

DRUG & ALCOHOL FINDINGS *Hot topic*

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With the vast majority of their clients suffering from mental health problems (1 2), 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, 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*" (italics added). The everyday use of the term 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.

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Substance use and mental health problems: 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 we now [understand that](#) (among other things):

- Drinking and drug use can *directly cause* mental health problems.
- Drinking and drug use can *aggravate or exacerbate* existing mental health problems or symptoms.
- People may drink and take drugs to *relieve* the adverse symptoms of mental health problems (sometimes referred to as 'self-medication').
- The effects of withdrawing from many illicit drugs can *produce or mimic symptoms* of mental health problems, as can the excessive use of stimulants.

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 problems developing substance use problems and people with substance use problems developing mental health problems 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?

[Last published](#) in 2017 there is no more important document for clinicians treating problem drug use in the UK than the so-called 'Orange guidelines'. Given the high prevalence of comorbid problems in drug and alcohol services and mental health services, this guidance states that suitable interventions are needed for substance problems in *all* mental health services, and for mental health problems in *all* substance use services, with competent staff available to deliver such interventions. [Guidance from](#) the UK's National Institute for Health and Care Excellence (NICE) in 2016 also emphasised the need for overlap and collaboration, as opposed to specialist dual diagnosis services. Focusing on patients with substance use problems and *severe* mental health problems, NICE advised that health and social care (including substance use) services should adapt to and collaborate in the care of this group of patients, but led by the mental health service.

[According to](#) Public Health England in 2017, better care for people with co-occurring mental health and substance use problems begins with commissioners and service providers adopting the principles that there is 'no wrong door' for

accessing support, and it is 'everyone's job' the other side of the door to help. What this means in practice is that all services should be proactive, flexible, compassionate and anti-discriminatory in their response, offer rapid assessment and referral if appropriate, offer a rapid response to urgent physical, mental health, and social care needs, while also making plans for longer term care and support, and have a named lead who can coordinate care and wrap-around support from multiple providers effectively. Complementing this is a set of NICE quality statements published in August 2019 for improving the quality of care that people with [co-existing severe mental illness and substance use problems](#) receive:

Statement one: "People aged 14 and over with suspected or confirmed severe mental illness are asked about their use of alcohol and drugs."

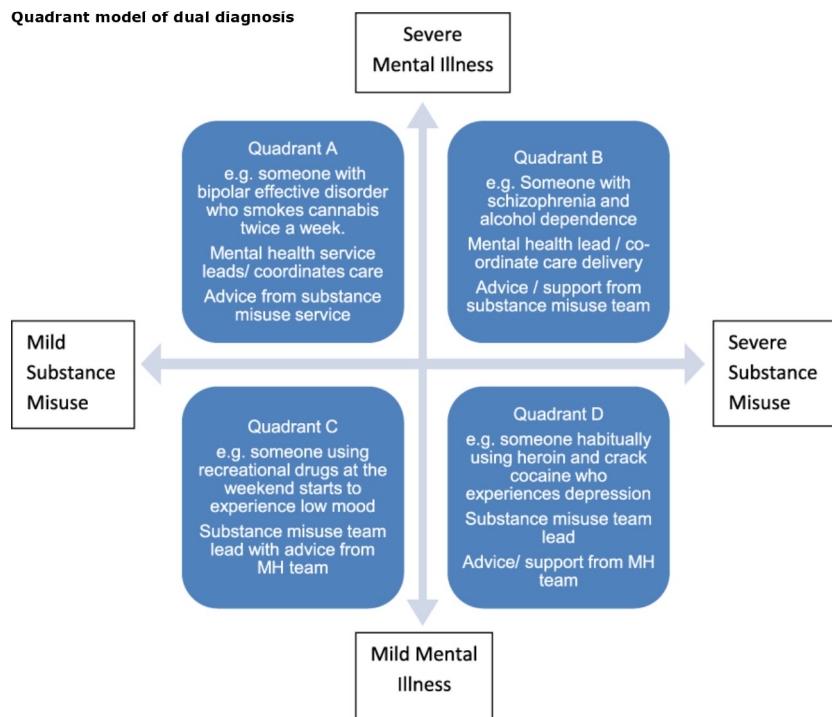
Statement two: "People aged 14 and over are not excluded from mental health services because of coexisting substance misuse or from substance misuse services because of coexisting severe mental illness."

Statement three: "People aged 14 and over with coexisting severe mental illness and substance misuse have a care coordinator working in mental health services when they are identified as needing treatment from secondary care mental health services."

Statement four: "People aged 14 and over with coexisting severe mental illness and substance misuse are followed up if they miss any appointment."

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 schematic 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 resolves some issues about 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 treatment services needed by people with coexisting mental health and substance use problems.

Quadrant model of dual diagnosis



Department of Health guidance published in 2002 (report no longer available), recommended that primary responsibility for people with severe mental illness should lie with mental health services, who [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, who can be reassured to a degree that patients often improve after usual substance-focused treatments, possibly because at least some mental health 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 normally 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. In addition, where it is unclear which service should take the lead, or there is a dispute about which agency should take the lead, 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 – for example, for mental health and substance use support services – or look to share budgets to provide social care for vulnerable groups.

In a 2015 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 funding came from the Government’s Life Chances Fund. In January 2016, then 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 was 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 raised a specific point about this funding, [recommending](#) that those making an application 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 the dual diagnosis caseload 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 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 of a parallel approach 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?

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 health and substance use problems (1,2), partly due to a lack of high quality trials. 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 people with mental health and substance use problems.

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. However, this is 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.

Where do we go from here?

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 dual diagnosis is associated with greater challenges for practitioners and treatment services it can be marginalising for service users, despite evidence to suggest that people with overlapping mental health and substance use problems are in the majority not the minority. 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.

[Progress](#), a group of [consultant nurses and expert practitioners](#) working in the National Health Service (NHS) committed to improving the dual diagnosis landscape, runs a website offering useful resources for service users, carers and professionals. The website includes the [stories of David, Martha, 'God' and Jason](#), based on real-life experiences of people with a dual diagnosis. You can find a member of [Progress](#) working in your region [here](#).

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. The international mental health recovery movement stresses the importance of personal and subjective experiences of recovery, distinguishing the [deeply personal](#) process of change and "living a satisfying, hopeful and contributing life, within the limitations imposed by illness" from clinical conceptualisations of recovery such as the absence of symptoms and illness.

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