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GO The complexity and challenge of 'dual diagnosis'

With as many as three quarters of their clients suffering from mental health problems, deciding how to respond is a major concern for Britain's drug and alcohol services. The issues are many, long-standing, and generally unresolved. Should substance use services take the lead in coordinating their clients' care, or should this be taken on by psychiatric services? Is either willing and able to take on both issues and deal with mentally ill substance users, or would a better option be to create new integrated services?

People with coexisting mental health and substance use issues often have high support needs, and poor treatment outcomes. There are various barriers to the provision of appropriate support, but equally many opportunities and occasions to improve the lives of those affected.

Dual diagnosis: more complex than the name suggests

The term 'dual diagnosis' is used widely, but not often consistently. The World Health Organization defines it as "the co-occurrence in the same individual of a psychoactive substance use disorder and another psychiatric disorder", whereas the UK National Institute for Health and Care Excellence (NICE) refers to "young people and adults with severe mental illness who misuse substances". What these two definitions have in common is a leaning towards the severe end of experiences of mental health and substance use issues. The everyday use of the term dual diagnosis is much broader, describing the presence of *coexisting* mental health and substance use issues, where the person *may or may not* have a formal diagnosis of, or meet the formal criteria for, mental illness, substance use disorder or dependence. In fact, many people categorised as having a dual diagnosis do not have a diagnosis, and many people have more than the two problems or support needs that 'dual' diagnosis implies. Rather than thinking of people with dual diagnosis as having two support needs, it may be more useful "to acknowledge that they have complex needs", both directly related to *and* extending beyond their substance use and mental health. It is because of this that some working in the field have advocated either moving away from the term dual diagnosis altogether, or adopting the broader, more inclusive, everyday interpretation of dual diagnosis to accommodate all who would benefit from treatment that considers their coexisting mental health and substance use problems (regardless of levels of severity or diagnosis).

Mental illness and substance use: which is chicken, and which is egg?

Dual diagnosis has been on the radars of researchers and clinicians for over thirty years. In terms of the complex relationship(s) between mental health and substance use (1,2,3,4) we now understand that (among other things):

- Drinking and drug use can *aggravate or exacerbate* existing mental health problems or symptoms
- People may drink and take drugs to try to *relieve* the adverse symptoms of mental health problems (sometimes referred to as 'self-medication')
- Long-term, heavy drinking can cause damage to the brain which can impair cognitive functioning
- Drinking or taking drugs can *induce* temporary or longer-term mental health problems in some people, which may subside after the substance use has stopped
- Withdrawing from alcohol and many illicit drugs can *produce or mimic symptoms* of mental ill health

> *The chicken and egg debate may have helped to foster a climate of fragmented services*

There has been somewhat of a preoccupation in the literature and in practice about understanding which comes first, the substance use issue or mental health issue – which is chicken, and which is egg? Though the answer to this question may have important implications for treatment, it would not necessarily be the most immediate or pressing concern for patients, and has arguably helped to foster a climate of fragmented services – with mental health and substance use services feeling ill-prepared or unwilling to treat patients where their own specialism isn't seen as the primary treatment issue.

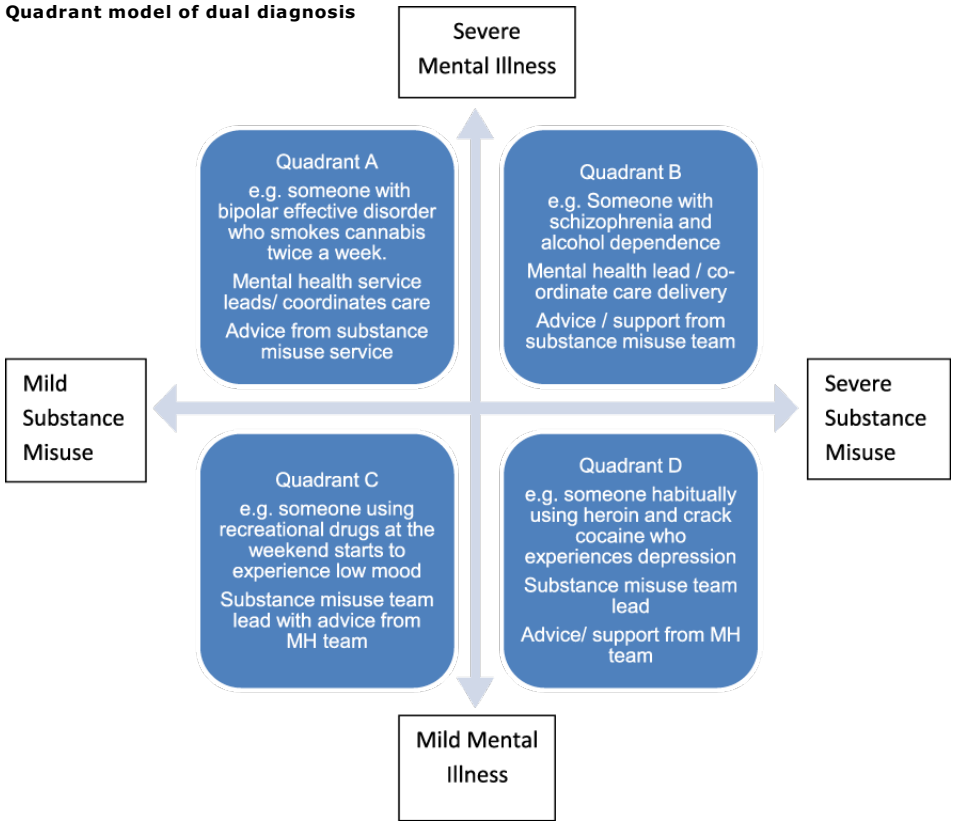
Which agency should take the lead?

The risks of people with mental health issues developing substance use problems and people with substance use problems developing mental health issues are much higher than the risks of developing mental health or substance use issues within the general population. The high prevalence of coexisting mental health and substance use problems within mental health services is well-documented, with recorded prevalence rates in various UK studies at 32%, 36%, 44%, and 46%. Rates in substance use services could be even higher, with recorded rates of 75% in drug services and 86% in alcohol services. With so many people who are affected by dual diagnosis coming through the doors of both mental health and substance use services, clinicians face a difficult challenge. How can they best serve their patients given that they only hold one piece of the jigsaw?

An influential framework for determining the appropriate approach to treatment and care is the quadrant model, illustrated (▶ figure) in South Staffordshire and Shropshire Healthcare's dual diagnosis policy. It describes four presentations of dual diagnosis based on levels of severity: mild substance use and severe mental illness; severe substance use and severe mental illness; mild substance use and mild mental illness; severe substance use and mild mental illness. The provisions for treatment described in the quadrant model focus on one service taking the lead (either substance use or mental health), and then this lead service coordinating care, and seeking advice and support from the other service (either substance use or mental health). This partly resolves where ultimate responsibility lies, but leaves unanswered other questions about the nature and practicalities of the relationship between mental health and substance use services (eg, information sharing), and also leaves unstated the roles of other support and

and substance use services (eg, information-sharing), and also leaves unstated the roles of other support and treatment services needed by people with coexisting mental health and substance use issues.

Quadrant model of dual diagnosis



Department of Health guidance (published in 2002) recommended that mental health services take primary responsibility for people with *severe* mental illness, as they would be "better placed to offer services such as assertive outreach, crisis management and long term care than the substance misuse services". For less severe cases not eligible for psychiatric care, substance use services are seen as taking the lead. We can be reassured to a degree that patients often improve after usual substance-focused treatments, possibly because at least some emotional problems are generated by substance use and associated lifestyles. This was why NICE recommended that alcohol services faced with seriously depressed or anxious patients should treat their drinking problems first, and consider referring the patient for specialist mental health care only if psychological conditions persist after three to four weeks of abstinence.

Despite this policy direction, there are many circumstances where people are unable to access mental health or substance use services. Sometimes those with low support needs can fall short of criteria for services, and not receive anything. Where which service should take the lead is unclear or is disputed, the result can be a stalemate where neither service can or will act. The danger of these barriers being unresolved is "service users being shifted between services and falling through the net of care".

How can we prevent people falling through the gaps?

Coordination or joint working could be the answer. But a number of practical and cultural barriers make it difficult to achieve – sectors and services are guided by different policies, there is often a disconnect between available resources and service user or professional preferences for treatment and care, and there is a shortage of designated dual diagnosis funding. A dual diagnosis handbook published by social care organisation Turning Point suggests that "commissioners might want to explore concurrent funding streams – (eg, for mental health support services and substance misuse) – or look to share budgets to provide social care for vulnerable groups".

In a recent piece for the *Guardian*, Professor Liz Hughes, who has extensive clinical and academic experience in mental health, substance use and dual diagnosis, warned that "the UK dual diagnosis scene is running on nothing but goodwill by a few enthusiastic champions". The challenge is "being able to provide effective services to people with high needs, in a time of unprecedented crisis in mental health provision and loss of mental health expertise within the substance use sector."

One potential source of new funding comes from the Government's Life Chances Fund. In January 2016, Prime Minister David Cameron announced that "up to £30 million" would be available for "the development of new treatment options for alcoholism and drug addiction, delivered by expert charities and social enterprises". This funding pot is based on the model of Social Impact Bonds, designed to leverage funding to service providers, and improve the outcomes of services by making funding conditional on achieving results, rather than inputs (eg, number of counsellors) or outputs (eg, number of counselling sessions). The independent Mental Health Taskforce to the NHS recommends that applicants should "demonstrate how they will integrate assessment, care and support for people with co-morbid substance misuse and mental health problems".

Integrated services with staff trained and skilled specifically for dual diagnosis clients represent an alternative to independent working, or joint/coordinated working. This seems like the ideal solution on paper – clinicians in these services would have shared values, policies and processes, and there would presumably be no obstacles to information-sharing. However, the evidence about the effectiveness of integrated care has so far been inconclusive. This does not necessarily preclude the development of integrated services now or in the future, but does indicate that "the case for integration [may need to be] based on practice-based evidence rather than evidence-based practice".

Unique opportunities (and challenges) in prison settings

Dual diagnosis is a common problem in prisons. "Nine out of ten people in prison have a mental health or substance

Dual diagnosis is a common problem in prisons: "Nine out of ten people in prison have a mental health or substance abuse problem – often together – but most do not receive the right care". Many prisons in the UK apply a "parallel approach" to dual diagnosis, where patient care is provided by more than one treatment service *at the same time*. The main advantage is that the patient receives specialist help for each of the different aspects of their problem. However, given the overlap of many problems, and the historic compartmentalisation of services (whereby substance use and mental health teams have tended to refer prisoners onto each other, rather than seeking to work together), the parallel approach has been perceived as *fragmented care*.

Overall, the evidence suggests that prison environments present an opportunity to provide integrated care to people with mental health and substance use issues. The recommendation is that more energy should be put into improving communication, information-sharing and referrals between services, and more research should be conducted into effective psychological interventions for prisoners with a dual diagnosis.

What treatments work?

Partly due to a lack of high quality trials, there has been no compelling evidence to support the use of any one particular psychosocial treatment over 'treatment as usual' for people with both severe mental illness and substance use problems (1,2). A recent review of psychosocial treatments for co-occurring cannabis use (the dominant drug problem in the UK among patients new to treatment) and mental health problems found poor results across the board, equivalence among therapies, and a failure to improve on usual treatments. When the authors looked beyond the trials where participants were randomly allocated (ie, beyond the most rigorous trials), they found some evidence for the use of motivational interviewing in psychiatric settings combined with cognitive-behavioural therapy, but little for cognitive-behavioural therapy alone.

Depression plus problem substance use is the most common combination encountered by substance use services. Experts disagree about the best general approach. An Australian study suggested that in some cultures this may differ for men and women – or at least, that for men an alcohol-focus may be a more acceptable and effective way of tackling their depression and drinking, while for women a focus on depression may be preferable. Given the difficulty of identifying which problem is primary, and the risks of getting this wrong (both *could* have equal weight and/or be independent of each other), guidelines from the British Association for Psychopharmacology say that "pragmatically, both disorders may have to be treated concurrently". Their freely available resource offers extensive guidance on medication-based treatments for mentally ill problem substance users.

It seems likely that many patients with depression would benefit more from addressing this directly at the same time as addressing problem substance use. One medication-based strategy was tried in a US study which selected alcohol-dependent patients whose depression was judged independent of their drinking. It found that combining sertraline for depression with naltrexone for drinking substantially and significantly promoted abstinence compared to either alone or to placebos, and also helped more with depression. This is, however, not a universal finding. Prompted by that study, researchers in New Zealand tried adding the similar antidepressant citalopram to naltrexone in the treatment of dependent drinkers suffering what for three-quarters was judged to be major depression independent of their drinking. In this case adding the medication led to no significant overall benefits in respect either of depression or drinking.

Establishing what works for patients with a dual diagnosis is not easy given the wide spectrum (and combination) of substance use and mental health problems that exist. The label of dual diagnosis itself can facilitate or impede access to treatment, and its subsequent success. Where dual diagnosis is associated with negative stereotypes it can be stigmatising for services users. Where the term is associated predominantly with severe mental health or substance use issues, it can exclude people with lower level issues who would still benefit from treatment tailored to their coexisting issues. Where the term can be powerful is in raising awareness of the gaps in support for people with complex and coexisting difficulties. Where it can also be beneficial is in promoting a language which emphasises the importance of collaboration between mental health and substance use services.

Where do we go from here?

Progress, a group of consultant nurses and expert practitioners working in the National Health Service (NHS), runs a website offering useful resources about dual diagnosis for service users, carers and professionals. This includes the stories of David, Martha, 'God' and Jason (based on the experiences of people with mental health and substance use issues), and information about how to find a member of Progress working near you.

NICE is in the final stages of producing guidance to improve services for people (aged 14 and over) with severe mental illness and substance use problems, not just for their immediate mental health and substance use support needs, but those relating to physical health, social care, and housing. The expected publication is November 2016, but draft guidance is available here. Recommendations include collaboration between services in mental health, substance use, primary care, and social care, as well as organisations in the community and the voluntary sector, and the agreement of a protocol for information-sharing between all relevant services. It also recommends that people with coexisting mental health and substance use issues should be encouraged to stay in contact with services, and be involved (along with their family and carers) in developing their own care plan, which should take into account how their abilities, strengths and past experiences can help support engagement and recovery.

Dual diagnosis is not a single entity but a label for differing constellations of troubling substance use and psychological problems. Present gaps in resources, knowledge and evidence about dual diagnosis are putting a strain on clinicians, and risking many patients getting lost in the system. Historically, the values and treatment approaches of substance use and mental health services haven't always been aligned. One potentially "binding philosophical strand" going forward is the increasing importance of recovery within both services, with opportunities to define what recovery means for people under the umbrella of dual diagnosis, and create new shared values around these aims.

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