

# LOCAL RESPONSES TO DUAL DIAGNOSIS IN ENGLAND AND SCOTLAND

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## The English Context

Dual diagnosis or the coexistence of severe mental illness and substance misuse has emerged against a background of major change in the Health Service. Over the past decade hospital based psychiatric care has shifted towards community orientated services and hospital beds have fallen significantly. Caring for large numbers of patients outside the community setting has brought new challenges. No longer can the focus remain exclusively on a single diagnosis with its defined psychiatric intervention. Complex social, economic and other needs must be addressed to enable patients to live outside hospitals. Multidisciplinary community mental health teams emerged to coordinate the range of skills and interventions to meet patient's needs. However poor planning, staff reluctance in some instances to change working practices and a failure to invest resources from the hospital closures lead to uneven community services across the country. Occasional high profile violent incidents by patients lead to considerable political embarrassment and the decision by the Department of Health to impose a top down approach.

The Care Programme Approach recommended a multidisciplinary model of working where each patient had a designated individual from the community team to coordinate the various interventions and maintain contact with the patient over time. Regular team review meetings were to be held and the whole process was underpinned by a bureaucracy of paperwork to enable external monitoring. While many professionals undoubtedly needed to change their clinical practice it remains to be seen whether this in reality is being achieved through local clinical leadership rather than the plethora of documentation which characterises the National Health Service in England.

During the 1990's a rising level of substance misuse occurred. In 1995 the estimated level of alcohol dependence in the general population was 47 per 1000, drug dependence 22 per 1000 and psychosis 4 per 1000 (Farrel M, Howes S, Taylor C et al 98). Substance abuse was common among psychiatric patients partly because it helped reduce social barriers between the marginalized mentally ill and health peers. Other explanations included self medication of symptoms and side effects of medication. Studies showed that 1 in 3 patients with severe mental illness had a substance misuse disorder. Epidemiological studies from London and it's surroundings ranged from 33 - 37% (Menezes 96, Wright 2000) and an unpublished retrospective case note study by Baldacchino (2000) in Colchester, a rural town near Cambridge, identified 30 - 35 % were dual diagnosis cases. The traditional view that drug abuse justified minimal psychiatric intervention was no longer tenable.

Nevertheless services had difficulty meeting this new challenge. Many in the community mental health teams lacked the knowledge and skills needed to respond to substance misuse while addiction services were often poorly resourced, lacking psychiatrist and isolated from mental health services. In the community patients had the freedom to choose to use drugs despite it's harmful effects. Community mental health teams responsible for these patient's health felt frustrated and powerless. Addiction services, although used to these dilemmas, did expect

patients to show enough motivation to engage in a programme of treatment. Furthermore substance misuse agencies were under political pressure to focus on those with personality disorders and divert offenders from the criminal justice system. Not surprising demarcation disputes arose between services with some patients failing to receive any help. Although dedicated dual diagnosis teams were developed most areas attempted to draw existing core services together into a coordinated working relationship.

#### Cambridge - a local response

In the early 1990's four community mental health teams were established to serve Cambridge and the surrounding rural areas. They were multidisciplinary teams of mental health professionals with social workers attached to the team. They adopted the Care Programme Approach for the severely mentally ill. Simultaneously the Addiction Service integrated its separate alcohol and drug treatment wings to meet the rising needs of younger patients presenting with polydrug problems.

As in the rest of England dual diagnosis patients presented a major challenge. However in Cambridge there were mitigating factors that contributed to a coordinated approach between services. Although the Addiction Service was managed in a separate Health Trust the psychiatrists worked across both organizations. Rising house prices during the 1990's and difficulty recruiting nurses to Cambridge lead to the appointment of more staff from the local psychiatric service who were then trained in the addiction field. These personal links helped to foster a common understanding of the roles of the respective services and modify working practices. A training group within the substance misuse service also provided training to hospital and community staff within the psychiatric services.

The community mental health teams developed at an uneven pace reflecting the attitudes of local clinical leadership and investment. The most developed team appointed a dual diagnosis outreach nurse with a restricted caseload. This produced an interesting conflation of approaches. The outreach nurse assumed considerable responsibility for her patients, conveying them to appointments and managing their food and finances, while the substance misuse workers emphasised personal responsibility and choice in the use of drugs and alcohol. Patients nevertheless responded to this varied approach. The non statutory (voluntary) sector in Cambridge have also played a major role by providing services outside working hours such as day centres, befriending schemes and practical support.

The model that has thus far emerged in Cambridge has achieved a degree of success. However the community mental health teams need to be more fully developed. An audit of severely mentally ill patients discharged from hospital found that one in five were lost to follow up in the next six months even though all had previous hospital admissions. The National Service Framework for Adult Mental Health (2000) produced by the Department of Health now requires the creation of assertive community teams working extended hours within the statutory psychiatric services. Dual diagnosis patients are cases with multiple needs including the use of drugs or alcohol that range widely in severity. For treatment to be effective the community mental health teams must take a leading role in assertively supporting patients over the long term and coordinating appropriate input from other agencies, including the substance misuse services.

#### The Scottish Context

The subgroup of people with severe enduring mental illness and substance misuse is well known to have an extremely high service utilisation with frequent contacts with the criminal justice system and other social services departments (eg child protection cases, housing and benefit agencies). The majority find it exceedingly difficult to engage and comply with treatment. In a survey of patients resident in psychiatric intensive care units in Scotland there was evidence that

young people with co-morbid conditions were over represented (Mitchell 92). Other negative outcomes related to mental illness and substance abuse include successive relapses into both or either condition, demoralisation, disengagement from the services, non-compliance with treatment, repeated hospitalisation, suicide, violent behaviour, imprisonment, homelessness, medical illness including HIV/AIDS and early mortality.

As a result of the poor prognostic features mentioned above people with comorbidity tend to fall through gaps in services. They experience the 'revolving door syndrome' or 'ping pong' effect where neither drug services nor mental health services want to take responsibility for such difficult clientele. There is also a significant difference in philosophies between drug and mental health services (Brown 89). Drug services primarily treat those willing to be helped whereas mental health services try to treat everyone with a mental health disorder.

Within Scotland the above still holds since services are resourced by people who participated in a UK integrated national training structure which of course effects the political and organisational philosophies within the health and social service providers. The legal framework in Scotland provides a different interpretation of the law. This also includes the provision of a Mental Health Act for Scotland (1984) which is based upon a written constitution. These differences tend to help identify people who are falling between the current service provisions. The formation of the Scottish Parliament and associated structures (eg Scottish Intercollegiate Guidelines Network (SIGN), Health Technology Board (Scotland) and Clinical Standards Board (Scotland)) encourages the 'tartanisation' of tried and tested initiatives in the rest of the UK or elsewhere in Europe. The emerging boundaries between Scotland and the rest of the United Kingdom has also encouraged new initiatives.

#### Fife - A Local Response

For those of us working with co-morbid patients, it is necessary to find different ways of assessing their needs, engaging them and their carers and achieving a better co-ordinated service delivery (Mitchell 92). A joined-up approach involving diverse agendas was deemed a core component to ensure a rounded response to local Fife needs in patients with co-morbid conditions.

The Fife Intensive Outreach Team is a specialised resource who work with people who have co-morbid conditions. Funding was originally obtained through Mental Illness Specific Grants (MISG) to set up a Care Management Project following concerns made in 1991 by the Mental Welfare Commission in Scotland. The original remit was to focus on an intensive care management approach to people with longstanding mental health problems and was based in Stratheden Hospital, Cupar, Fife. The main goals were to

- (1) Maximise engagement with the clients
- (2) Maximise liaison and co-ordination between existing services
- (3) Develop new service provisions for the clients
- (4) Assisting carers and their families

The Six Principles Of Practice include:-

- (1) Focus on individual strengths rather than pathology

- (2) The case manager/user relationship is primary and essential
- (3) Interventions are based on the principle of user self-determination
- (4) Assertive outreach is the preferred mode of intervention
- (5) People with long-term and severe mental health problems can continue to learn, grow and change and can be assisted to do so
- (6) Resource acquisition goes beyond traditional mental health services and actively mobilizes resources for the entire community. Community is defined as a resource not an obstacle (Rapp & Wintersteen 1989)

The core team in 1992 consisted of a social work team leader, a part-time clinical psychologist and consultant psychiatrist with a seconded psychiatric nurse. Their role was primarily co-ordination and consultation with a limited case load.

The Intensive Care Management Project was reorganised in 1995 to become the Fife Intensive Outreach Team. The core team was still multidisciplinary and in 2001, it is still managed by the social work department and incorporates a senior psychiatric nurse, two social care workers from the housing department, two social workers and a part-time (non-contracted) consultant psychiatrist.

The current services offers:

- (1) A full assessment of need
- (2) Assertive outreach
- (3) Service users and family/carer support
- (4) Collaborative working within a multi-agency network (working with, and referral onto, other agencies as appropriate)
- (5) Risk assessment and risk management
- (6) Education and awareness of mental health and substance misuse issues to service users, family/carers and other interested parties

The characteristics of the patient population has changed from people with severe mental health problems who are poorly integrated into the community to a more focused population with multiple diagnoses that are resistant to treatment. They are often homeless, lead chaotic lifestyles with repeated minor criminal offences and intravenous polydrug dependencies .

The team carries an active case load of 60 clients and provides support to all sectorised mental health teams in Fife (catchment population of 300,000).This team is a recognised model of good practice in Scotland and future development include more effective ways to identify service-users, improvements in data collection and evaluation, targeting the homeless population ,training and better integration between social work and mental health directorates.

Conclusion

Models for delivering care to patient population with co-morbidity are:

- (1) A specialist team within existing mental health and substance misuse service frameworks. The team to be responsible for some clients and to train and advise other workers.
- (2) A specialist worker within existing mental health and substance misuse service frameworks. This person to work jointly on the most difficult cases and to train and advise other workers.
- (3) Community Mental Health Teams to be responsible for this client group, with link worker from substance misuse service to support/advise.
- (4) Community Mental Health Teams to be responsible for this client group. CMHT workers to have skills in both areas.
- (5) Addiction Teams to be responsible for this client group, with link worker from mental health service to support/advise.
- (6) Both substance misuse and mental health services working in a co-ordinated way with shared responsibility
- (7) A dedicated specialist service providing all mental health and substance misuse inputs to the entire client group

We have described two different models operating in Cambridge and Fife. Both recognize that these clients have complex needs and services must be tailored to the individual rather than a single problem or diagnosis. Whichever model of care is chosen should represent the best solution within the context of the local range of available services.

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