

briefing

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Seeing double: meeting the challenge of dual diagnosis

Key points

- Dual diagnosis affects a third of mental health service users, half of substance misuse service users and 70 per cent of prisoners.
- There are some examples of excellent mainstreamed services in this area. However, at a national level provision is patchy and remains an area of concern.
- Service users with a dual diagnosis typically use NHS services more and cost more. Improving provision for users with dual diagnosis could save money.
- Providing effective care and treatment requires a high degree of effective collaborative working between agencies.
- Key recommendations include improving workforce development and training; promoting awareness of dual diagnosis in primary care and outreach services; utilising the care programme approach; and listening to service users.

Dual diagnosis is the term used to describe people who have concurrent mental health and substance misuse or alcohol problems. It affects a third of mental health service users,¹ half of substance misuse service users² and 70 per cent of prisoners.³

This *Briefing* identifies the key issues around dual diagnosis, explains existing policy and makes recommendations on what mental health providers and commissioners should be doing in this area.

Introduction

The nature of the relationship between mental health conditions and substance misuse or alcohol problems is complex, though 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.⁴

Historically, the provision of mental health and drug and alcohol services has evolved separately. This presents providers and commissioners with some challenges when it comes to providing appropriate and effective services for this group of people. While there are examples of innovative and joined-up services in this area, good practice needs to be spread widely across the NHS.

It is an area that, more recently, has begun to attract high-level interest and concern. In 2008, Louis Appleby, national clinical director for mental health, said: "The management of

'Research has shown that service users with a dual diagnosis typically use NHS services more and cost more'

people with dual diagnosis remains an area of concern and one of high priority for mental health policy and within clinical practice".⁵

Relevant trends

Alcohol misuse is often co-existent with common mental disorders, such as anxiety or depression, as well as with misuse of other substances. High levels of hazardous and dependent drinking have been recorded in people under treatment for serious mental health problems. Alcohol dependence is more common amongst particularly vulnerable groups, such as homeless people and the prison population.

In the general population 9.3 per cent of men and 3.6 per cent of women are classified as being dependent on alcohol. 3.4 per cent of adults showed signs of dependence on drugs in the past year, including 2.5 per cent who were dependent on cannabis and 0.9 per cent who were dependent on other drugs. Rates of dependence varied with age and gender. Of men aged between 16 and 24, 13.3 per cent showed signs of dependency on drugs.

Compared with 15 years ago, rates of drug dependency have almost doubled (from 2.2 per cent of the population in 1993 to 4.1 per cent in 2007). There has been a big rise in the number of young people dependent on cannabis, from 7.7 per cent in 2000 to 10.4 per cent in 2007.⁶

When we combine the knowledge of long-term trends on drug and alcohol misuse with what we know about

increasing prevalence of common mental disorders, such as anxiety and depression, we could infer that the numbers of people likely to have a dual diagnosis is also likely to be increased. The proportion of the English population meeting the criteria for one common mental disorder has increased from 15.5 per cent in 1993, to 17.6 per cent in 2007.⁶

Challenges for services

As has already been noted, service users presenting with a dual diagnosis are very common, representing a third of mental health service users,¹ half of substance misuse service users² and 70 per cent of prisoners.³

Research has shown that service users with a dual diagnosis typically use NHS services more and cost more. A study of services in South London found a greater proportion of the patients with dual diagnosis used the support of community psychiatric nurses, inpatient care and emergency clinics. Their analysis found that dual diagnosis patients had significantly higher 'core' psychiatric service costs (a difference of £1,362) and non-accommodation service costs (£1,360) than patients without a dual diagnosis.⁷ That is before we start to calculate the economic impact on other agencies, and the untold costs to service users and their families.

Service users with a dual diagnosis are more likely to be non-compliant and fail to respond to treatment than people with substance misuse issues or a mental illness. The Healthcare Commission and the Royal College of Psychiatrists, in their *National audit of violence*, identified drug and alcohol use as a major trigger for violence in mental health services.⁸

People with a dual diagnosis are also more likely to be homeless or be involved with the criminal justice system, which underlines the need for good collaborative working between the many key stakeholders in dual diagnosis. These include clients and their carers; NHS organisations; independent sector providers; social services; local implementation teams; addiction, drug and alcohol teams; prisons; housing authorities and providers, benefits officials; police; probation services; employment services and educational institutions.

Getting the right treatment for this group of service users is important. The challenges resulting from the complex nature of physical, social, psychological and other issues associated with dual diagnosis makes detection, assessment, treatment and the provision of good quality care challenging. Despite this, 40 per cent of local implementation teams do not have a local strategy or gather data on user satisfaction with services.⁹

Relevant policy and guidance for NHS organisations

Over the past ten years, a large number of key policy documents and guides to good practice have been developed on the issue of dual diagnosis. A summary of these is included in the online appendices to this *Briefing* (see Further information).

The National Service Framework of 1999 made a number of recommendations, including creating stronger links between drug and alcohol services with community mental health provision, plus developing more assertive outreach and crisis resolution services.

Following on from that, the 2002 *Dual diagnosis good practice guide* stressed the need for joint planning between mental health and substance misuse services and the need for local strategies to recognise the importance of substance misuse in mainstream mental healthcare, with provision of a lead clinician and training for staff. Responsibility for implementation of the guidance was given to local implementation teams. Specific guidance has also been issued related to particular settings, such as prisons and inpatient and day hospital facilities. Following the *Themed review* report of 2008, ten Strategic Health Authority (SHA) specific reports were produced highlighting local information compared with the national picture, with the aim of enabling SHAs to focus on further developing services locally.

Good commissioning is vital to making the sorts of improvements needed in this area. To that end, the National Mental Health Development Unit will be launching commissioning guidance later this year.

Key themes and messages

Within existing policy and good practice guides, there are a number of recurrent themes.

Workforce development and training

Mental health services have, historically, often evolved separately from drug and alcohol services.

Many staff, therefore, working in mental health services are not trained to assess and treat substance misuse, and vice versa in the case of drug and alcohol services.

'Of local implementation teams, 40 per cent do not have a local strategy or gather data on user satisfaction with services'

Workforce development to support delivery of effective services is key.⁸ The NHS Litigation Authority (NHSLA) has for some time recommended the development of staff training in substance misuse management in all mental health trusts. Effective management of service users with a dual diagnosis is one of the criteria for meeting clinical care standards within the NHSLA risk management framework for mental health and learning disability providers. Significant financial incentives exist in the system for providers to make improvements in the management of service users with dual diagnosis. NHS organisations that achieve level one in the relevant standards receive a 10 per cent discount on their Clinical Negligence Scheme for Trusts (CNST) and Risk Pooling Schemes for Trusts (RPST) contributions, with discounts of 20 and 30 per cent available to those passing the higher levels.¹⁰

The Department of Health recommend that specialist teams of dual diagnosis workers, where possible, provide support to mainstream mental health services; that staff in assertive outreach teams are trained and equipped to work with dual diagnosis; and that there are adequate numbers of suitably trained staff in crisis resolution, early intervention, community mental health teams and inpatient services. The assessment and management of drug and alcohol misuse should be considered to be core competences required by clinical staff in mental health services.

The 2008 *Themed review* on dual diagnosis recommended that workforce capabilities in this area be strengthened, using existing resources such as the dual diagnosis capability framework.

Effective joint working and commissioning

The second major theme of the literature available is that of strengthening the capacity for effective joint working and commissioning. Because of the complex nature of dual diagnosis, the stakeholders involved in delivering effective interventions are numerous. The National Service Framework for mental health stresses the importance of creating stronger links between drug and alcohol services and community mental health services. Integrated and co-ordinated services with cross-agency working is a key message from the guidance.

Other relevant recommendations include having clear, designated local responsibility for the strategic development of dual diagnosis services. All health and social care economies should have a lead commissioner for dual diagnosis issues. The role of primary care trusts (PCTs) and local authorities is also critical in terms of their responsibility for the joint strategic needs assessment (JSNA). The JSNA should be used to help raise dual diagnosis issues, with the resulting data contributing to the development of a clear local definition of the target population for services.

People with dual diagnosis problems should receive high-quality, patient-focused and integrated care within mental health services, though mainstreaming dual diagnosis can only work if local services develop and agree focused definitions of dual

'All mental health provider agencies should designate a lead clinician for dual diagnosis issues'

diagnosis; that local health and social care economies map services and need; that all mental health provider agencies designate a lead clinician for dual diagnosis issues; and that all health and social care economies designate a lead commissioner.⁹

Awareness in primary care and outreach services

A third message is that of raising awareness in primary care and outreach services. Trends in morbidity show that there are an increased number of people presenting with common mental disorders, such as mild to moderate levels of anxiety and depression, that are commonly seen within primary care settings, and who do not come into contact with specialist mental health services. The National Service Framework for mental health stresses the need for primary care clinicians to know how to access specialist services and consider the potential role of substance misuse when assessing individuals with mental health problems. We also know assertive outreach and crisis resolution services

are essential for helping people with dual diagnosis problems.

Dual diagnosis in prisons

Good practice for dual diagnosis patients is particularly crucial in the prison setting, and is likely to attract further focus. More help for people involved with the criminal justice system who have mental health problems and learning disabilities is the focus of *The Bradley Report*, published in April of this year. The review makes recommendations to Government, including the organisation of effective liaison and diversion arrangements and the services needed to support them.

It calls for the urgent development of improved services for prisoners who have a dual diagnosis, for all courts to have access to liaison and diversion services, and a Government investigation into how defendants with a dual diagnosis are currently served by all courts. The review also calls for better links between prisons and community mental health providers to support people leaving prison with mental health and dual diagnosis problems better.

The Government has said it recognises the need for reform, and

the new Health and Criminal Justice National Programme Board will consider the recommendations and develop a national delivery plan by October.

Implementation of the Care Programme Approach

The National Service Framework recommends that the Care Programme Approach should be applied to people with a dual diagnosis, whether they are located in mental health or drug and alcohol services. They should have a full risk assessment and an assessment of their physical health needs.

Meaningful service user and carer involvement

As noted earlier, the *Themed review* report of 2008 found that 40 per cent of local implementation teams did not gather data on user satisfaction with services. Collecting the views of users and carers, as part of needs assessment, strategy development and quality monitoring, is vital to understand satisfaction with services and where unmet needs lie.

For further information on the issues covered in this *Briefing* please contact Rebecca Cotton, Policy Manager, Mental Health Network, at rebecca.cotton@nhsconfed.org

Case study: Avon and Wiltshire Mental Health Partnership NHS Trust in partnership with the University of the West of England

A consultant nurse and senior lecturer post in co-existing mental health and substance misuse (dual diagnosis) has been established by Avon and Wiltshire Mental Health Partnership NHS Trust, in partnership with the University of the West of England. Since the appointment, pre-registration training on dual diagnosis has increased by around 900 per cent, and the programme is more structured, allowing students to adapt theory to practice by 'shadowing' a nurse consultant.

It has also helped to develop support for clinical work following training, for example, with clinical network meetings, local support/steering groups and one-to-one supervision. Having this post has also led to specific roles within teams and supported the training of dual diagnosis 'champions'. It has helped support more flexible understanding of service delivery, which identifies training needs.

Case study: Birmingham and Solihull Mental Health NHS Foundation Trust

The COMPASS (Combined Psychosis and Substance Use) Programme has been run by Birmingham and Solihull Mental Health NHS Foundation Trust since 1998. The COMPASS team supports people with a dual diagnosis problem and offers a consultation liaison service to people who are being supported by staff in either adult services or substance misuse services.

This is based on six sessions over a 12-week-period where the individual, their mental health/drug worker and a member of the COMPASS Programme team discuss the problems the person is facing. The aim is to help people access the services they need using an integrated, shared care approach. Most of the people referred to the team are seen in their own homes or local mental health centre. The team is a specialist multi-disciplinary team that trains and supports existing mental health and substance misuse services to provide integrated treatment.

A large part of the COMPASS Programme's work is in training and supporting staff within mental health settings, particularly assertive outreach teams, to deliver integrated treatment. To date, around 550 staff have been trained so far by COMPASS and 870 service users have been seen and helped. It helps staff to agree shared care agreements and protocols between mental health and substance misuse services.

Key questions for boards

For mental health service providers

- What is our staff training policy on dual diagnosis?
- Do we have a designated lead clinician for dual diagnosis?
- What links do our community mental health teams have with local prisons?

For commissioners

- Do we have a lead commissioner for dual diagnosis?
- Have our PCT and local authority addressed dual diagnosis as part of the joint strategic needs assessment?
- Are those people working in primary care locally aware of dual diagnosis and how to access appropriate services?

For all organisations

- Do we have an agreed definition of dual diagnosis with our partner agencies?
- Does our local implementation team have a strategy on dual diagnosis?
- Does our local implementation team systematically gather data on user satisfaction on services involved in dual diagnosis?
- Is the care programme approach being applied to service users across local mental health and drug and alcohol services?

Further information

For references and a comprehensive list of key policy and guidance documents, please see the appendices www.nhsconfed.org/publications

The Mental Health Network

The Mental Health Network was established as part of the NHS Confederation to provide a distinct voice for mental health and learning disability service providers. We aim to improve the system for the public, patients and staff by raising the profile of mental health issues and increasing the influence of mental health and disability providers.

For further details about the work of the Mental Health Network, please visit www.nhsconfed.org/mhn or email mentalhealthnetwork@nhsconfed.org

The Primary Care Trust Network

The PCT Network was established as part of the NHS Confederation to provide a distinct voice for PCTs. We aim to improve the system for the public, patients and staff by raising the profile of the issues affecting PCTs and strengthening the influence of PCT members.

For further details about the work of the Primary Care Trust Network, please visit www.nhsconfed.org/pcts or email primarycaretrust@nhsconfed.org

The National Mental Health Development Unit

The National Mental Health Development Unit (NMH DU) is the agency charged with supporting the implementation of mental health policy in England by the Department of Health in collaboration with the NHS, Local Authorities and other major stakeholders.

The Unit was launched in April of this year, and is made up of a number of programmes including the National Dual Diagnosis Programme. The Dual Diagnosis Programme leads are Ann Gorry (ann.gorry@nmhdu.org.uk) and Tom Dodd (tom.dodd@nmhdu.org.uk). More information is available at www.nmhdu.org.uk

Further copies or alternative formats can be requested from:

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