Dilemmas in Dual Diagnosis
Royal Hospital Kilmainham
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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 high 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-occurring 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 opioids, 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.

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)

“...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.”
Psychosis with coexisting substance misuse
Clinical case scenarios for primary, secondary and third sector services

Educational Resource
Implementing NICE guidance

March 2011

NICE clinical guideline 120
Current consultation from NICE running until 25\textsuperscript{th} 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**.
• 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

(\textit{Mental Health Policy Implementation Guide} Dual Diagnosis Good Practice Guide DH 2002)

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

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<thead>
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<th>Severity of problematic substance misuse</th>
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<tr>
<td>High</td>
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<td>- e.g. an individual with schizophrenia who misuses cannabis on a daily basis to compensate for social isolation</td>
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<th>Severity of mental illness</th>
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<tr>
<td>Low</td>
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<td>- e.g. a dependent drinker who experiences increasing anxiety</td>
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<tr>
<td>High</td>
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<td>- e.g. a recreational misuser of ‘dance drugs’ who has begun to struggle with low mood after weekend use</td>
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<th>Severity of mental illness</th>
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<td>Low</td>
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<td>- e.g. an individual with bi-polar disorder whose occasional binge drinking and experimental misuse of other substances de-stabilises their mental health</td>
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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 health 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)
• 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
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.
• “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”.
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.
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

“...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 health 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:
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...

- 35% in inpatient costs
- 39% in ER cost
- 26% in total medical cost

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

- 86 spent fewer nights homeless
- There were 50 fewer hospitalizations for mental health reasons
- 17 fewer nights in detox
- 17 fewer ER visits

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

- Maintenance of ideal body weight (BMI = 18.5 – 25)
- Maintenance of active lifestyle (~30 min walk daily)
- Quit Smoking

= 35%-55% decrease in risk of cardiovascular disease
= 35%-55% decrease in risk of cardiovascular disease
= 50% decrease in risk of cardiovascular disease

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 health check
- Risk of polypharmacy
- Particular benefits from Clozapine
NHS Addiction Services in England are disappearing

- 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.”

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?
• 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.”
• “..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.”
• “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 v
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 treatments 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)*
Psychosis with coexisting substance misuse
Clinical case scenarios for primary, secondary and third sector services

Educational Resource
Implementing NICE guidance

March 2011

NICE clinical guideline 120
Key resource

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

The role of addiction specialist doctors in recovery orientated treatment systems
A resource for commissioners, providers and clinicians

Delivering quality care for drug and alcohol users: the roles and competencies of doctors
A guide for commissioners, providers and clinicians
September 2012
Guidance for doctors

Drug misuse and dependence
UK guidelines on clinical management

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 15, 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 version of normal. 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)
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)

Resources

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

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<th>Description</th>
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<td>Integrated services</td>
<td>Mental health and substance abuse treatment are integrated to meet the needs of people with co-occuring disorders.</td>
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<tr>
<td>Cross-trained practitioners</td>
<td>Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses.</td>
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<td>Stage-wise treatment</td>
<td>Integrated treatment specialists match services to the consumer’s stage of recovery.</td>
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<tr>
<td>Motivational interventions</td>
<td>Motivational interventions are used to help consumers identify and pursue personal recovery goals.</td>
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<td>Cognitive-behavioral approach</td>
<td>A cognitive-behavioral approach is used to help consumers identify and change their thoughts, feelings, and behaviors related to their co-occurring disorders.</td>
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<td>Multiple formats</td>
<td>Services are available in individual, group, self-help, and family formats.</td>
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<tr>
<td>Integrated medication services</td>
<td>Medication services are integrated with other services.</td>
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Integrated Treatment programs fully support consumers in their recovery process.
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.
  - Consideration should be given to initiating Safeguarding procedures given Tom’s vulnerability.
  - 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.
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. 

• 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. 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) should be devised making clear the responsibility of each person or agency in line with local protocols. 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.

- Cassandra’s family should be offered information about local groups that support the families of people with drug problems.

- 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.
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\textsuperscript{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\textsuperscript{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\textsuperscript{23}.

• The inpatient mental health service should ensure it has policies and procedures in place promoting a therapeutic environment free from drugs and alcohol\textsuperscript{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. There may be scope within local protocols to share assessment information.
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 therapy for 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
National Mental Health Dementia and Neurology Intelligence Network

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

Resources

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