Dilemmas in Dual Diagnosis

Royal Hospital Kilmainham

21st November 2014

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Disclosure

- I have attended two national training events and a European conference as a guest of Lundbeck.
- I have attended meetings or received speaker's fees from Pfizer and Schering-Plough. I have attended a European conference and received payment for attending a European workshop held by Reckitt Benckiser Pharmaceuticals Inc.
- I am an Addiction Psychiatrist
- This presentation reflects my own personal views and opinions

Aims and objectives

- To discuss the term “dual diagnosis”
- To highlight some of the difficulties in the care pathways for people with dual diagnosis
- To discuss how mental health, addictions and primary care services can deliver more joined-up services

Dual diagnosis – a definition

- ‘Dual diagnosis’ covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently.
- In UK often refers to a tighter definition, limited to severe mental illness with co-existing substance misuse, usually nicotine, alcohol or cannabis
- Emerging focus on co-existing physical disorders

Importance of addressing dual diagnosis

"Services for people with 'dual diagnosis' – mental illness and substance misuse – are the most challenging clinical problem that we face".

(Professor Louis Appleby, 2004 report to the Secretary of State for Health on the implementation of the National Service Framework for Mental Health)

Importance of addressing dual diagnosis

"People who misuse drugs have a hih rate of suicide"

"the management of suicide risk and of drug use are rarely integrated"

"bridging the gap between these services and improving the skills of front line staff are all steps we can take now"

Drug misuse and suicide: a tale of two services Louis Appleby Addiction (2000) 95(2), 175-177

Dual diagnosis- what's in a word?

"Dual diagnosis" is an unsatisfactory term as often more than two disorders

Other alternatives include:-

- "Co-existing disorders"
- "Co-occurring disorders" (COD) may be a better alternative term to dual diagnosis

Co-occuring disorders

- Anxiety
- Depression
- Sleep disorders
- Complex trauma /PTSD
- Personality disorder
- ADHD
- Alcohol related brain damage
- Learning disability
- Psychosis

- Obesity
- Type 2 diabetes
- Hypertension
- Cardiovascular disease
- Hyperlipidaemia
- Epilepsy

Dual Diagnosis –treatment issues

- Dual diagnosis often perceived as a complex, untreatable condition but commonest problematic substances used are nicotine, alcohol, cannabis and probably prescription drugs.
- Mental Health Staff may not feel they have the skills to address substance use and refer to an addiction service.
- Addiction Service can provide advice or co-work cases where there is addiction to opiods, stimulants or less commonly misused drugs

Relationship between mental health and substance misuse

- The nature of the relationship between these two conditions is complex. Possible mechanisms include:
  - **a primary psychiatric illness precipitating or leading to substance misuse**
  - **substance misuse worsening or altering the course of a psychiatric illness**
  - **intoxication and/or substance dependence leading to psychological symptoms**
  - **substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses.**
  - **The nature of the relationship between these two conditions is complex.**

    (Dual Diagnosis Good Practice Guide *Mental Health Policy Implementation Guide Department of Health London 2002)*

The “primary diagnosis” conundrum

- Which disorder came first?
- Which disorder is the more serious?
- Which disorder should be treated first?
- Which service should manage the patient?

What do we know about the treatment of “dual diagnosis?”

- Substantial number of publications from late 1990s, including Assertive Outreach Services
- Guidance mainly based on expert opinion rather than high quality research
- Major difficulties in carrying out RCTs in this area
- Individuals with dual diagnosis may be hard to reach, hard to treat and present a significant risk to self and sometimes others “The unlearned lesson”

Cochrane Review (2013)

Psychosocial interventions for people with both severe mental illness and substance misuse (Review)

Hunt GE, Siegfried N, Morley K, Sitharthan T, Cleary M

THE COCHRANE COLLABORATION®

This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in *The Cochrane Library* 2013, Issue 10

http://www.thecochranelibrary.com

WILEY

- "We included 32 RCTs and found no compelling evidence to support any one psychosocial treatment over another for people to remain treatment or to reduce substance use or improve mental state in people with serious mental illnesses."

NHS
National Institute for
Health and Clinical Excellence

Psychosis with coexisting substance misuse

Clinical case scenarios for primary, secondary and third sector services

Educational Resource

Implementing NICE guidance

March 2011

Clinical Guideline Implementation Tools

NICE clinical guideline 120

Current consultation from NICE running until 25th Nov 2014

- **Dual diagnosis: community-based services to meet people's wider health and social care needs when they have a severe mental illness and misuse substances**
- Severe mental illness in this guideline refers to a clinical diagnosis of :
    - schizophrenia, schizotypal and delusional disorders
    - bipolar affective disorder
    - severe depressive episode(s) with or without psychotic episodes
    - specific personality disorder.
- Expected to be published in September 2016

Mental Health Policy Implementation Guide (MHPIG); **Dual Diagnosis Good Practice Guide** ***DH London 2002***

- Summarised policy and good practice in the provision of mental health services to people with severe mental health problems and problematic substance misuse.
- Substances concerned included legal and illegal drugs, alcohol and solvents, but not tobacco.

Mental Health Policy Implementation Guide (MHPIG); **Dual Diagnosis Good Practice Guide *DH London 2002***

- Substance misuse is usual rather than exceptional amongst people with SMI
- "Individuals with these dual problems deserve high quality, patient focused and integrated care. **This should be delivered within mental health services."**
- "This policy is referred to as "mainstreaming". Patients should not be shunted between different sets of services or put at risk of dropping out of care completely".

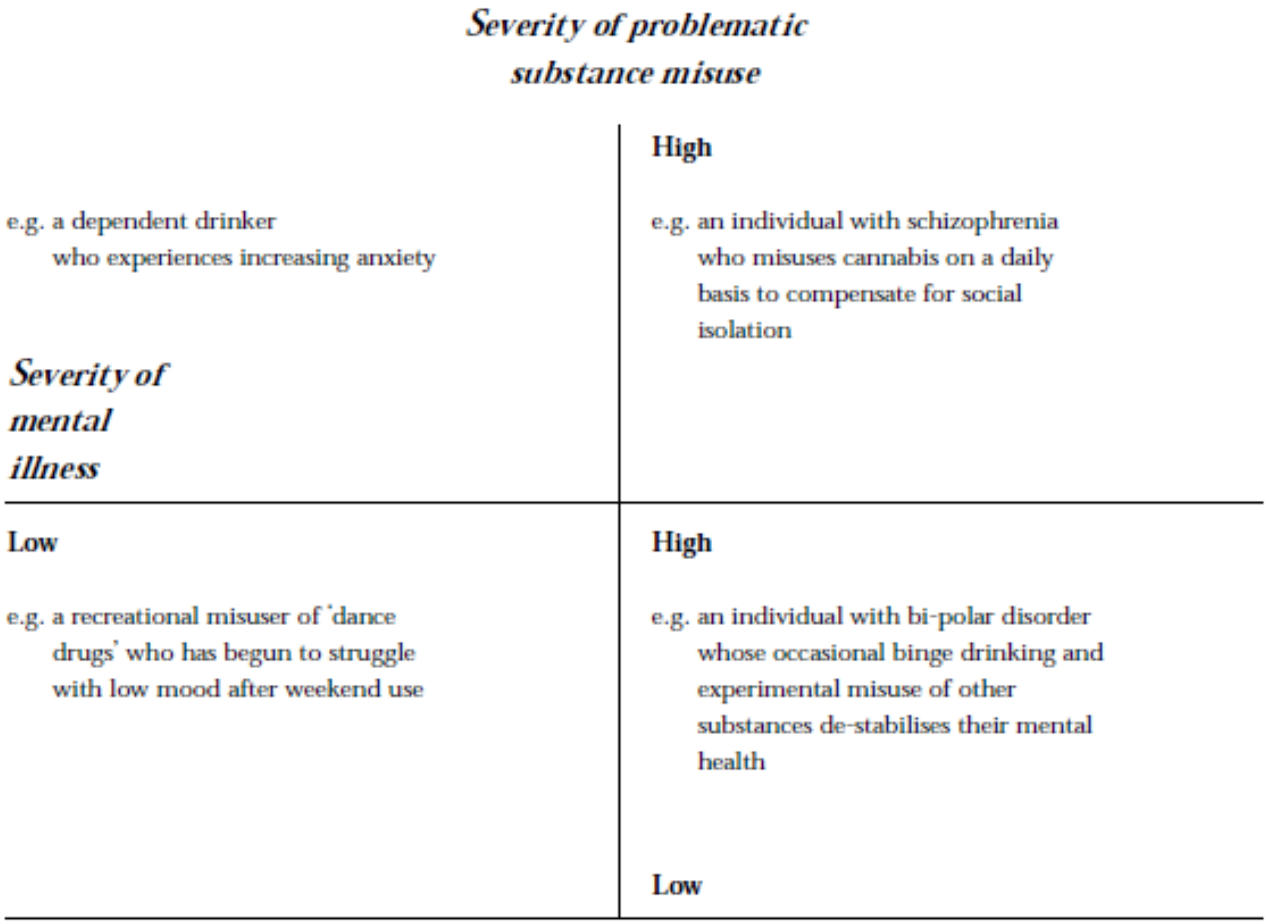
Mental Health Policy Implementation Guide (MHPIG); **Dual Diagnosis Good Practice Guide** ***DH London 2002***

- Around a third to a half of people with severe mental health problems
  - alcohol misuse is the most common form of substance misuse
  - where drug misuse occurs it often co-exists with alcohol misuse
  - homelessness is frequently associated with substance misuse problems
- CMHTs typically report that 8-15% of their clients have dual diagnosis problems although higher rates may be found in inner cities.
- Prisons have a high prevalence of drug dependency and dual diagnosis.

Co-existent psychiatric and substance misuse disorders

(*Mental Health Policy Implementation Guide* Dual Diagnosis Good Practice Guide DH 2002)

Figure 1: The scope of co-existent psychiatric and substance misuse disorders



Mental Health Policy Implementation Guide (MHPIG); **Dual Diagnosis Good Practice Guide** ***DH London 2002***

- Service models
  - Serial (sequential)
  - Parallel (co-working)
  - Integrated (single service)
- Stages of treatment:
  - engagement
  - motivation for change (persuasion)
  - active treatment
  - relapse prevention.

Mental Health Policy Implementation Guide (MHPIG); **Dual Diagnosis Good Practice Guide** *DH London 2002*

- Criticisms
  - Excluded tobacco
  - Focus on narrow locally agreed definition of SMI
  - Personality disorder barely mentioned
  - No guidance on screening for co-existing physical heath problems
  - Did not seem to view substance dependence as a mental disorder in its own right.

Dual Diagnosis post 2002

- Focus on implementation and developing services
- Dual Diagnosis Workers or Services established in some areas with varying success
- Lone workers are vulnerable to clinical overload or unrealistic demands
- Recent efforts to re-energise dual diagnosis and integrate with physical healthcare

  (NICE guidelines being developed)

THE BAMFORD REVIEW MENTAL HEALTH AND LEARNING DISABILITY (Alcohol and Substance Use) 2005

- People with co-existing substance misuse and mental health problems should be treated using an integrated treatment model within a single service:
- the needs of those with complex, enduring and relapsing mental disorders should be met by adult mental health services;
- the needs of those with less severe mental health problems, whose
- when main difficulties are directly related to substance misuse, can best be met by substance misuse services

THE BAMFORD REVIEW MENTAL HEALTH AND LEARNING DISABILITY (Alcohol and Substance Use) 2005

79 There should be systems of liaison between substance misuse and other mental health services to ensure that people with dual diagnosis have access to the full range of the most appropriate treatment services; and

physical health problems associated with substance misuse need to be identified and addressed.

80 The needs of people with co-existing substance misuse and mental health problems in contact with the criminal justice system should be identified and addressed.

81 There should be locally agreed clear care pathways between mental health and substance misuse services for dual diagnosis cases.

A Vision for Change REPORT OF THE EXPERT GROUP ON MENTAL HEALTH POLICY IRELAND 2006

- "The major responsibility for care of people with addiction lies outside the mental health system. These services have their own funding structure within Primary and Continuing Community Care (PCCC) in the HSE. The responsibility of community mental health services is to respond to the needs of people with both problems of addiction and serious mental health disorders".

A Vision for Change REPORT OF THE EXPERT GROUP ON MENTAL HEALTH POLICY IRELAND 2006

- **Mental Health Services for people with co-morbid severe mental illness and substance abuse problems**
  - **Recommendation 15.3.1: Mental health services for both adults and children are responsible for providing a mental health service only to those individuals who have co-morbid substance abuse and mental health problems.**
  - **Recommendation 15.3.2: General adult CMHTs should generally cater for adults who meet these criteria, particularly when the primary problem is a mental health problem.**

A Vision for Change REPORT OF THE EXPERT GROUP ON MENTAL HEALTH POLICY IRELAND 2006

- **Mental Health Services for people with co-morbid severe mental illness and substance abuse problems**
  - **Recommendation 15.3.4: Specialist adult teams should be developed in each catchment area of 300,000 to manage complex, severe substance abuse and mental disorder.**
  - **Recommendation 15.3.5: These specialist teams should establish clear linkages with local community mental health services and clarify pathways in and out of their services to service users and referring adult CMHTs.**

“Drug addiction is a mental illness”

Is there a relationship between childhood ADHD and later drug abuse? See page 2.

NIDA NATIONAL INSTITUTE ON DRUG ABUSE

Research Report Series

from the director:

Comorbidity is a topic that our stakeholders—patients, family members, health care professionals, and others—frequently ask about. It is also a topic about which we have insufficient information, so it remains a research priority for NIDA. This Research Report provides information on the state of the science in this area. Although a variety of diseases commonly co-occur with drug abuse and addiction (e.g., HIV, hepatitis C, cancer, cardiovascular disease), this report focuses only on the comorbidity of drug use disorders and other mental illnesses.*

To help explain this comorbidity, we need to first recognize that drug addiction is a mental illness. It is a complex brain disease characterized by compulsive, at times uncontrollable drug craving, seeking, and use despite devastating consequences—behaviors that stem from drug-induced changes in brain structure and function. These changes occur in some of the same brain areas that are disrupted in other mental disorders, such as depression, anxiety, or schizophrenia. It is therefore not surprising that population surveys show a high rate of co-occurrence, or comorbidity, between drug addiction and other mental illnesses. While we cannot always prove a connection or causality, we do know that certain mental disorders are established risk factors for subsequent drug abuse—and vice versa.

It is often difficult to disentangle the overlapping symptoms of drug addiction and other mental illnesses, making diagnosis and treatment complex. Correct diagnosis is critical to ensuring appropriate and effective treatment. Ignorance of or failure to treat a comorbid disorder can jeopardize a patient's chance of recovery. We hope that our enhanced understanding of the common genetic, environmental, and neural bases of these disorders—and the dissemination of this information—will lead to improved treatments for comorbidity and will diminish the social stigma that makes patients reluctant to seek the treatment they need.

Nora D. Volkow, M.D.
Director
National Institute on Drug Abuse

Comorbidity:

Addiction and Other Mental Illnesses

What Is Comorbidity?

When two disorders or illnesses occur in the same person, simultaneously or sequentially, they are described as comorbid. Comorbidity also implies interactions between the illnesses that affect the course and prognosis of both.

continued inside

*Since the focus of this report is on comorbid drug use disorders and other mental illnesses, the terms “mental illness” and “mental disorders” will refer here to disorders other than substance use disorders, such as depression, schizophrenia, anxiety, and mania. The terms “dual diagnosis,” “mentally ill chemical abuser,” and “co-occurrence” are also used to refer to drug use disorders that are comorbid with other mental illnesses.

U.S. Department of Health and Human Services | National Institutes of Health

- “To help explain this comorbidity, we need to first recognize that drug addiction is a mental illness. It is a complex brain disease characterized by compulsive, at times uncontrollable drug craving, seeking, and use despite devastating consequences—behaviors that stem from drug-induced changes in brain structure and function.”

Nora Volkov *Director*
National Institute on Drug Abuse

The interface between mental and physical health

- Physical and mental health are intimately linked: the same risk factors affect both;
- Mental ill health can present with both mental and physical symptoms;
- Physical ill health often has an impact on mental health, and vice versa.
- Effective health services provide care that addresses both physical and psychological needs.

- *(Source: New Horizons: A shared vision for mental health. Mental Health Division, Department of Health London 2010)*

Bringing mental health and physical heath together

- “There is now a focus on bringing mental health and physical health together to provide holistic care and reduce inequality both in access to and provision of mental and physical healthcare for people with severe and enduring mental illnesses”.

- *(Choosing Health: Supporting the physical health needs of people with severe mental illness DH London 2006)*

The components of a well-being support programme (1)

- General health: blood pressure, pulse rate, body mass index, thyroid function, serum prolactin levels, blood glucose levels, lipid and cholesterol levels.
- Lifestyle: smoking rates, diet, physical activity levels, illicit substance use, alcohol use.
- Side-effect management: regular LUNSERS (Liverpool University Neuroleptic Side Effect Rating Scale) assessment.
- Interventions: one-to-one nursing time to discuss overall health and well-being and agree lifestyle plan to suit the individual.

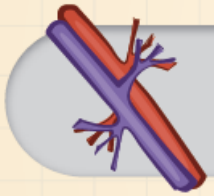
(*Choosing Health: Supporting the physical needs of people with severe mental illness DH/ Mental Health London 2006)*

The components of the well-being support programme (2)

- Referral to other NHS agencies when health issues are identified requiring specialist intervention.
  - Weight management advice – group participation or individual support.
  - Physical activity support – group participation or individual support.
  - Recommendations to healthcare team regarding side-effect management.

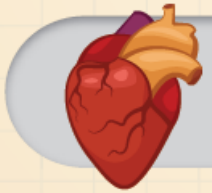
(*Choosing Health: Supporting the physical needs of people with severe mental illness DH/ Mental Health London 2006)*

Co-occurrence between mental illness and other chronic health conditions:

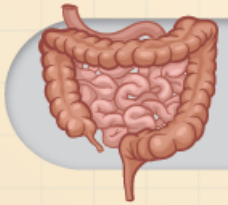


	Mental Illness	No Mental Illness
High Blood Pressure	21.9%	18.8%

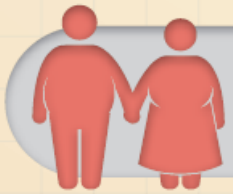
	Mental Illness	No Mental Illness
Smoking	36%	21%



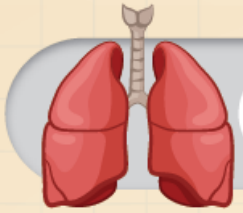
	Mental Illness	No Mental Illness
Heart Disease	5.9%	4.2%



	Mental Illness	No Mental Illness
Diabetes	7.9%	6.6%

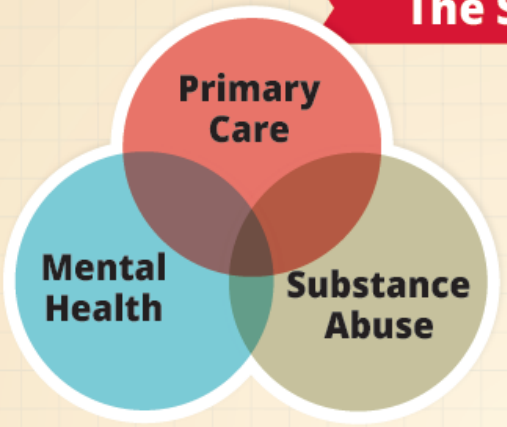


	Mental Illness	No Mental Illness
Obesity	42%	35%



	Mental Illness	No Mental Illness
Asthma	15.7%	10.6%

The SOLUTION

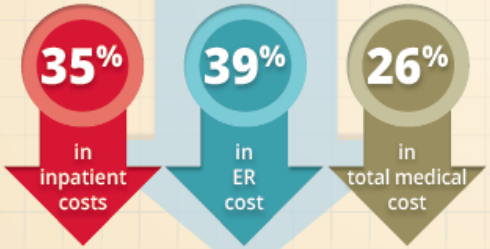


The solution lies in integrated care – the coordination of mental health, substance abuse, and primary care services.

Integrated care produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs.

INTEGRATION WORKS

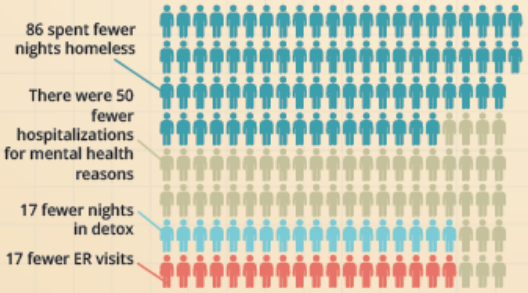
Community-based addiction treatment can lead to...



Reduce Risk ➡ Reduce Heart Disease
(for people with mental illnesses)

Maintenance of ideal body weight (BMI = 18.5 – 25)	=	35%-55% decrease in risk of cardiovascular disease
Maintenance of active lifestyle (~30 min walk daily)	=	35%-55% decrease in risk of cardiovascular disease
Quit Smoking	=	50% decrease in risk of cardiovascular disease

One integration program* enrolled 170 people with mental illness. After one year in the program, in one month:



This is **$213,000** of savings per month.

That's **$2,500,000** in savings over the year.

Integration works.
It improves lives.
It saves lives.
And it reduces healthcare costs.

Difficulties in providing dual diagnosis services

Knowledge, skills and attitudes

Dual Diagnosis - challenges for community mental health teams

- Community based assessment and treatments now the norm
- Fewer inpatient psychiatric beds for assessment and/or treatment
- Medication misuse
- Little support from Addictions
- Limited or no input from dual diagnosis workers
- Difficult to accurately diagnose and treat those with active substance use disorder and a co-occurring mental disease
- Difficulties arranging physical heath check
- Risk of polypharmacy
- Particular benefits from Clozapine

NHS Addiction Services in England are disappearing

Insight

News

Addiction services in England: in need of an intervention

With change comes both opportunity and chaos: an assertion nowhere more true than with England's addiction services. Over the past 5 years, government initiatives to increase cost-effectiveness have opened up bidding for local services to third-party providers. With increased competition, the thinking went, bloated NHS trusts would sharpen their edges and the quality of care would be improved.

But for Gail Critchlow, a psychiatrist at the NHS' Warneford Hospital, Oxford, the restructuring has created a fractured system that risks failing the most vulnerable. After 15 years as a specialist addiction psychiatrist, Critchlow last year switched to general psychiatry because she says the new working conditions made her position untenable. "Both doctors and patients would have to jump through hoops, which really slowed down people's access to treatment."

Critchlow had been working in a service in Oxfordshire where a pilot scheme was introduced 3 years ago. Under the scheme, patients would be sent by their GPs to local assessment and referral centres. There, she says, an often non-qualified person would see them and assign a tariff on the basis of their complexity. If they needed methadone maintenance, they would go to the Harm Minimisation Service, a partnership between the NHS trust and a voluntary provider. Those deemed to be more motivated would go to a Recovery Service, provided by a voluntary organisation.

Critchlow explains that, in line with their contract with the local authority, the Harm Minimisation Service would receive payment based on the proportion of patients being passed to the recovery provider. "The pressure was on the Harm Minimisation Service to move patients on", she says, "but many people weren't ready—huge waves of people were coming in and out of the recovery provider and along the way many would drop out of the system altogether."

Critchlow's concerns are felt by many across the NHS. Such bureaucratic hurdles and lack of continuity between systems, explains Colin Drummond, Professor of Addiction Psychiatry at King's College London, hold up treatment for patients who move between providers. Chief among Drummond's concerns about the new system is what he refers to as an ideologically and cost-driven move away from methadone maintenance for patients with heroin addiction.

"There's good evidence that methadone maintenance keeps people alive", he says. "It prevents risky behaviour and blood-borne virus infection, like hepatitis and HIV, and is approved by NICE. " He adds that its pharmacological actions decrease illicit drug use, crime, and the risk of overdose. On this note, he expresses concern over the most recent Office of National Statistics report saying deaths from heroin or morphine overdose have increased by 32% in 2013 compared with 2012.

"Methadone treatment needs to be...based on clinical need... rather than being determined by bureaucrats, politicians, and ideologues"

"It would be wrong to portray this simply as methadone versus recovery. Methadone treatment needs to be readily available based on clinical need as part of a balanced treatment system rather than being determined by bureaucrats, politicians, and ideologues", he adds. "If it was a NICE-approved treatment for cancer that was being denied, there would be a national outcry. But perhaps drug addicts are not afforded the same level of importance by society."

Oscar D'Agnone, Medical Director of Crime Reduction Initiative (CRI), a major third-sector provider, does not agree with Drummond. "I don't think there is a drive away from methadone but a drive towards a more balanced system offering people the opportunity to recover", he says, pointing out he cannot speak for the entire sector. "Over the years it became apparent that the harm minimisation approach [methadone maintenance] was good for getting service users in and retaining them in treatment but offered almost no option to get out. As some say, people were 'parked on methadone'."

"The so-called recovery model", he continues, "needed a more dynamic approach to achieve its aim. That was something that the NHS organisations, due to their large and complex structures, were not ready to offer. That is the main reason most of the new contracts formerly provided by NHS services have been re-tendered and awarded to third sector organisations."

Data are scarce for just how many contracts have been awarded to third-sector organisations. Peter Burkinshaw, commissioning and clinical lead at Public Health England, says

For the Office of National Statistics' report on deaths related to drug poisoning in England and Wales, 2013 see http://www.ons.gov.uk/ons/dcp171778_375498.pdf

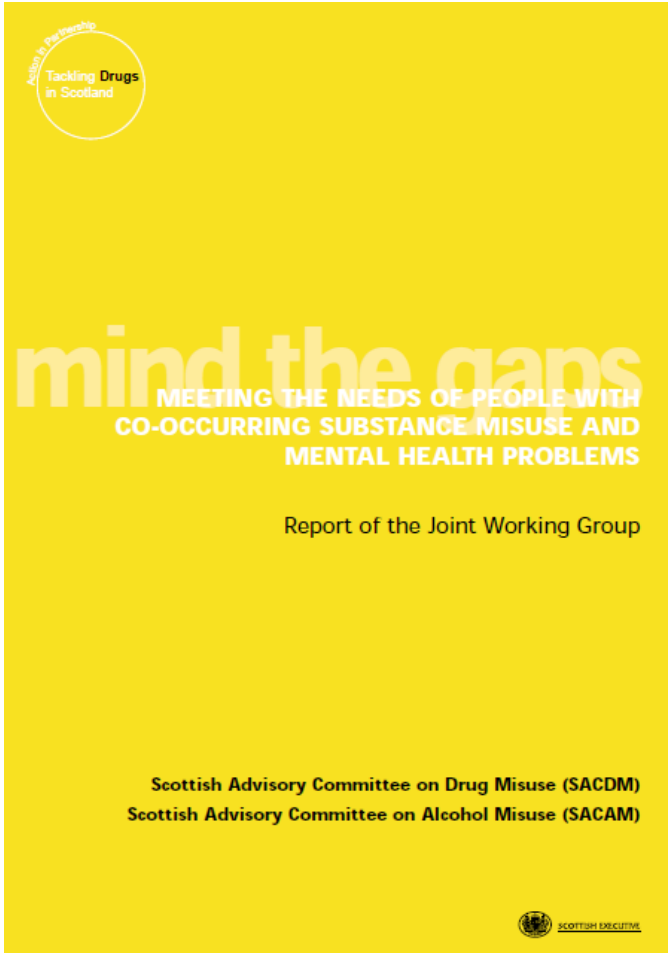
Colin Drummond, Professor of Addiction Psychiatry at King's College London, discusses his concern about the state of England's addiction services

www.thelancet.com/psychiatry Vol 1 November 2014

421

- Changes to commissioning have caused NHS Addiction Services to close in England
- Loss of expertise
- Less training
- Less capacity for complexity
- QUALITY OF COMMISSIONING DECISIONS OF CENTRAL IMPORTANCE

Key resource



- **Mind the gaps- Meeting the Needs of People with co-occurring substance misuse and mental health problems**

Scottish Advisory Committee on Drug Misuse (SACDM)

Scottish Advisory Committee on Alcohol Misuse (SACAM) (2003)

“DUAL DIAGNOSIS” –A DOUBLE BIND

- Individuals with a mental illness and substance misuse/ dependence may be:-
  - excluded from substance misuse services because they have a mental health problem.
  - excluded from mental health services as they have a substance misuse issue

Variations in provision of services for those with co-occurring mental health and substance use disorders

- lack of specified core competencies, and thus training for staff in generic and frontline services;
- lack of willingness to work with this client group, and stigmatisation associated with their problem; this sometimes results in treatment not being offered and inappropriate and rapid referrals on to other services when their significance is not clear;

Mind the gaps- Meeting the Needs of People with co-occurring substance misuse and mental health problems (2003)

Variations in provision of services for those with co-occurring mental health and substance use disorders

- some mental health services working on too narrow a model of assessment and care;
- general lack of communication at both operational and planning levels between addiction and mental health services;
- lack of clarity in defining clients with co-occurring mental and substance misuse problems (.multi-problematic., as opposed to .dual diagnosis.), with poor assessment by generic workers and primary diagnosis often reflecting source of referral rather than causation;

Mind the gaps- Meeting the Needs of People with co-occurring substance misuse and mental health problems (2003)

Comment on MIDAS STUDY BMJ 13 December 2010 Elizabeth C Hughes

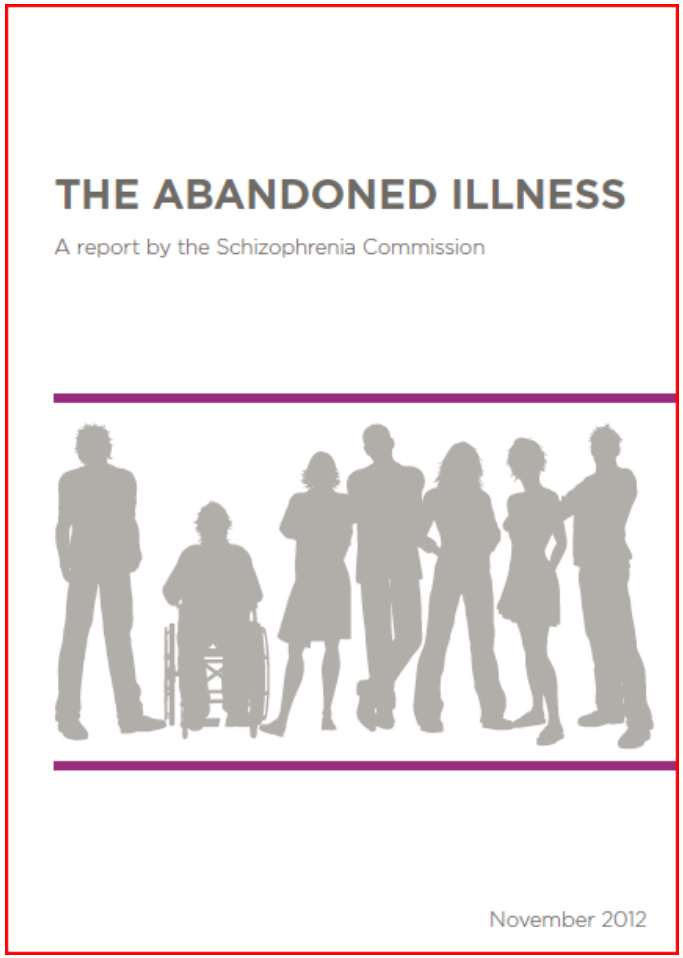
- “I believe that the problems that people with dual diagnosis present with are in some ways a product of a health and social care system that is unable to address complexity, ambiguity of diagnosis and need, and co-morbidity of any form. The other issue that I have found to be a huge barrier to receiving care is the general negative attitude towards people who use drugs and alcohol both in the general population and indeed in mental health services”

Dual Diagnosis and healthcare in prisons

- “Improved services for prisoners who have a dual diagnosis of mental health and drug/alcohol problems should be urgently developed.”

  (Improving Health, Supporting Justice: The National Delivery Plan of the Health and Criminal Justice Programme Board DH London 2009)

Meeting the needs of the most marginalised



- "we were concerned about the experience of a number of groups who are already marginalised:
  - People with schizophrenia and psychosis in the criminal justice system.
  - Homeless people
  - People with a "dual diagnosis" of addiction problems and severe mental illness."


THE BEST THING YOU CAN DO IS GIVE UP SMOKING, DRINKING AND FRIED FOOD
WHAT'S THE SECOND BEST?

FIVE YEAR FORWARD VIEW
NHS October 2014

- *Maintaining the NHS in austerity*
- *"Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together."*

FIVE YEAR FORWARD VIEW
NHS October 2014

- **"..the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals,** between physical and mental health, between health and social care.
- The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases."

FIVE YEAR FORWARD VIEW
NHS October 2014

- "A further new option will be the integrated hospital and primary care provider - **Primary and Acute Care Systems - combining for the first** time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too."

Conclusions

Suggestions for service development

What sort of services should we be developing?

- Addiction Only Services
- Psychiatric Disorders Services excluding addictions unless co-occurring with other mental illness
- Dual Diagnosis Capable Services within Addictions
- **Dual Diagnosis Capable Services within mainstream Mental Health √**

Suggestions for Mental Health Services, including Addictions (1)

- Don’t divorce Addictive Disorders from Mental Disorders
- Routinely use screening tools for alcohol/drug use
- Ensure all staff carrying out mental health assessments have core skills in addiction
- Avoid redirecting referrals to another service purely on the basis of what is thought to be their “primary diagnosis.” Help the referrer find the most appropriate service in discussion with other agencies

Suggestions for Mental Health Services, including Addictions (2)

- Maintain Assertive Outreach Teams for people with SMI + substance misuse
- Inpatient psychiatric beds are still required for assessment and treatment
- Be aware of medications with potential for misuse
- Integrate treatment s for physical , mental and addictive disorders

Suggestions for Mental Health Services, including Addictions (3)

- Get to know the range of service providers in your locality
- Consider co-working rather than excluding individuals with co-morbid conditions

Skills expected of Mental Health Nurses (MHNs)

- **“MHNs will have the skills and opportunities to improve the physical wellbeing of people with mental health problems”.**

- **“All MHNs to have access to sources of specialist advice on working with people with dual mental health and substance misuse problems”.**

- **“All MHNs to have received training on dual diagnosis issues, including:**
  - **recognition;**
  - **assessment (physical and psychological);**
  - **motivational interviewing techniques;**
  - **availability of resources”.**
- *(From values to action: The Chief Nursing Officer’s review of mental health nursing DH London 2006)*

NHS
National Institute for
Health and Clinical Excellence

Psychosis with coexisting substance misuse

Clinical case scenarios for primary, secondary and third sector services

Educational Resource

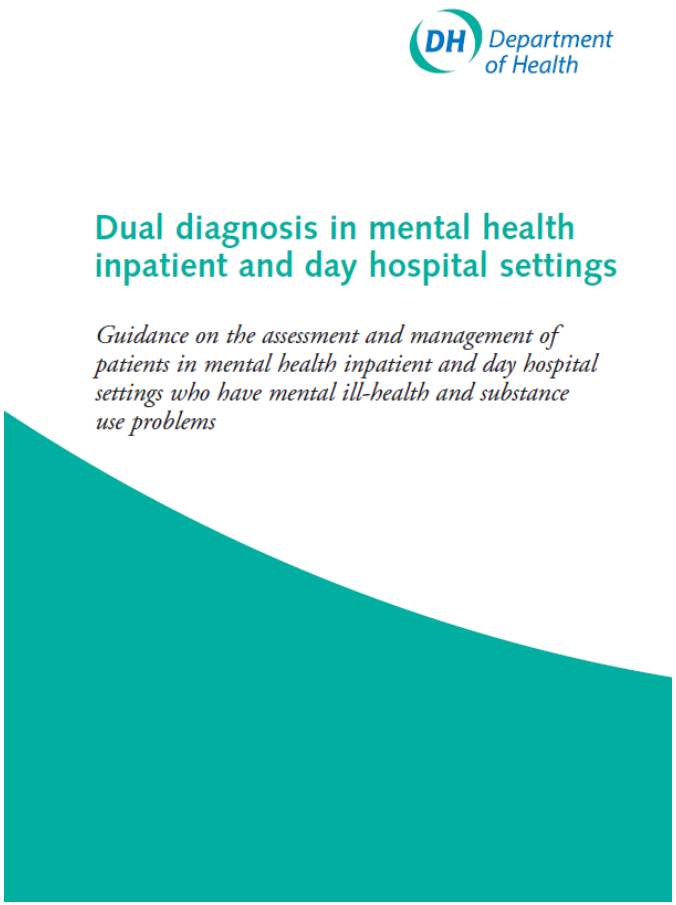
Implementing NICE guidance

March 2011

Clinical Guideline Implementation Tools

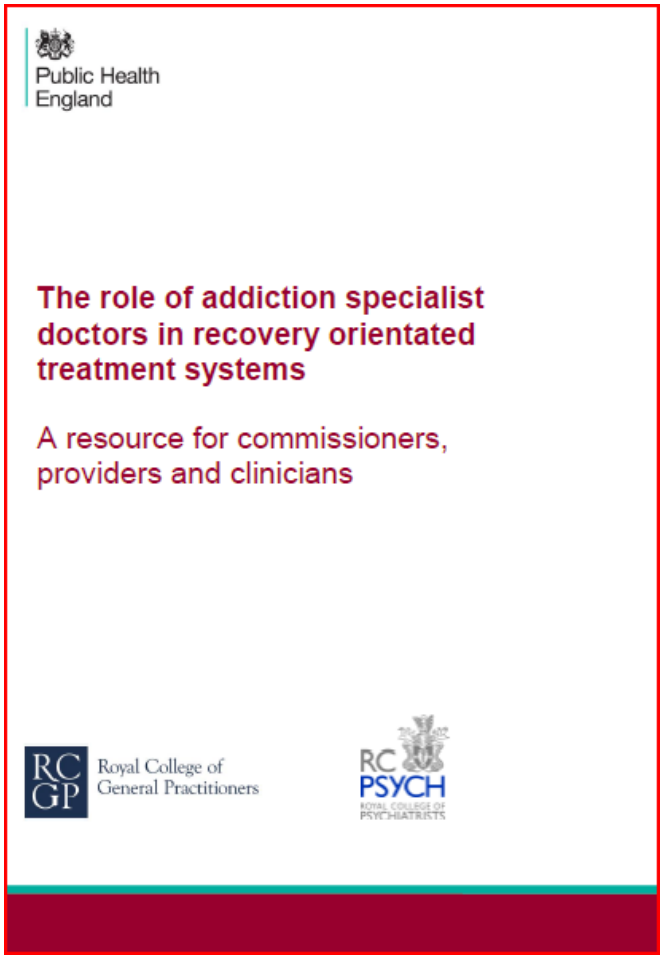
NICE clinical guideline 120

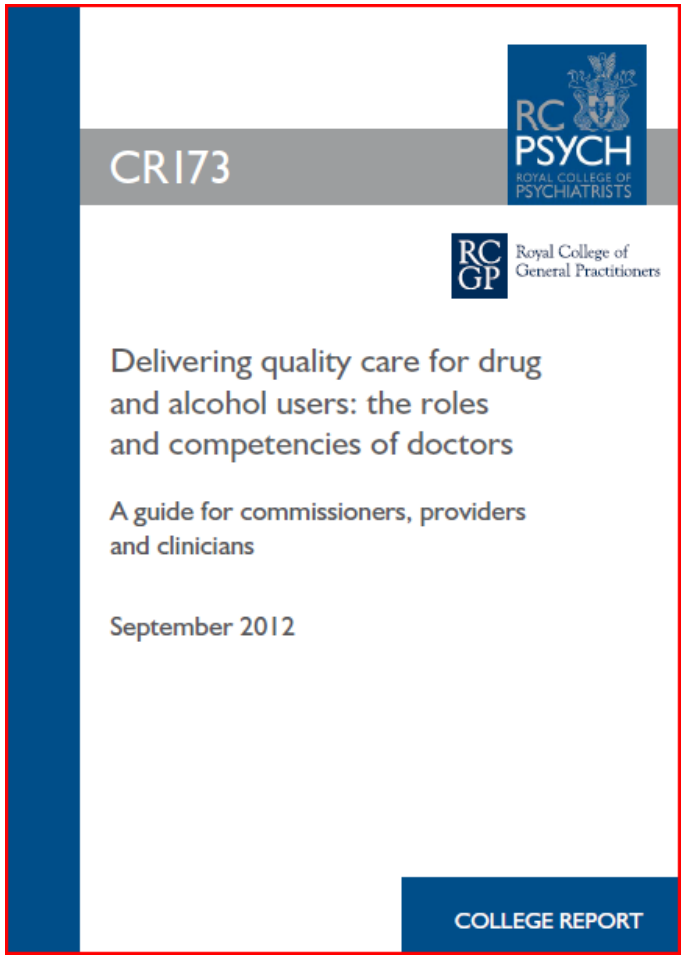
Key resource



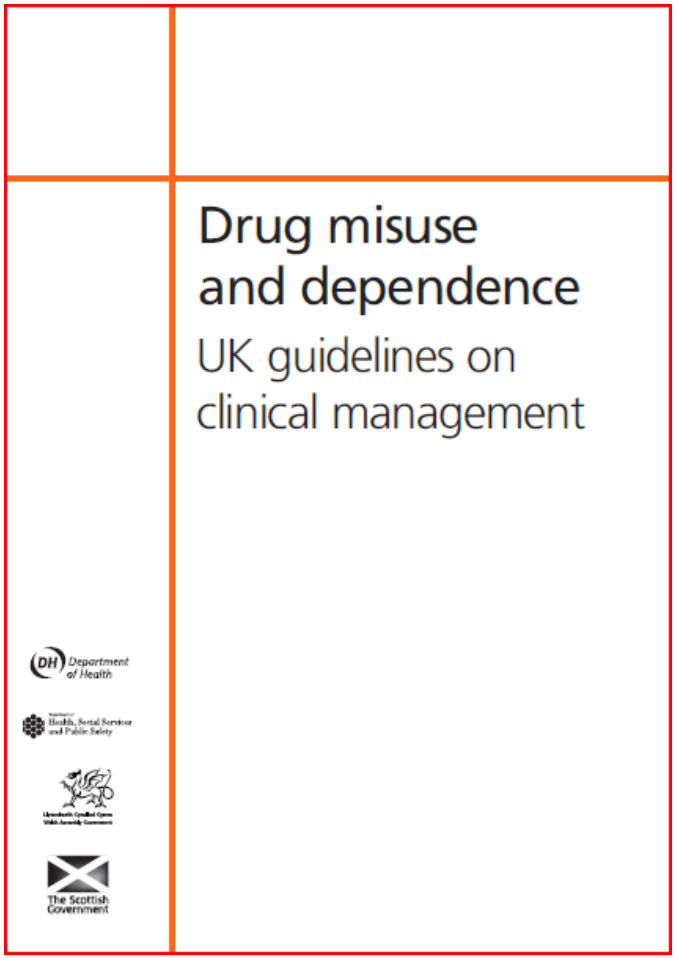
- **Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings (DH, 2006)**

Guidance for doctors





Guidance for doctors



Addiction to Medicines Consensus Statement

January 2013

Thriving, not just surviving:

One person, diverse needs: Living with a mental illness as well as the challenges from difficulties with alcohol and drug use

Lani, Queensland

I was diagnosed with bipolar 2 and ADHD in 2006. I was 24 then. After going through an extreme manic episode, I knew I needed help. And fast.

When I look back on the years preceding my diagnosis, there were big warning signs I wasn't well. From the age of 16, my head suddenly began to operate independently of what I wanted it to do. I now understand that was bipolar. Back then I thought it was normal.

So I began to self-medicate. A treatment plan I devised myself; so dangerous to someone with mental health issues.

Over the next eight years, I struggled with alcohol and drug use. I couldn't just drink a few drinks. I had to wipe myself out. For that was my intention always. I didn't want to feel the hurt from depression and I wanted to numb the confusion and anxiety of hypomania.

The comedowns were horrifying but that brief moment of escape made it seem worthwhile.

Until I kept going down, down, down.

I'm now on an extensive treatment plan that includes medication, therapy, being mindful and working with my amazing husband, family and friends. I have two degrees, about to start my Masters, a great job and am leading a life I'm proud of.

I've found that doing the things I love helps greatly. For me that includes writing, reading, study, sport and music. I still have my down days, my up days and my all over the shop days. But doing the things I love regularly keeps me excited, engaged, and looking to the future.

I have to confront my mental illness by managing it every day. It doesn't own me. I can own it. I no longer just want to survive. I want to thrive.

I choose happiness. I choose health. I choose life.

Watch Lani's video at www.mentalhealthcommission.gov.au

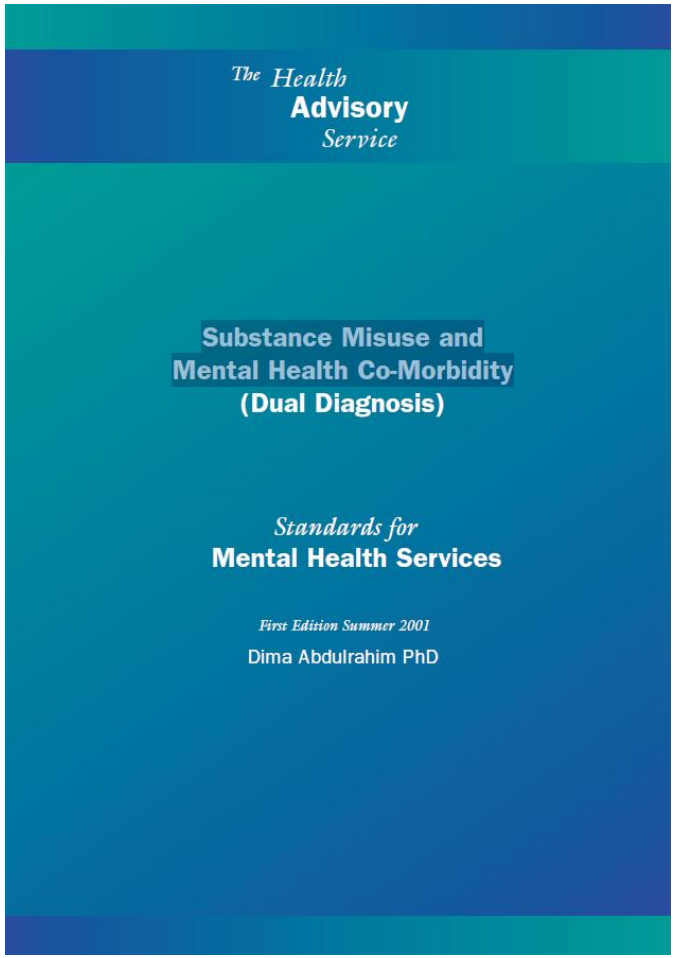
Dual diagnosis presentations available on the internet

- ***Welcome to Dual Diagnosis Australia & New Zealand website***

  ***Richard Clancy*: Good Practice Models in Integrated Treatment *or* Integrated Practice in a Parallel Universe.**

- http://www.dualdiagnosis.org.au/home/index.php?option=com_content&task=view&id=75&Itemid=1

Resources

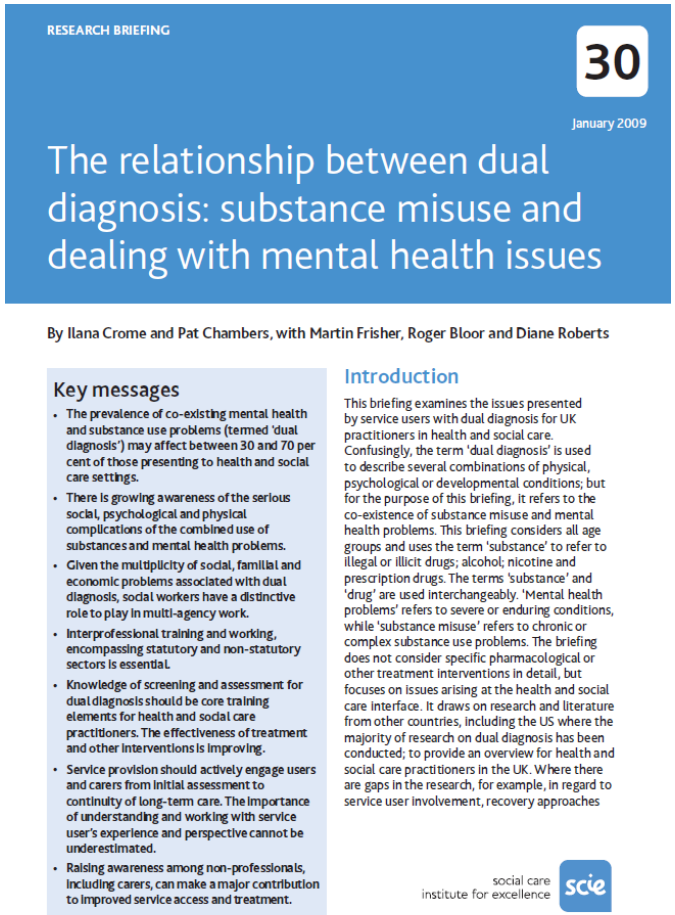


- Substance Misuse and Mental Health Co-Morbidity (Dual Diagnosis)

  Standards for Mental Health Services The Health Advisory Service

  Dima Abdulrahim (2001)

Resources



RESEARCH BRIEFING

30

January 2009

The relationship between dual diagnosis: substance misuse and dealing with mental health issues

By Ilana Crome and Pat Chambers, with Martin Frisher, Roger Bloor and Diane Roberts

Key messages

- The prevalence of co-existing mental health and substance use problems (termed 'dual diagnosis') may affect between 30 and 70 per cent of those presenting to health and social care settings.
- There is growing awareness of the serious social, psychological and physical complications of the combined use of substances and mental health problems.
- Given the multiplicity of social, familial and economic problems associated with dual diagnosis, social workers have a distinctive role to play in multi-agency work.
- Interprofessional training and working, encompassing statutory and non-statutory sectors is essential.
- Knowledge of screening and assessment for dual diagnosis should be core training elements for health and social care practitioners. The effectiveness of treatment and other interventions is improving.
- Service provision should actively engage users and carers from initial assessment to continuity of long-term care. The importance of understanding and working with service user's experience and perspective cannot be underestimated.
- Raising awareness among non-professionals, including carers, can make a major contribution to improved service access and treatment.

Introduction

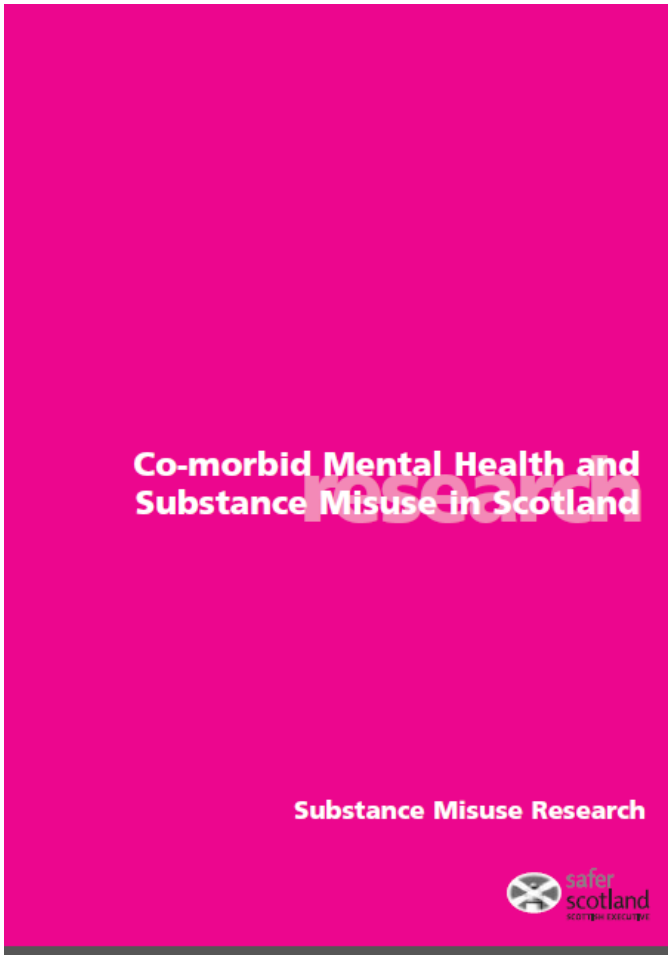
This briefing examines the issues presented by service users with dual diagnosis for UK practitioners in health and social care. Confusingly, the term 'dual diagnosis' is used to describe several combinations of physical, psychological or developmental conditions; but for the purpose of this briefing, it refers to the co-existence of substance misuse and mental health problems. This briefing considers all age groups and uses the term 'substance' to refer to illegal or illicit drugs; alcohol; nicotine and prescription drugs. The terms 'substance' and 'drug' are used interchangeably. 'Mental health problems' refers to severe or enduring conditions, while 'substance misuse' refers to chronic or complex substance use problems. The briefing does not consider specific pharmacological or other treatment interventions in detail, but focuses on issues arising at the health and social care interface. It draws on research and literature from other countries, including the US where the majority of research on dual diagnosis has been conducted; to provide an overview for health and social care practitioners in the UK. Where there are gaps in the research, for example, in regard to service user involvement, recovery approaches

social care institute for excellence scie

- The relationship between dual diagnosis: substance misuse and dealing with mental health issues.

  Ilana Crome,Pat Chambers, Martin Frisher, Roger Bloor and Diane Roberts SCIE Research Briefing 30 (2009)

Resources

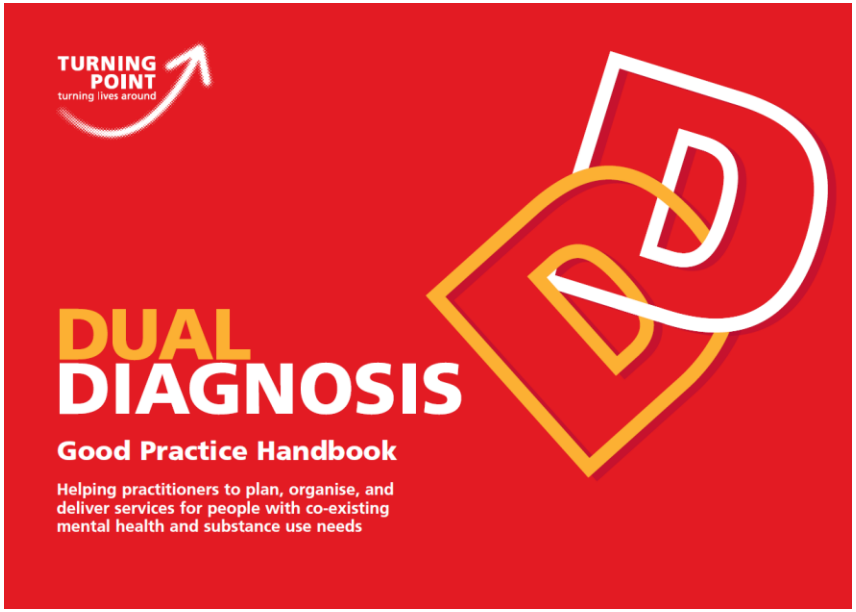


- **Co-morbid Mental Health and Substance Misuse in Scotland**

  Scottish Executive Social Research Substance Misuse Research Programme (2006)

  http://www.scotland.gov.uk/Resource/Doc/127647/0030582.pdf

Resources



- **Dual Diagnosis: Good Practice Guide** Turning Point London 2007
- http://www.turning-point.co.uk/media/170796/dualdiagnosisgoodpracticehandbook.pdf

What is
Integrated Treatment for Co-Occurring Disorders?

In evidence-based Integrated Treatment programs, consumers receive combined treatment for mental illnesses and substance use disorders from the same practitioner or treatment team.

Why participate in Integrated Treatment?

Substance use disorders are common among people with serious mental illnesses and put people at risk for many other problems. Integrated Treatment programs help consumers develop hope, knowledge, skills, and the support they need to manage their problems and to pursue meaningful life goals.

How does Integrated Treatment work?

Integrated services	Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders.
Cross-trained practitioners	Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses.
Stage-wise treatment	Integrated treatment specialists match services to the consumer's stage of recovery.
Motivational interventions	Motivational interventions are used to help consumers identify and pursue personal recovery goals.
Cognitive-behavioral approach	A cognitive-behavioral approach is used to help consumers identify and change their thoughts, feelings, and behaviors related to their co-occurring disorders.
Multiple formats	Services are available in individual, group, self-help, and family formats.
Integrated medication services	Medication services are integrated with other services.

Integrated Treatment programs fully support consumers in their recovery process.

NHS
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Case scenario 1

- **Tom**

- Tom has a diagnosis of schizo-affective disorder. He has a care coordinator in the local community mental health team (CMHT). He uses alcohol and cannabis most days and claims that these do not cause him any difficulties. He does not want to be referred to drug and alcohol services.
- Tom has recently become friendly with Joe, another service user who has a significant drug (crack and cannabis) and alcohol problem. A further service user, who lives in the same block, has reported that Joe spends a lot of time at
- Tom's flat and sometimes takes other friends there too. This service user adds that Joe is taking money from Tom to buy his own drink and drugs, and that when he is drunk he becomes angry and aggressive and has hit Tom.

Case scenario 1

- ***1.1 Question:***
- How should you approach treating and developing a care plan for Tom?

Case scenario 1

- ***1.1 Answer:***
- Treatment for Tom's mental health disorder, alcohol and cannabis problems should all be provided within the community mental health team[1].
- Ensure that time is taken to communicate and engage with Tom right from the start of his assessment, treatment and development of a care plan. A flexible, non-judgemental and motivational approach should be used to ensure a trusting relationship is formed[2].
- As part of the care plan, Tom's care coordinator should offer written and verbal information and advice about the nature and treatment of both his psychosis and his substance misuse, and about the risks of alcohol and cannabis on his mental health. This information should be provided in a format Tom will understand[3, 4].

Case scenario 1

- ***1.1 Answer continued:***
- Tom's care coordinator should ensure they are competent to work with Tom's psychosis and substance misuse issues and possibly seek out supervision for their work around his substance misuse from a specialist in substance misuse problems[5].
- Consideration should be given to initiating Safeguarding procedures given Tom's vulnerability[6].
- An annual review of Tom's physical health will be carried out paying particular attention to the effects of his alcohol and cannabis use on his health[7].

Case scenario 2

- **Cassandra**
- Cassandra has a diagnosis of schizophrenia. She also misuses cannabis, and sometimes alcohol, on a regular basis. Her care is managed by her local community mental health team. She has a care coordinator. Cassandra recently started taking heroin and says she is using it most days. She thinks she needs a methadone prescription.
- ***2.1 Question:***
- What should be considered when assessing and modifying Cassandra's care plan?

Case scenario 2

- ***2.1 Answer:***
- The mental health team should find out more detail about her substance use including: which substances she is taking, the quantity, frequency and pattern of use, route(s) of administration and duration of current use. They should also conduct an assessment of dependency[8].
- Her risk assessment should be reviewed taking account of the risks associated with her substance misuse and the impact that use may have on other risks[9]. Cassandra may be at risk of accidental overdose, the substances she is taking may interact with her prescribed medication, if she is injecting she may be at risk of contracting blood-borne viruses and developing local and systemic infections. She may be at risk of accidents if she becomes overly sedated, particularly if she is combining alcohol with opioids. This would also increase the risk of accidental overdose.

Case scenario 2

- ***2.1 Answer continued:***
- The local substance misuse service should be contacted for advice and to discuss the possibility of joint working[10]. It is likely that they will require the information obtained in the assessment above as part of a local protocol to negotiate shared care[11].
- Ensure that the local substance misuse service does not exclude Cassandra because she has a diagnosis of psychosis[12].
- Conduct a comprehensive substance misuse assessment and, if appropriate, initiate substitute prescribing (in line with NICE Drug misuse: opioid detoxification or NICE technology appraisal TA114) [13]. Risk assessment would again need to be reviewed and risk management plan updated[9].

Case scenario 2

- ***2.1 Answer continued:***
- A joint care plan (community mental health team, substance misuse service, Cassandra and Cassandra's family or carer[14]) should be devised making clear the responsibility of each person or agency in line with local protocols[11]. The care plan should take into account the complex and individual relationships between substance misuse, psychotic symptoms, emotional state, behaviour and Cassandra's social context[15].
- Cassandra's family should be offered information about local groups that support the families of people with drug problems[16].
- The community mental health team should invite a member of staff from the local substance misuse service to provide some training on treatment of heroin problems so that they can better understand the treatment that Cassandra will receive and support her in achieving her goals[17,18].

Case scenario 2

- ***2.2 Question:***
- Cassandra has an 8-year-old daughter who lives with her. What concerns might there be and what action should be taken?
-

Case scenario 2

- ***2.2 Answer:***
- Assess needs according to local safeguarding procedures[19]. It may be necessary do develop a child protection plan[20.]

Case scenario 2

- ***2.3 Question:***
- Following a relapse in her mental health, Cassandra is admitted to an acute psychiatric ward. How should her care be coordinated?

Case scenario 2

- ***2.3 Answer:***
- The substance misuse team should provide advice to the inpatient team regarding Cassandra's ongoing drug treatment during her admission[21].
- The worker(s) from the substance misuse team should attend ward reviews so that they are able to contribute to the review of her care plan, and be involved in planning future care[22].
- During her inpatient admission, Cassandra completes a detoxification from opioids. When she is discharged she is advised of the risk of overdose if she resumes use[23].
- The inpatient mental health service should ensure it has policies and procedures in place promoting a therapeutic environment free from drugs and alcohol[24].

Case scenario 3

- **Jade**
- Jade has been attending the substance misuse service for several years. For the past six months, she has been on a reducing dose of methadone and has now completed detoxification. However, she continues to use other substances including alcohol, crack cocaine and cannabis. Her use of these substances has escalated since she completed detoxification, which coincided with the death of her partner through an accidental heroin overdose. Although it is not uncommon for her to experience feelings of suspiciousness and think that other people are talking about her, over the past few weeks the frequency and intensity of these feelings has increased. Jade has started to think that her neighbours have bugged her flat and says that she has been receiving messages from the television. The mental health lead in the service has seen Jade to assess her mental health and risks and has identified that she has signs of psychosis[25.]

Case scenario 3

- ***3.1 Question:***
- What should the mental health lead do next with case scenario 3?

Case scenario 3

- ***3.1 Answer:***
- Jade should be referred to the secondary mental health service for further assessment and management as she may have a coexisting psychotic disorder[26].
- The mental health service should accept Jade for further assessment and not exclude her because of her substance misuse[27].
- The assessment may need to take place over several meetings to gain a full understanding of Jade and the range of problems she may be experiencing and to promote engagement[28]. She may fear being detained, being given psychiatric medication forcibly or that she is 'mad'[2].

Case scenario 3

- ***3.1 Answer continued:***
- The assessment should be comprehensive, multidisciplinary and include: personal history; mental, physical and sexual health; social, family and economic situation; accommodation; current and past substance misuse and its impact on life; criminal justice history and current status; personal strengths and weaknesses, and readiness to change substance misuse and other aspects of her life[28]. There may be scope within local protocols to share assessment information[11].

References

- *Mental Health Policy Implementation Guide (MHPIG);* Dual Diagnosis Good Practice Guide *Department of Health London 2002*
- *Closing the Gap: A capability framework for working effectively with people with combined*
- *mental health and substance use problems (Dual Diagnosis) (Hughes 2006) provides a competency* framework that informs the training agenda for dual diagnosis
- Mental Health NSF Autumn Assessment 2007 Dual Diagnosis Themed Review *Care Services Improvement Partnership (CSIP)*

- Integrated motivational interviewing and cognitive behavioural therapyfor people with psychosis and comorbid substance misuse: randomised controlled trial. *Christine Barrowclough , Gillian Haddock, Til Wykes et.al ,* BMJ 2010;341:c6325 doi:10.1136/bmj.c6325

http://www.yhpho.org.uk/resource/view.aspx?RID=198654

National Mental Health Dementia and Neurology Intelligence Network

Improving the health of communities by making data and information accessible

Coexisting substance use and mental health issues

Mental Health

Coexisting substance use and mental health issues

Mental health issues and drugs and alcohol problems are often interrelated [link to SCIE]. Regardless of the causes and relationships, providing rapid assessment and individualised care is the priority. NICE has produced quality standards for drug and alcohol treatment which highlight the need for comprehensive assessment and appropriate intervention.

Local authorities commission drug and alcohol treatment from the public health budget. Mental health services are commissioned by Clinical Commissioning Groups (CCGs). Local areas may have information about the high service use by this client group (such as frequent accident and emergency attendance or use of police custody suites) which shows the need for joined-up commissioning across substance misuse and mental health pathways.

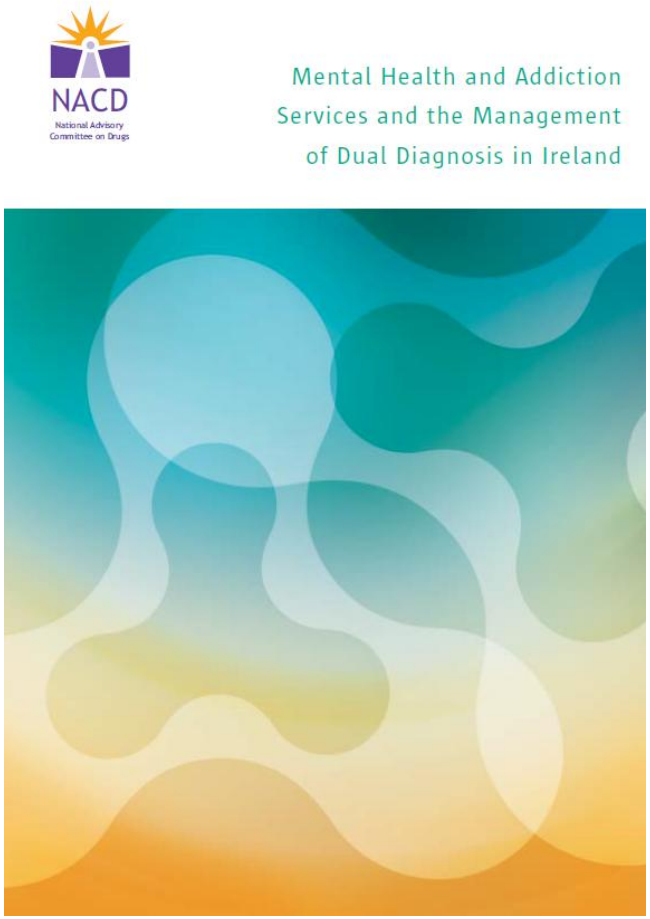
Health and wellbeing boards provide a structure for relevant partners to come together to look at these issues. The Joint Strategic Needs Assessment can inform the development of a local Joint Health and Wellbeing Strategy in which the needs of people with co-existing mental health and addictions can be addressed.

Resources

A guide for the management of dual diagnosis for prisons DH/Offender Health 2009

http://www.nta.nhs.uk/uploads/prisons_dual_diagnosis_final_2009.pdf

Resources



- Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland
  National Advisory Committee on Drugs 2004