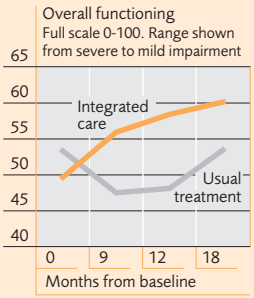
11.3 Dual diagnosis add-on to mental health services improves outcomes and may save money

Findings A unique British study has found that treatment-resistant schizophrenic patients benefit from additional integrated substance use/mental health therapy, which may also save costs by reducing the need for inpatient care.

The study recruited 36 patients from NHS mental health units. All were in treatment for chronic schizophrenia and diagnosed as abusing alcohol and/or other drugs. Each was in close contact with a parent or other 'carer' also prepared to enter the study. Patient/carer pairs were randomly assigned to normal psychiatric care or additionally to a nine-month programme of 29 individual patient-therapist sessions plus up to 16 family sessions. The individual sessions adopted a motivational interviewing style aiming at first to assess and enhance motivation to change substance use, then to help patients deal with their mental health problems through cognitive-behavioural techniques. Family sessions concentrated on promoting interactions consistent with the individual therapy. Two reports cover the period up to 12 months ❶ and 18 months ❷ after the intervention started.



During treatment and over the following nine months, control subjects tended to deteriorate but intervention subjects showed statistically significant improvements in their overall level of psychological, social, and occupational functioning (the main goal) and psychiatric symptoms. Throughout there was a substantial anti-relapse effect. Over the 18 months of the trial, three-quarters of control patients required altogether 24 episodes of intensified care (including admission to hospital), compared among intervention patients to just over a third and 11 episodes. This result was that the intervention reduced overall health and social care costs. Though the exact financial balance was uncertain, there was a high probability that the intervention would 'buy' improved patient functioning at little or no extra cost to the health service. Among other outcomes there was a consistent reduction in days of substance use amounting to a 20% fall for intervention subjects but none for the controls.

In context Reversing the deterioration of these seriously mentally ill patients was a substantial achievement consistent with the belief that their substance use was aggravating their mental illness or impeding its treatment. Effects outlasted the intervention by at least nine months with no sign of tailing off, suggesting that the benefits to patients and the savings to the health service will accumulate. The emotional and practical burden imposed on carers and the severity of their own psychosocial needs also tended to improve, potentially both a response and a further contribution to the patient's improvement.

The study is best seen as a small-scale pilot requiring confirmation, albeit one rigorously controlled and thoroughly analysed. Due to the small number of subjects and the high variability of outcomes, effects were often large but not statistically significant. Typically patients were fairly young white men cared for by their mothers. It remains an open question whether the intervention (or adaptations of it) would benefit women or minority cultural groups, patients without close contact with a carer, or even patients like those in the study but less prepared (or their carers are) to engage in extra treatment – 30 such pairs refused to enter the study. Also, how severe the patients' substance misuse problems were (they used mainly alcohol and cannabis and were not necessarily dependent) is unclear.

Though the extra intervention was an integrated 'dual diagnosis' programme, the whole service was not, consisting of the added elements plus a parallel track of usual care which also included family support. Conceivably a fully integrated approach might have worked even better, but it would have been be harder to implement. Simply adding extra elements (especially when these are conducted in the patient's home) to normal care does not require extensive restructuring of services or resource re-allocation.

Practice implications The approach tested in the study is compatible with those recommended nationally (◤ *Additional reading*) and incorporates elements (flexibility in response to readiness to change, avoidance of confrontation, stepped but integrated care, cognitive-behavioural counselling) supported by previous research. It provides one model for improving the care of patients whose main problem is severe mental illness potentially aggravated by a degree of substance misuse, but who are stable and motivated enough to engage with an extensive outpatient programme. Other strategies will be required for other 'dual diagnosis' patients. Mental health services and commissioners are envisaged as taking the lead in integrated service provision for severely mentally ill patients. The featured study gives them a way forward for patients not too severely affected by substance misuse, and an incentive to implement it to achieve mental health gains and possible cost-savings.

Featured studies ❶ Barrowclough C. *et al*. "Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders." *American Journal of Psychiatry*: 2001, 158, p. 1706–1713. DS ❷ Haddock G. *et al*. "Cognitive-behavioural therapy and motivational intervention for schizophrenia and substance misuse: 18-month outcomes of a randomised controlled trial." *British Journal of Psychiatry*: 2003, 183, p. 418–426. DS

Additional reading ❶ Department of Health. *Mental health policy implementation guide. Dual diagnosis good practice guide*. 2002. Copies www.doh.gov.uk ❷ *Mind the gaps. Meeting the needs of people with co-occurring substance misuse and mental health problems*. Scottish Executive, 2003. Copies: www.scotland.gov.uk.

LINKS Nuggets **4.9 2.12**

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