Spotlight on Dual Diagnosis

A Clinical Perspective

Have we made any progress?

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1. Epidemiology

Comorbidity of Substance Misuse and Mental Illness Collaborative (COSMIC) study

(Weaver et al 2002)

- Cross-sectional prevalence survey in four urban UK centres (Brent, Hammersmith & Fulham, Nottingham & Sheffield) (n=560).

- CMHT patients:
  - **44% reported past-year problem drug use and/or harmful alcohol use;**
- Drug services
  - **75% of drug service patients had a past-year psychiatric disorder;**
- Alcohol services
  - **85% of alcohol service patients had a past-year psychiatric disorder;**

- Most comorbidity patients appeared ineligible for cross-referral between services.

Dual Diagnosis in A Primary Care Group (PCG), (100,000 Population Locality)

Strathdee et al 2002

- Multi-staged sampling process to identify prevalence of positive screen for dual diagnosis in primary care sector of Brent (n=589):
  - Substance Misuse agencies: **83%**
  - Forensic Services: **56%**
  - Inpatient Mental Health Service: **43%**
  - Community Mental Health Service: **20%**
  - Primary Care: **8%**

- Dual diagnosis clients demonstrated significantly more complex and multi-axial needs:
  - personality disorder,
  - physical health problems,
  - risk / violence,
  - lower quality of life and
  - overall level of disability.

National Confidential Inquiry into Suicide and Safety in Mental Health (2019)

England, Wales & Scotland 2007-2017:

7818 (45%) suicides in patients with a history of alcohol misuse
5961 (34%) had a history of drug misuse
9533 (55%) had a history of either alcohol or drug misuse or both, an average of 867 deaths per year.

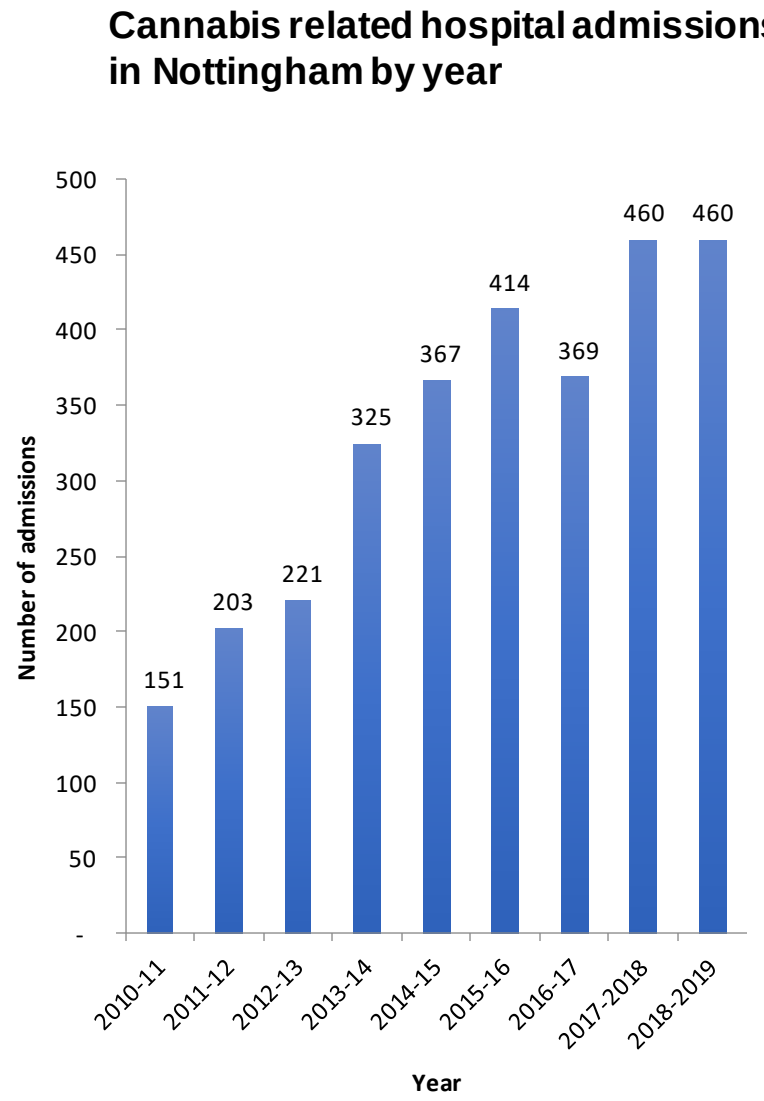
Figure 24: Patient suicide in England: number with a history of alcohol or drug misuse

Clinicians reported in that **availability of dual diagnosis services would have reduced the risk of suicide in 1,380 suicides** (9% of all deaths, 14% of all deaths with a history of alcohol or substance misuse)

Our local picture:

- 97/1007 (**9.6%**) of patients with diagnosis of F60.3 (EUPD) have lifetime history of black mamba or spice use*
- 662/1511 (**43.1%**) of patients with diagnosis of F20.—F29.0 had history of cannabis use*

Note hx of cannabis use associated with £10k in increased admission costs in first five year of psychosis (Patel et al 2016) & early cannabis use is associated with a year increased inpatient admissions in patients with schizophrenia over 35 years (Manrique-Garcia et al 2014)



*Thanks to Sally Morton & Christian Slade at Nottshealthcare Trust

2. Landscape

Coexisting severe mental illness and substance misuse: community health and social care services (NICE Guideline 58 2106)

- “The committee was aware of moderate evidence from 13 UK studies (2 high, 9 moderate and 2 low quality) that there were ***inconsistencies in the current configuration of 'dual diagnosis' services in NHS trusts across the UK. These inconsistencies lie in several areas, including sources of funding, structure of services, type of staff members, services delivered and coordination of care.*** The committee considered the evidence on configuration of services and observed there were few specialist services for adults.

- The committee agreed that the recommendations for specialist services (secondary care mental health services and 'dual diagnosis' services) need to ***focus on improving existing services using the expertise that is available instead of creating a specialist 'dual diagnosis' service. It felt that the standard care delivered in the UK could be improved by increasing the level of engagement people with severe mental illness and substance misuse have with existing services and that existing capacity and resources could be used to deliver this.*** “

Better care for people with co-occurring mental health and alcohol/drug use conditions
A guide for commissioners and service providers (Public Health England, 2017)

Two key principles:

- “1 ***Everyone’s job.*** Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.

- 2 ***No wrong door.*** Providers in alcohol and drug, mental health and other services have an open door policy for individuals with co-occurring conditions, and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point. “

“No wrong door”

- Resultantly widespread changes took place and the specialist dual diagnosis service set up in Nottingham (and other places across the UK) were decommissioned. This service provided support to around 350 people.

- It has been anecdotally noted that the guidance of ‘*no wrong door*' may have paradoxically led to increased barriers for these individuals who may have found themselves between services.

3. Where do we go from here?

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NICE 2019 Quality Indicators (QS188)

Statement 1 People aged 14 and over with suspected or confirmed severe mental illness are asked about their use of alcohol and drugs.

Statement 2 People aged 14 and over are not excluded from mental health services because of coexisting substance misuse or from substance misuse services because of coexisting severe mental illness.

Statement 3 People aged 14 and over with coexisting severe mental illness and substance misuse have a care coordinator working in mental health services when they are identified as needing treatment from secondary care mental health services.

Statement 4 People aged 14 and over with coexisting severe mental illness and substance misuse are followed up if they miss any appointment.

Where do we go from here?

What we are doing

-Transformation Project To Embed Mental Health and Substance Use workers into Community Mental Health Teams and vice versa. Case-holding and training function. Steering groups to clinically deliver manageable services

- Inpatient pilot funding to look at supporting individuals with substance. Piloted x 2 with winters pressures money. Recently been extended

- Set up a multi-professional Dual Diagnosis Clinical Network (consultant psychiatrists (addiction general adult, forensic), members of the dual diagnosis teams, service line managers, public health consultants, Director level representation from representation from Clinical Directors, researchers). Functions as an advisory group for Trust and other initiatives, discusses instances of good practice and helps build relationships between providers. Meets on a two monthly basis.

- Active involvement with Consultants in Public Health aiding in overseeing Trust Strategy in the area

Where do we go from here?

Ways forward

- Acceptance that dual diagnosis is part of mainstream work, not a specialist area.
- Creation of clear roles and agreed responsibilities across key service providers.
- Provision of cross training between local services to enhance multi-agency relationships and share expertise.
- Provision of training to meet the specific needs of groups of professionals e.g. mental health awareness for drug workers; drug awareness for mental health staff; issues concerning the management of intoxication and withdrawal for police; child protection issues for mental health staff.
- Creative use of limited resources to meet the needs of this client group. This may include joint working between agencies.
- Acceptance that clients have different levels of motivation and willingness by services to adapt approaches and treatment options as appropriate.

Bannerjee et al, 2002 **Co-existing Problems of Mental Health and Substance Misuse (dual diagnosis) An Information Manual.** Available from: http://www.dualdiagnosis.co.uk/uploads/documents/originals/PracManualRCpsych.pdf