



A Networking Distant Neighbours keynote paper on....

Dual Diagnosis: Collaboration and Good Practice for Services

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Dual Diagnosis: Collaboration and Good Practice for Services

A paper to promote discussion by Sean Murphy

'Supporting someone with a mental health illness and substance misuse problems - alcohol and/or drugs - is one of the biggest challenges facing frontline mental health services.'

These were the words with which Professor Louis Appleby, the National Director for Mental Health, began the foreword to the Department of Health's Dual Diagnosis Good Practice Guide.

Equally, a case might be made that the challenge is also one for frontline substance misuse services and particularly alcohol services. Moreover, it also has implications for the allocation and organisation of resources, implications that are often ignored due to lack of dual expertise between services or because of gaps in provision - and sometimes gaps in understanding. In this article I will be concentrating on alcohol misuse and mental health rather than the broader spectrum of substance misuse.

It is difficult to unravel the degree of overlap between people with mental health problems and those with substance misuse. Without doubt, though, the number of people with both is highly significant. UK data cited in the DoH guide give a clue to the scale of the problem by suggesting that substance misuse affects a third to a half of people with severe mental health problems. Within the subsection of those with dual diagnosis, alcohol is the 'most common form of substance misuse' and 'where drug misuse occurs it

often co-exists with alcohol misuse'. The degree of crossover between mental illness

'substance misuse affects a third to a half of people with severe mental health problems...'

and substance misuse is therefore considerable and an integrated care plan for dual diagnosis clients is possible only through the co-ordinated involvement of both treatment services.

Yet though the problem might be self evident, there has historically been reluctance at local and national level to provide an integrated strategic approach to dual diagnosis services. Even today, although there are models of real excellence in the field, the number of organised dual services that offer a holistic treatment plan to patients is minimal.

There are several reasons for the absence of unified treatments. One of the reasons is that alcohol services have evolved in isolation, both geographically and organisationally. Perhaps the lack of a codified government strategy and the collective denial of the scope and effect of

alcohol misuse in the UK have contributed to the absence of integrated treatments for clients. Clients with dual diagnosis were often bounced between services based on the state of inebriation upon contact with 'authorities'. Besides, if presenting with difficult or challenging behaviour, some clients were merely redirected to the alternate service - a case of convenient diagnosis. Some clients fell through the gaps of both mental health and alcohol services by presenting with problems beyond the scope of either service in isolation.

The lack of coordinated care has meant that some aspects of a client's cluster of problems have not been dealt with appropriately. Consequently, outcomes are negatively skewed as the issues not addressed in treatment can influence other elements in client behaviour. Clients who possess a cluster of interdependent problems may not improve if that cluster is not treated holistically because of an absence of clear-cut diagnostic criteria and treatment responsibility.

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It is this interconnected relationship between alcohol misuse and mental health that causes much of the confusion and debate around diagnosis and treatment. Some of the debate is around chicken and egg questions relating to the causal relationship between prolonged misuse and, say, anxiety or depression. Does one lead to the other or are they mutually exacerbating factors forming cycles of misuse and self-medication?

Furthermore, the DoH guide refers to 'severe mental health and problematic substance misuse', which may sound like a tidy definition, but what constitutes severe is perhaps open to discussion.

A diagnosis of schizophrenia sounds severe enough but the depressive who becomes suicidal is probably as much in need of specialised intervention as the more severe disorder. Clearly the relationship is a complex one.

A lack of consensus around diagnosis, and a particular focus on treating the primary problem first can lead to circular discussions that do not benefit the client or use resources optimally. Kingston CDAT Dual Diagnosis service formulated what they have called a Liaison model, which states boldly:

'Do not argue what is a primary problem – DD clients present with multiple needs. They require expert and high quality response from both services. Useful time is wasted by mental health and substance misuse teams debating what is the primary and what is the secondary problem. In a significant number of cases the chronology of the disorder is not absolutely clear.'

The DoH guide posits four broad 'mechanisms' for the relationship between mental health and substance misuse:

- A primary psychiatric illness precipitating or leading to substance misuse
- Substance misuse worsening or altering the course of psychiatric illness
- Intoxication and/or substance dependence leading to psychological symptoms
- Substance misuse and/or withdrawal leading to psychiatric symptoms or illness

The guide also says that services need to be clear at the outset, which individuals they intend to provide interventions for and allocate their resources and services accordingly. Clearly, not everyone embraced by the above definitions is suitable for - or wants - treatment. An individual drinking 20 units in one session per week and experiencing depression as part of his hangover matrix of symptoms is not a likely candidate. An individual with bi-polar disorder who drinks 20 units every day to even out emotional highs and lows, almost certainly is.

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The clinical implications of correct diagnosis followed by appropriate treatment will become increasingly more important in the future. If the National Treatment Agency 'takes on' national responsibility for alcohol services as is widely expected, then a more outcomes-focused commissioning agenda is to be expected. Given that substance misuse among individuals with psychiatric disorders has been associated with significantly poorer outcomes, a co-ordinated inter-agency approach is more necessary than ever if funding is to be secured. This inter-agency collaboration should include statutory and voluntary services along with the criminal justice system. It is hoped that the Crime and Disorder Reduction Partnerships (CDRP) will facilitate this collaboration but it is unlikely that more funds will be available at least in the short term.

Some of the complications of Dual Diagnosis that have repercussions for both clients and services are suggested below:

- Worsening psychiatric disorder
- Treatment resistance
- Poor medication adherence
- Violence
- Suicide
- Homelessness
- Negative impact on carers and family
- Criminal behaviour
- Possible rejection from either service

Mainstreaming

The policy framework currently emerging in the National Service Framework for Mental Health focuses on mainstreaming the care of people with severe mental health problems and substance misuse problems so that mental health services take the lead responsibility. This does not diminish the role of treatment agencies but it does make referral/treatment pathways much clearer as well as allocating defined responsibilities. It is envisaged that Local Implementation Teams (LITs) will work closely with Drug Action Teams (DATs) and, presumably, with CDRP's to monitor and commission for the most effective and rational dual diagnosis provision.

Another level of support is via training and education between services. Drug and Alcohol services can provide specialist training for mental health services and vice versa. This happens already in some areas. For example, The Lambeth Dual Diagnosis Project has given formal training to 115 nurses and Social workers around clients with substance misuse issues and there is apparently considerable demand for more. However, the current situation is sketchy in terms of provision. Some areas may have only a nurse consultant to liaise on DD issues and that may be only in an advisory capacity.

Three items of particular note in the National Service Framework for Mental Health are:

- **The importance of primary care in assessing the impact of substance misuse for those with mental health problems.** It is often at this stage that clients can be classified as having isolated problems rather than a network of interdependent ones. Anecdotal feedback suggests that many primary care clinicians are more familiar with medical models of mental health disturbance than the less clear definitions of alcohol misuse and may favour one service over another. Clinicians need to be aware of Community Mental Health Teams (CMHT) and local drug and alcohol services to ensure that clients do not slip between services. Generally, there must be significant liaison between specialist and generic services (e.g. homelessness organisations and prisons)
- **The Care Programme Approach (CPA)** should be applied to people with dual diagnosis whether in alcohol or drug or mental health services and this must start with a 'proper' care assessment and a full risk assessment
- **There will be a need for intensive outreach with this group and a commitment to long-term engagement.** Both severe mental health and substance misuse are chronic relapsing conditions and thus need an on going and phased approach. Teams must be able to work with various elements of client problems and have training and awareness around dual diagnosis issues.

Making a distinction between serial, parallel and integrative treatments the DoH DD Good Practice Guide recommends the latter as most pertinent and effective for Dual Diagnosis clients. The first, offering one treatment followed by another and the second offering both unconnectedly, fall short of providing a full coordinated care pathway for the client with multiple interdependent needs. A better approach is by both CMHTs working together via a dedicated liaison person, say, with substance misuse expertise and by agreed procedures of referral and assessment between agencies. Furthermore, a dedicated Dual diagnosis worker may work with care coordinators and support, train and educate CMHTs generally.

Some areas have Dual Diagnosis Teams that often have assertive outreach focus along with a more general consultancy and education remit. These include The Compass Programme, The Haringey Dual Diagnosis Service, The Kingston CDAT Dual Diagnosis Service and The Lambeth Dual Diagnosis Service among others. Not all areas will require a specialised team and it is advised to provide dual diagnosis services appropriate to the needs, severity and distribution of the client group in respective regions.

Whether by a team or lead clinician, there is clearly a need for comprehensive and structured training around dual diagnosis pitched according to needs and responsibility.

Conclusion

The publication of a Good Practice Guide for Dual Diagnosis within a Mental Health National Framework is an encouraging acknowledgement of the scale of the issue. It is reasonable to assert that no national strategy for alcohol can be deemed comprehensive if the dual diagnosis agenda is not realistically addressed.

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The guide recognises the need for cross agency working that incorporates statutory and voluntary sectors and the criminal justice system. However, in an under-resourced sector forging long-term structures for joint working is easier said than done. If extra work is required for liaison, administration and cross referrals then alcohol services will be hard pressed to contribute as much as other sectors and may be left out of the discussion loop.

There are other complicating factors as well. Dual diagnosis can lead people into contact with the law. If the government's crime agenda is emphasised over appropriate treatment strategy, then dual diagnosis clients may find themselves considered in terms of criminal potential rather than as a group with complex treatment needs.

Part of the problem is that both mental health and alcohol misuse are historical foci for prejudice and social stigma. Taken - and suffered - together they engender a double difficulty to services and to those responsible for developing and funding those services.

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Paradoxically, despite their respective high social profile, they are often overlooked and especially so when diagnostic distinctions are unclear. But it is essential that, as some measure of successful outcome becomes paramount for effective commissioning, strategists and funders re-examine their commitment to dual diagnosis investment.

About Networking Distant Neighbours

NDN's mission is to support your work with people affected by problem drinking by creating opportunities for you to:

- **Develop knowledge** - through events
- **Influence policy** - our National Forums give you a voice at national and regional level
- **Change** - your practice, your working environment and policy

The NDN team:

Sheryl Hobbs - Project Officer, Developing Effectiveness

Juliette Hough - NDN Team Assistant

Sean Murphy - Project Officer, Agency Practice

Bethany Williams - Project Officer, Regional Development

Contact us:



**Alcohol Concern, Waterbridge House, 32-36 Loman Street,
London SE1 0EE**



020 7928 7377



020 7928 4644



ndn@alcoholconcern.org.uk



www.alcoholconcern.org.uk

Alcohol Concern is the national agency on alcohol misuse. It works to reduce the level of alcohol misuse and to develop the range and quality of helping services available to problem drinkers and their families. Since beginning work in 1984, Alcohol Concern has built up expertise on a wide range of alcohol-related issues and uses this to influence and support health and social policies, nationally and locally. It is England's primary source of information and comment on a wide range of alcohol-related matters.