

Mental Health & Alcohol Misuse Project

Briefing: Dual Diagnosis and Alcohol

This briefing outlines recent developments in dual diagnosis policy and practice. It provides information on the Dual Diagnosis Good Practice Guide ('the Guide'), published by the Department of Health in April 2002. Alcohol Concern was involved in the development of the Guide, as a member of the Dual Diagnosis Steering Group. This paper summarises the salient points of the Guide and its implications for alcohol agencies, mental health services and local health planning authorities. The paper provides tips for including alcohol misuse in local service plans developed in response to the Guide, and features an insert of useful materials for dual diagnosis service planning, courtesy of Kingston CDAT. This document also contains information on the new manual, Co-existing Problems of Mental Health Disorder and Substance Misuse (dual diagnosis). Alcohol Concern consulted on this manual, produced by the Royal College of Psychiatrists' Research Unit.

Summary: The Dual Diagnosis Good Practice Guide at a glance

- Alcohol misuse can precipitate and lead to mental health problems (and vice versa).
- The Dual Diagnosis Good Practice Guide ('the Guide') focuses on clients with co-existent *severe mental illness* and problematic substance misuse (including alcohol).
- The Guide recognises alcohol as the most commonly misused substance.
- Local Implementation Teams (LITs) should implement the policy requirements outlined in the Guide, in partnership with Drug Action Teams.
- Project teams (reporting to LITs) should be established to deliver local service plans on dual diagnosis.
- Mental health services should take the lead in the treatment of dual diagnosis patients with severe mental illness.
- Treatment will be "mainstreamed" in mental health, with clear treatment pathways across mental health and drug and alcohol agencies.
- Drug and alcohol services should provide specialist support, consultancy and training to mental health services.
- Mental health services should offer similar support to drug and alcohol agencies to help them treat people with less severe mental illness.
- This briefing suggests means of including alcohol misuse in dual diagnosis local service plans.
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The Mental Health & Alcohol Misuse Project (MHAMP) provides fact sheets, a newsletter and web pages aimed at sharing good practice between clinicians and professionals working in the mental health and alcohol fields. MHAMP promotes the inclusion of alcohol in strategies developed for the Mental Health National Service Framework, and updates the mental health and alcohol fields on current mental health and alcohol-related issues.

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Defining Dual Diagnosis

The term 'dual diagnosis' is subject to considerable debate, partly because of the differing complex needs of people with multiple diagnoses and health problems. Indeed, a variety of other terms have been used to describe dual diagnosis, including medically ill chemical abuser, chemically addicted mentally ill, co-morbidity (of substance misuse and mental disorder), co-occurring addictive and mental disorder, and co-existing problems of mental health and substance misuse (Prunty 2002).

At present, 'dual diagnosis' is the most commonly used term in clinical practice to describe clients who have "...co-existing problems of mental disorder and substance misuse (which includes both drugs and alcohol)" (Banerjee et al. 2002). This definition broadly encompasses the needs and problems of the client group.

Why is Dual Diagnosis Important?

People with concomitant mental illness and substance misuse problems are among the most vulnerable in the community. When compared with a mental health problem alone, people with dual diagnosis are more likely to have:

- Increased suicide risk
- More severe mental health problems
- Homelessness and unstable housing
- Increased risk of being violent
- Increased risk of victimisation
- More contact with the criminal justice system
- Family problems
- History of childhood abuse (sexual/physical)
- More likely to fall through the net of care
- Less likely to be compliant with medication and other treatment (Banerjee et al. 2002).

The presentation of people with dual diagnosis has become standard in mental health, social care and drug and alcohol services. Thus, clinicians need to be equipped to identify, assess and treat those with dual diagnosis (Banerjee et al. 2002).

Alcohol Misuse and Dual Diagnosis

Alcohol misuse is frequently a significant factor contributing to dual diagnosis, as evidenced by the following examples:

- In the UK, it is estimated that one-third of psychiatric patients with serious mental illness have a substance misuse problem
- In drug *and alcohol* services half of clients also have some form of mental health problem (mostly depression or personality disorder)
- There are consistent reports of increasing prevalence of dual diagnosis by forensic mental health services and inpatient psychiatric units
- Long term alcohol misuse is associated with conditions such as Korsakoff's syndrome, delirium and seizures (Department of Health 2002)
- A study by Regier et al. (1990) found that 37% of those with an alcohol disorder had another mental disorder
- People with alcohol problems are themselves concerned about their mental health. The National Census of UK alcohol treatment agencies in 1996 found that the *main* presenting problem at alcohol services was clients' worry about psychological well-being (47%) (Luce et al. 2000).

Dual Diagnosis Policy

Dual diagnosis features prominently in the Government's mental health strategy, the **Mental Health National Service Framework (MHNSF)**. The MHNSF clearly states that the primary responsibility for the treatment of severe mental illness (such as personality disorder and *dual diagnosis*) lies with mental health trusts and specialist services (Standards 4 and 5) (Department of Health 1999).

Launched in April 2002, the **Dual Diagnosis Good Practice Guide** ('the Guide') summarises policy and good practice in the provision of mental health services to people with dual diagnosis. The Guide is a landmark document because it brings together substance misuse *and* mental health policy.

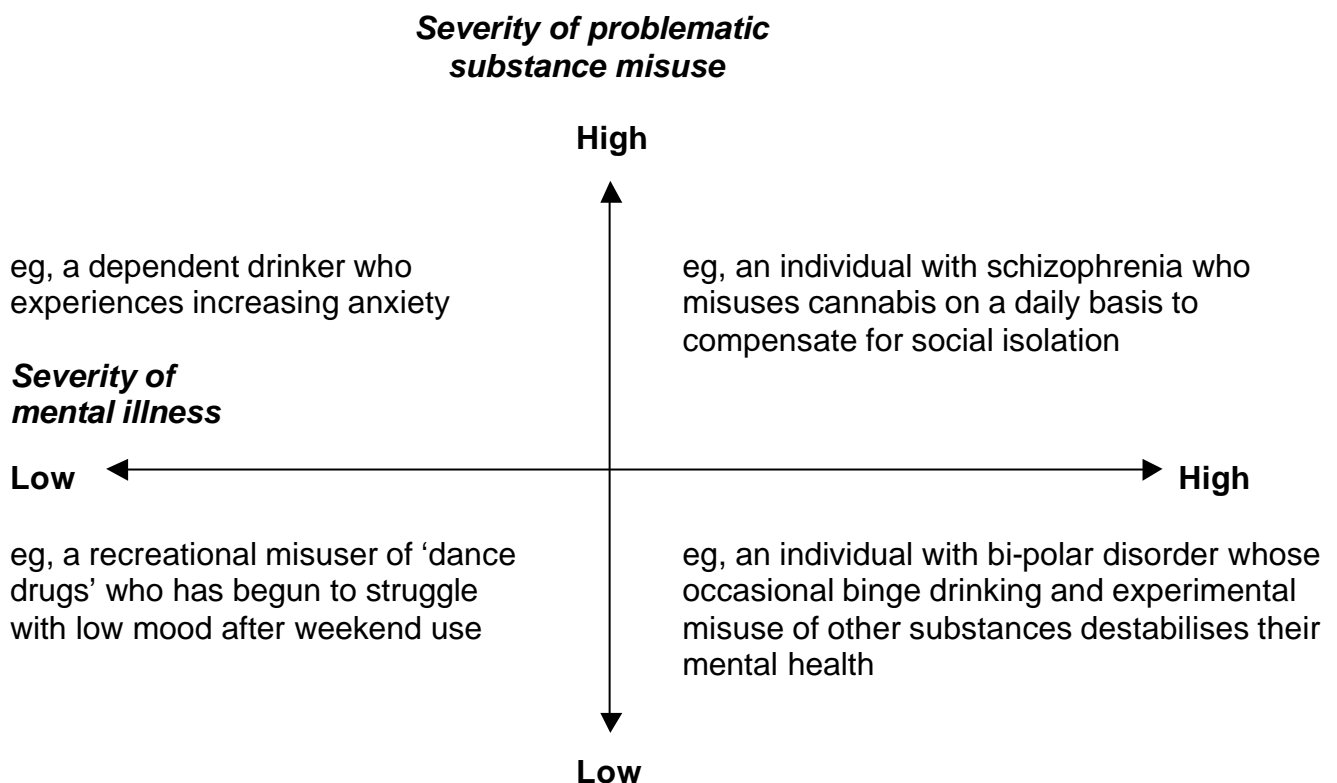
The Guide supports the implementation of Standards 4 and 5 of the MHNSF, and recognises the value of integrated and streamlined care for people with dual diagnosis (Department of Health 2002).

The Dual Diagnosis Good Practice Guide

The Scope of the Guide

The Guide outlines the scope of co-existent psychiatric and substance misuse disorders, demonstrated by the figure below. Each quadrant in the figure is illustrated with an example. The Guide focuses on people with concomitant severe problematic substance misuse *and* severe mental illness (top right quadrant), but also partly covers those people who fall in the bottom right quadrant.

The scope of co-existent psychiatric and substance misuse disorders



(Department of Health 2002: 8).

Where alcohol fits in the Guide

As with other strategies of the MHNSF, it is noteworthy that substance misuse in the Guide does not refer solely to illicit substances, but covers alcohol as well, recognising that:

- Alcohol misuse is the most common form of substance misuse.
- Alcohol is a (misused) substance in the same manner as illicit substances.
- Where drug misuse occurs it often co-exists with alcohol misuse.

The Guide stresses the importance of alcohol misuse in dual diagnosis planning strategies. The Guide states that drug *and alcohol* services should be represented on Local Implementation Teams (LITs) in order to provide comprehensive services for people with a dual diagnosis (Department of Health 2002).

The Dual Diagnosis Guide in practice

The Guide indicates that *mental health services* are primarily responsible for providing care to people with substance misuse and severe mental illness. “Mainstreaming” treatment in mental health services aims to avoid the problem of clients being shifted between services and falling through the net of care.

This will not, however, mean a reduction in the role of drug and alcohol services. Clear pathways of joint working and treatment will be developed in dual diagnosis strategic planning, and, as a result:

- Drug and alcohol agencies will provide specialist support, consultancy, and training to mental health services to support “mainstreaming” of clients with severe mental health problems (top right quadrant)
- Mental health services will offer similar support to drug and alcohol agencies to help them effectively treat people with *less severe* mental health problems (top left quadrant).

Local Implementation Teams (LITs) are responsible for implementing policy requirements described in the Guide, working in partnership with Drug Action Teams (DATs).

Data collection and needs assessment

Agencies are not required to carry out extensive work to establish local dual diagnosis prevalence. Local services should instead proceed with implementing the Guide on the basis of *perceived need*, and agree improved data collection methods with partner organisations for future needs assessment. DATs and LITs are valuable resources for these purposes, as are the views of staff, clients and carers. Substance misuse services can provide information on substance misuse trends in the local community.

Developing local service plans and commissioning

All health and social care economies must set up a project team to lead work on implementing the Guide. The project team should contain a lead commissioner, provider manager, clinical representative from mental health services and drug and alcohol services (one of whom is a lead clinician), and representatives from the LIT and the DAT. The project team reports to the LIT and is responsible for delivering the local service plan, which must be based on the needs assessment.

The project team is responsible for designating a lead commissioner, who can be located within a Primary Care Trust (PCT), Strategic Health Authority (SHA) or Social Services Authority. The key role of the lead commissioner is to use the local plan as a basis for joint commissioning across the SHA/PCTs and DAT.

The project team must produce and agree on a local focused definition of dual diagnosis, care pathways and other required protocols/agreements. The team should also devise a training strategy. Training should be available *to all staff* who routinely come into contact with people with a dual diagnosis.

Including Alcohol Misuse in Dual Diagnosis Local Service Plans

- Keep in mind that illicit substances are not the only misused substances. Alcohol is the most commonly misused substance
- Ensure that both statutory and non-statutory (voluntary) alcohol services are contacted when conducting local needs assessment
- Include a representative from your local alcohol service in your dual diagnosis project team
- Include alcohol misuse training (assessment and treatment) in your training strategies
- Identify local experts to help deliver and plan alcohol misuse training.

Improving Treatment of Dual Diagnosis

The Guide provides information on steps that can be taken to help improve services for dual diagnosis clients. The relevant sections concern assessment and treatment approaches and service models.

Assessment Process

Given the high prevalence of substance misuse among people with mental health problems, mental health services must assess for the presence of substance misuse in clients. The assessment process covers:

- Detection and screening: The role of substance misuse, conducted through self-report methods, laboratory tests and collateral data sources
- Specialised assessment: Comprehensive assessments to determine the degree of substance misuse and mental health problems and corresponding need
- Risk assessment: Assessment protocols to address specific risk factors relevant for individuals with a dual diagnosis.

Treatment Approaches

Staff should maintain a realistic and longitudinal view in approaching treatment of dual diagnosis clients as they enter different stages of the treatment process. American researchers have described the following stages of treatment:

- Engagement: The development and maintenance of a therapeutic alliance between staff and client
- Motivation: Motivational interviewing and discussion strengthens a client's motivation and commitment to change
- Active treatment: Anticipated goals are agreed with the client, and followed with integrated treatment of the client's mental health problems and substance misuse
- Relapse prevention: Once a client has reduced his/her substance misuse or become abstinent, interventions should be offered aimed at the prevention and management of future relapses to problematic substance misuse or mental health problems.

Service models

The Guide describes three types of service model for treating dual diagnosis:

- Serial: The treatment of one condition before commencing treatment for another condition
- Parallel: Concurrent but separate treatment of more than one condition)
- Integrated: Concurrent provision of psychiatric and substance misuse interventions, but requiring the same staff member (or clinical team), working in one setting, to provide relevant interventions in a coordinated manner.

The integrated model tends to produce better health outcomes over the other models. Integrated treatment in the UK can be delivered by existing mental health services following training and with close liaison and support from substance misuse services.

The Guide suggests the following means of achieving more integrated care:

- Closer links between substance misuse and psychiatric services (eg, nominating a liaison substance misuse specialist for each team and formulating agreed care pathways)
- Training and supervision
- Expanding mental health teams with a specialist dual diagnosis worker.

To support service change it is essential for each service provider to identify a lead clinician with specialist dual diagnosis knowledge, who can provide advice to the project team that implements this guidance (Department of Health 2002).

Example of Good Practice: Kingston CDAT Dual Diagnosis Service

The Dual Diagnosis Good Practice Guide cites the Kingston Community Drug and Alcohol Team as an example of good practice in the treatment of dual diagnosis. Kingston CDAT launched their dual diagnosis model of joint working with mental health services in 1998.

Aims: The model aims to provide a set of interventions for people with dual diagnosis, with mental health and substance misuse services working concurrently and cooperatively in a flexible but coordinated way.

The model: Each CMHT, rehabilitation service and assertive outreach team has identified a CDAT link clinician. The main tasks of the link person are:

- To respond to all requests for joint assessments and referrals of dual diagnosis clients, either in the community or hospital. The link person is usually the first point of client contact/referral, and offers a rapid response to the request for a joint assessment from mental health services.
- To attend allocations meetings, identify cases requiring joint assessment, advise mental health services on treatment strategies, feedback on jointly worked cases and discuss CDAT cases requiring CMHT intervention or resources
- To attend other relevant meetings such as CPA reviews.

Intervention philosophy: Kingston CDAT operates a proactive outreach model, encompassing four stages:

- Assessment, including risk assessment
- Education
- Harm reduction
- Abstinence and relapse prevention.

Kingston CDAT delivers five days comprehensive training for their colleagues in Mental Health Services, including staff from CMHTs, day care and residential rehabilitation services, and inpatient/acute admission wards. Over 50 clinicians have benefited from this training programme thus far, which is offered four times a year by Kingston CDAT staff.

Included with this briefing is a full description of the Kingston CDAT Dual Diagnosis Service model. Please note that this model and its definition of dual diagnosis was developed in a local context, but may provide useful ideas for service planning in your area.

For **further information** on Kingston CDAT, contact Mandeep Navak, Dual Diagnosis Development Worker (tel. 020 8549 9279).

'Co-existing Problems of Mental Disorder and Substance Misuse (dual diagnosis)'

Commissioned by the Department of Health, this information manual was produced by the Royal College of Psychiatrists' Research Unit and coincides with the release of the Guide. The manual was produced in response to the lack of UK publications providing hands-on information to practitioners in the dual diagnosis field. The manual offers readers an opportunity to consider their practice in relation to the assessment and care of people with dual diagnosis (Banerjee et al. 2002).

While the manual is not a systematic review or clinical guide, it includes case examples, questions and suggestions which will help the reader's critical assessment of the issues and ideas presented.

The manual contains a number of practical sections, including:

- Conceptual and theoretical issues
- Practice and policy issues
- Ethical issues and the mental health act
- Assessment
- Interventions
- Organisational issues
- Information sources
- Basic drug and mental health awareness
- Training materials (Banerjee et al. 2002).

Resources

Copies of Co-existing Problems of Mental Disorder and Substance Misuse (dual diagnosis) can be ordered **free of charge** from Emma George, Events Marketing Coordinator at the Royal College of Psychiatrists' Research Unit, by email on emma1george@virgin.net or telephone 020 7227 0825.

The Dual Diagnosis Good Practice Guide can be downloaded from the Internet: (www.doh.gov.uk/mentalhealth/dualdiagnosis.htm). Copies of the Guide can also be obtained by contacting Department of Health Publications on 08701 555455, and quoting 27767.

See the Alcohol Concern website for information on local alcohol services: (www.alcoholconcern.org.uk)

References

Banerjee et al. (2002) *Co-existing problems of mental disorder and substance misuse (dual diagnosis)*. Royal College of Psychiatrists' Research Unit.

Department of Health (1999) *A national service framework for mental health*. (www.doh.gov.uk/nsf/mhnsf2a.htm)

Department of Health (2002) *Mental health policy implementation guide: dual diagnosis good practice guide* (www.doh.gov.uk/mentalhealth/dualdiagnosis.htm)

Luce et al. (2000) 'National census of UK alcohol treatment agencies : 1. Characteristics of clients, treatment and treatment providers', *Journal of Substance Use* 5: 112-121.

Prunty (2002) *Introduction: what is dual diagnosis or psychiatric comorbidity – the current policy context*. (Presented at Dual Diagnosis: Translating New British Research into Effective Practice, Keele University, 14-15 May 2002).

Regier et al. (1990) 'Comorbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiologic Catchment Area (ECA) study', *Journal of the American Medical Association* 264 (19): 2511-2518.

Request for Good Practice

Alcohol Concern is interested in examples of good practice in the mental health and alcohol-related fields to disseminate to other agencies. If your organisation has developed examples of good practice in planning, training, protocols, care pathways or other areas, please contact Slade Carter (tel. 020 7922 8657) or email scarter@alcoholconcern.org.uk

Further help from Alcohol Concern

Consultancy@alcoholconcern is carrying out two studies with Local Implementation Teams to identify shortfalls and development needs of the services for people with dual diagnosis. The studies will review all existing procedures and resources for dual diagnosis and will provide the commissioners with a treatment model based on the DoH guidance.

If you want to find out more about these studies and the consultancy service contact Enise Aymer, tel. 020 7922 8659, email: eaymer@alcoholconcern.org.uk