatment unit needs to have 1) a physician, preferably a psychiatrist working at the unit, 2) peer support for clients with mental health problems (i.e. not only addiction-related peer support), and 3) the role of mental health care as part of treatment needs to be documented, as undocumented practices do not count much in DDCAT. If these criteria are met, a treatment unit will be regarded as dual-diagnosis capable.

In addition, the above-mentioned DDCAT-criteria need to be combined with the (official or unofficial) “mandate to treat” mental health problems. For instance in Jyväskylä, the good medical capability within outpatient care is combined with a wide-ranging mandate (from psychiatry) to treat psychiatric patients. On the contrary, in Espoo the outpatient unit has only a partial mandate to treat mental health disorders and no clinical (medical) capability. In Vantaa, the outpatient addiction unit has a (partial) mandate to treat psychiatric conditions, and some medical capability, which is complemented with active cooperation with a psychiatry clinic. The case of Kotka is unique in the sense that the addiction clinic does not have any mandate (from psychiatry) to treat psychiatric problems, but still treats them in practice, made possible by the clinics’ medical resources.
We have to bear in mind that the DDCAT assessment tool is normative in its nature: It is built on an assumption that substance abuse treatment should be capable of treating also mental health disorders. High capability gives high points. Even if we stressed at the beginning of every interview session that we, as researchers, do not have a stance on what the ratings should be, we felt that often the interviewees tried to find arguments for higher scores. It is thus possible that the scorings (means) are rather overestimations than underestimations of capability. On the other hand, in each group, the interview questions were considered and negotiated quite carefully and thus the responses are also to be treated as well-founded and consensual expert views.

Implications
At the beginning of the article we described how one of the major concerns over the effects of integration was that the integration would mean a medicalization of substance abuse problems and a narrowing of the treatment goals. One fear was that a more medicalized system would not be able to meet the needs of marginalised substance abusers with social problems.

As there are several questions in DDCAT that concern medical competence (diagnostics, prescriptions, psychiatric expertise) as well as the share of medically trained staff and activities, and as this competence was found in most of the units studied, the results can be interpreted as a relatively strong medical component in Finnish substance abuse treatment. The medical competence could, however, be stronger in treatment units that were not integrated at the system level than in the integrated ones. It follows that a possible “medicalization” of treatment does not require integration at the system level. Conversely, service-level integration (in the form of talking therapies, support groups etc.) can take place without contributions from psychiatry, as in Espoo.

If, however, we define medicalization as a process where social problems will be regarded as conditions in need of medical–psychiatric treatment – or where social aspects of problems are ignored due to a “medical gaze” – then the DDCAT results do not allow us to say much, if anything, about the Finnish situation. It seems, however, that the Mieli-initiative – the call for integrated services and related development projects, working groups and public discussions around the initiative – has generally contributed to a strengthening of the mental health orientation in addiction treatment, whether integrated or not.

To be able to assess the overall competence to handle complex problems, including social problems often related to substance abuse and where the Finnish system has a tradition, we would need new “capability measures”, which would cover the capabilities of treatment to handle the patients’ social problems: work/unemployment, education, social security and child welfare issues. Our research project has started to develop an add-on to the DDCAT to account for the “social service capability” of a substance abuse treatment unit.
NOTES

1 This analyses will be followed by further studies, based mainly on registers, where the project will attempt to assess the effects of system integration and clinical integration on the total provision of treatment in the municipalities.

2 The Vantaa A-clinic is divided into two units, due to the size of the municipality and the distances between different parts of the municipality. The assessment in this study was made for both of them.

3 The item 6D (“Case review, staffing or utilisation review procedures emphasise and support co-occurring disorder treatment”) was discussed both with our first interviewees, as well as with a colleague with expertise in the psychiatric treatment system in Finland, and we concluded that the question is not clear enough to be included in the Finnish version of DD CAT.

4 http://www.samhsa.gov/co-occurring/ddcat/

5 The code-of-conduct within local psychiatry is that the patient needs to have maintained abstinence for three months before he/she can be taken into treatment for mental health disorders.

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Appendix 1.
ITEMS OF DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT (DDCAT), Version 3.2

I. PROGRAM STRUCTURE
IA. Primary focus of agency as stated in the mission statement (If program has mission, consider program mission)
IB. Organizational certification & licensure
IC. Coordination and collaboration with mental health services
ID. Financial incentives.

II. PROGRAM MILIEU
IIA. Routine expectation of and welcome to treatment for both disorders
IIB. Display and distribution of literature and patient educational materials.

III. CLINICAL PROCESS: ASSESSMENT
IIIA. Routine screening methods for psychiatric symptoms
IIIB. Routine assessment if screened positive for psychiatric symptoms
IIIC. Psychiatric and substance use diagnoses made and documented
IIID. Psychiatric and substance use history reflected in medical record
IIIE. Program acceptance based on psychiatric symptom acuity: low, moderate, high
IIIF. Program acceptance based on severity of persistence and disability: low, moderate, high
IIIG. Stage-wise assessment.

IV. CLINICAL PROCESS: TREATMENT
IVA. Treatment plans
IVB. Assess and monitor interactive courses of both disorders
IVC. Procedures for psychiatric emergencies and crisis management
IVD. Stage-wise treatment
IVE. Policies and procedures for medication evaluation, management, monitoring and compliance
IVF. Specialized interventions with mental health content
IVG. Education about psychiatric disorder & its treatment, and interaction with substance use & its treatment
IVH. Family education and support
IIV. Specialized interventions to facilitate use of peer support groups in planning or during treatment
IVJ. Availability of peer recovery supports for patients with CODs

V. CONTINUITY OF CARE
VA. Co-occurring disorder addressed in discharge planning process
VB. Capacity to maintain treatment continuity
VC. Focus on ongoing recovery issues for both disorders
VD. Facilitation of peer support groups for co-occurring disorders is documented and a focus in discharge planning, and connections are insured to community peer recovery support groups
VE. Sufficient supply and compliance plan for medications is documented

VI. STAFFING
VA. Psychiatrist or other physician or prescriber of psychotropic medications
VIB. On site clinical staff members with mental health licensure (doctoral or masters level), or competency
VIC. Access to mental health supervision or consultation
VID. Case review, staffing or utilization review procedures emphasize and support co-occurring disorder treatment
(VIE. Peer/Alumni supports are available with co-occurring disorders).

VII. TRAINING
VIIA. Direct care staff members have basic training in prevalence, common signs & symptoms, screening and assessment for psychiatric symptoms and disorders
VIIB. Direct care staff members are cross-trained in mental health and substance use disorders, including pharmacotherapies, and have advanced specialized training in treatment of persons with co-occurring disorders.