

# Dual diagnosis needs assessment

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**NHS**

*Brighton and Hove*



**Brighton & Hove  
City Council**



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## **Recommendations**

### **1. Agree a case definition for dual diagnosis for use across mental health and substance misuse services**

The 'classic' definition of dual diagnosis is that of serious mental illness plus substance misuse problems. The evidence gathered for this needs assessment indicates that there is a substantial group of people with complex needs involving substance misuse and mental health problems which fall outside this definition. Therefore a broad definition encompassing comorbid mental health and substance misuse problems of any severity is most appropriate for use in Brighton and Hove.

### **2. Improve data collection for dual diagnosis in Brighton & Hove.**

Dual diagnosis is not recorded in a consistent way across services in the city, in part due to the complexity of defining it and variations in the definition of dual diagnosis in different services. For this reason it is very difficult to ascertain the true burden associated with dual diagnosis in Brighton and Hove. At present service users are only recorded as having a dual diagnosis in substance misuse services if they are under the care of mental health services at the time of their initial assessment. Dual diagnosis is not currently recorded consistently within mental health services. This leads to substantial underestimates of the burden of comorbid mental health and substance misuse within the city.

The development of an agreed service definition for dual diagnosis is an important component of this and coding systems should be developed to ensure that dual diagnosis comorbidity of any severity can be monitored.

### **3. More formal data sharing across mental health and substance misuse services.**

Named staff within mental health and substance misuse services should have access to the Electronic Care Programme Approach system used within mental health services, and the Nebula system used within substance misuse services. At present these services are completely separate and the lack of shared IT systems reduces opportunities for joint working. It is important for clinicians to be able to identify cases which are under the care of both mental health and substance misuse services. However, patient confidentiality is an important consideration and information should only be shared when necessary between those involved in a patient's care (and information sharing should be consistent with information governance policies).

### **4. Development of closer partnership working between all services involved in working with clients with joint mental health and substance misuse needs.**

At present services for mental health and substance misuse operate entirely separately, and the impact of this is felt across the system. Joint working often relies on motivated individual staff working with other services, but it does not appear to be consistent across the system. Closer working relationships are urgently needed between the range of agencies working with dual diagnosis clients in Brighton & Hove.

Partnership working is needed both at a strategic level, and “on the ground”. For example, joint assessment of clients and development of joint care plans should be considered where appropriate and possible, where each service is clear about their role in an individual’s care. Other suggestions have included joint meetings, development of a ‘virtual’ multidisciplinary dual diagnosis team, and designating senior dual diagnosis leads within teams.

For example, regular multidisciplinary team meetings could review challenging cases and system issues that are impacting on patient care. This would provide support to staff who may feel unable to work with particular complex cases, and help to prevent patients becoming shunted between different services. These meetings should involve staff from the range of organisations involved in working with this client group, including substance misuse services, mental health services, hostel staff and others as appropriate.

#### **5. Training for staff who work with dual diagnosis clients to at least the core standard identified in the Dual Diagnosis Competency Framework.**

This should include staff within mental health and substance misuse services, and also staff working in hostels. Many professionals identified a lack of training as a key barrier to confident working with this client group, despite a motivation to do so.

#### **6. Development of clear pathways of care, and basic referral criteria for mental health and substance misuse services, in relation to clients with complex needs.**

Inconsistencies were identified in the system in terms of the severity of substance misuse and mental health problems that various services will accept, leading to confusion and variation in practice. The care pathway should include comorbid substance misuse and common mental health problems such as anxiety and depression, which do not necessarily fall within the accepted definition of dual diagnosis but nevertheless form the bulk of service users with joint mental health and substance misuse needs. People should not be excluded from care because of complex needs relating to dual diagnosis.

Professionals also noted the need for a clear care pathway for people with Korsakoff syndrome (a brain disorder resulting from thiamine deficiency, usually relating to long term alcohol misuse).

#### **7. Mapping of range of services available for people with dual diagnosis in Brighton & Hove, their referral criteria and contact details**

Professionals and service users identified a basic lack of awareness of the range of services available, their roles and responsibilities and referral criteria

as an important barrier to effective partnership working for service users with dual diagnosis.

**8. Improved accommodation options for people with dual diagnosis.**

A lack of accommodation for the most chaotic clients with complex needs who are actively using substances was noted as an issue. Women with a dual diagnosis are particularly vulnerable, as there is currently no women-only hostel accommodation within the city. Consideration should be given to the development of appropriate accommodation for this group.

**9. Continued development of shared working through the Brighton & Hove Dual Diagnosis working group.**

This group has been established by commissioners to take the lead in improving care for people with dual diagnosis in Brighton & Hove. It is important that the group includes senior multi-agency representation and is recognised as having a lead role in addressing dual diagnosis issues for the city.

**10. Continued monitoring of drug related deaths and suicides and identification of issues relating to mental health and substance misuse.**

This should aim to establish whether individuals may have had mental health and substance misuse needs which were not addressed by current systems, and identify a suitable course of action to ensure that these needs are met in the future.

Regular audits are carried out analysing information relating to drug related deaths in Brighton & Hove, however these are limited in their ability to detect dual diagnosis issues by a lack of recording of any mental health involvement. Consideration should be given as to how mental health can be considered in these audits.

**11. Consideration of the role of the new primary care mental health service in assessing the needs of those with comorbid anxiety or depression, and substance misuse problems, and signposting to appropriate support.**

This could include training one or more staff members within the service as a Dual Diagnosis Champion.

**12. Consideration of how to improve the flexibility of services as a means of improving clients' engagement with services.**

It was noted that clients can be reluctant to come to services in traditional settings. Consideration should be given to the use of a space outside traditional healthcare settings, for example at the First Base day centre, in which assessments of clients with complex needs relating to mental health and substance misuse issues could be carried out.

**13. Development of a multi-agency action plan for dual diagnosis in Brighton & Hove, establishing the range of services working with dual diagnosis clients.**

This should aim to address the needs of those with co-existing mental health and substance misuse problems, across the spectrum of severity, not only focusing on those with the most severe mental health problems. The plan should consider how best to coordinate the work of the wide range of agencies which are involved in the care of people with dual mental health and substance misuse needs in the city.

#### **14. Further needs assessment work**

This needs assessment has been limited by a lack of local data on dual diagnosis and includes a recommendation to improve data collection. An updated dual diagnosis needs assessment should be carried out when data collection issues have been resolved, and a clearer picture of need relating to dual diagnosis in Brighton & Hove can be established. This should be within three to five years, or in line with future commissioning cycles.

In addition this needs assessment has not fully considered the needs of young people in transition to adult services, and future needs assessment work should address this.

## **Executive summary**

The term dual diagnosis describes the coexistence of mental health problems and the problematic use of substances including alcohol and drugs. People with dual diagnosis are a very vulnerable group, and this complex condition is associated with significant clinical, social, legal and economic problems. Developing better services for people with comorbid mental health and substance misuse problems is a national and local priority.

This needs assessment attempts to capture the available evidence relating to the needs of those with dual diagnosis in Brighton & Hove. A city wide action plan for dual diagnosis is being developed and this needs assessment will inform its content.

## **Legislation and Policy**

- Dual diagnosis has been a priority area in national policy documents for many years.
- The Dual Diagnosis Good Practice Guide 2002 remains the most specific national policy document relating to dual diagnosis.
- 'Mainstreaming' is the key policy for delivering care to people with dual serious mental illness and substance misuse problems; this means that care for this group should be delivered within mental health services, supported by substance misuse colleagues.
- People with substance misuse problems and mild to moderate mental health conditions should be managed within specialist substance misuse services, and/or primary care, supported by mental health services where necessary.

## **Who is at risk and why?**

The relationship between mental health and substance misuse:

- Mental health and substance misuse problems frequently coincide
- Various mechanisms have been proposed to explain the relationship between substance misuse and mental health problems, and the relationship between the two is very complex
- Comorbidity can occur at any level of severity; it is not confined to 'serious mental illness'
- Substance misuse is most commonly associated with depression, anxiety and schizophrenia, but it also occurs in people with other mental health disorders
- Alcohol problems are common among people with bipolar disorders, schizophrenia and personality disorders
- People with comorbid mental health and substance misuse problems can have poorer treatment outcomes.
- Personality disorder is strongly associated with an increased risk of alcohol or drug dependence .

Mental health and substance use disorders can coexist in several forms:

- A primary psychiatric illness precipitating or leading to substance use, misuse, harmful use, and dependent use, which can also be associated with physical illness, and affect social ability.
- Substance misuse, harmful use and dependent use may worsen or alter the course of a psychiatric illness, and physical health problems.
- Substance use, intoxication, and/or substance dependence may lead to psychological symptoms, which may or may not amount to a diagnosis, and to social problems.
- Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses, physical illness and social dysfunction.<sup>4,23</sup>

Who is at risk and why?

- There are no routinely available national or local data on the prevalence of dual diagnosis
- The definition of dual diagnosis varies widely and therefore there are wide variations in prevalence estimates
- The prevalence of mental health problems among clients of drug and alcohol services has been estimated at between 50-85%. The most common problems are depression and personality disorder
- The prevalence of substance misuse problems among patients in mental health services has been estimated at between 30-80%
- The prevalence of comorbid mental health and substance misuse problems has increased in recent years
- An estimated 75% of prisoners have a dual diagnosis, and it is particularly common in female prisoners
- An estimated 56,000 people in the UK are experiencing multiple needs and exclusions relating to mental illness, drug and alcohol problems, homelessness and offending
- Dual diagnosis is more common in deprived areas, but it has been suggested that the rate is increasing more rapidly in affluent areas.

People with dual diagnosis are very vulnerable:

- They often experience problems relating to education, employment, economic hardship, accommodation, social isolation, and personal relationships
- They are at increased risk of experiencing domestic violence and sexual abuse, and women with dual diagnosis are particularly vulnerable
- Their general health may be poor and they are at increased risk of poor health outcomes including long term physical health problems, self-harm and suicide
- They may decline to readily engage with services and are more likely to be non-compliant with treatment
- They have a high risk of contact with the criminal justice system and imprisonment
- People with mild learning disabilities have a high risk of mental ill health, particularly anxiety and depression, higher levels of substance misuse than their peers, and are especially vulnerable.

## **The level of need in the population of Brighton & Hove**

- Brighton & Hove has a high prevalence of mental ill health, drug and alcohol use, and also has high rates of self harm, suicide and drug related deaths. This suggests that the rate of dual diagnosis in the city is also high.
- There is limited recording of dual diagnosis within NHS services in the city, in part due to the complexity of defining the condition.
- Data from mental health and substance misuse treatment services give a perspective on the level of dual diagnosis being detected and recorded by services; however this only provides a minimum estimate of the need relating to dual diagnosis in the city.
- Between 10-50% of clients within mental health services have a dual diagnosis recorded. This is below national estimates and is likely to reflect issues with data quality. The highest proportion of recorded dual diagnosis is among clients of the Assertive Outreach Team.
- At least 15% of people in drug treatment have a dual diagnosis. This has increased from 3% in 2005/06. Again, this is below the number suggested by national estimates and may be due to data quality.
- Substance misuse clients with dual diagnosis are more likely to have a risk assessment which considers them at risk of suicide, self neglect, violent behaviour or opiate overdose.

### Suicides and drug-related deaths:

- Of 26 suicides recorded in Brighton & Hove in 2010, 31% had an alcohol problem and 23% a drug misuse problem, and 77% had a mental health diagnosis, indicating a potentially high number with dual diagnosis.
- Brighton & Hove has one of the highest rates of drug related deaths in the country.
- Of 35 drug related deaths in 2010, seven were suicides and less than five had recorded mental health issues. However this is likely to represent a minimum estimate of the number of people with mental health, or potential dual diagnosis issues.

### Housing:

- The rate of homelessness in Brighton & Hove is high, at 3.7 per 1000 population, significantly above the England and South East rates and the rate of rough sleeping is thought to have risen recently.
- A high proportion of people living in hostels report a need to manage mental health and substance misuse issues – the proportion varies between hostels but is up to 60% in those which take the most chaotic clients.
- A recent snapshot analysis of referrals for mental health accommodation placements indicated that 73% of clients had a dual diagnosis.

- Among people in mental health accommodation placements, it is estimated that over 40% also have problems with substances, in particular alcohol.
- A recent review of mental health accommodation concluded that there is an increasing population in the city with dual diagnosis needs, particularly involving multiple drug use with alcohol. It also noted that there is a gap in accommodation provision for people with mental health issues and learning difficulties.

#### Criminal justice:

- 10% of people detained during a recent Mental Health Court pilot scheme were identified as potentially requiring support for mental health, learning disability or substance misuse problems.

#### Learning disabilities:

- Mental health and substance misuse have been identified as significant needs among people with learning disabilities in Brighton & Hove, and it is likely that there is a burden of unmet need among people with learning disabilities and unrecognised mental health or substance misuse problems.
- The 2011 joint strategic needs assessment for learning disabilities recommended specialist provision locally for people with learning disabilities and additional needs including mental health and substance misuse problems.

#### Lesbian, Gay, Bisexual and Transgender (LGBT) communities:

- A survey among LGBT communities in Brighton & Hove suggested high levels of need for support with mental health issues (39%) and complex substance misuse problems involving both drugs and alcohol (37%).

### **Views of service users**

- Dual diagnosis is consistently identified as a priority area of need in consultation with substance misuse service users.
- Service users consistently report that there is a lack of support for people with dual diagnosis, and care pathways are not clear for this client group.
- The most recent consultation indicated that these issues continue, and only a third of respondents felt there was good support for dual diagnosis in Brighton & Hove, and that more support was available than had been previously.

#### Specific issues raised regularly include:

- A need for more staff trained specifically in working with dual diagnosis clients, in both substance misuse and mental health services;
- A lack of awareness of available support and services, among both staff and service users;

- The need for a clear, accessible care pathway for dual diagnosis in the city;
- Insufficient support for people with dual diagnosis moving on from treatment services;
- An absence of partnership working between services.

### **Views of professionals**

- Professionals strongly agreed that there is an urgent need to develop closer working relationships between the range of agencies working with dual diagnosis clients in Brighton & Hove.
- Many staff felt that the term 'dual diagnosis' was not appropriate, as this client group generally have a range of complex problems but may not be dually diagnosed, and 'complex needs' was a more appropriate term.
- A general lack of joint working between substance misuse and mental health services was noted by many professionals across all services as a barrier to working with this client group, although they believed that joint working was very beneficial for clients.
- Staff often have different perceptions of what constitutes a dual diagnosis, and this complicates work with this client group.

#### Health services:

- Most professionals agreed that there are generally clear systems in place for working with people with a serious mental illness and substance misuse problem, with good communication and joint working; however there is less clarity for the quite significant group of people with complex needs involving common mental health problems, and these people are at risk of 'falling through the gaps' between services.
- A frequently identified problem was the need for improved information sharing between mental health and substance misuse services. At present neither service can access the other's patient record systems. Staff felt strongly that enabling shared access to information systems, where appropriate, would greatly aid joint working between services.
- GPs in Brighton & Hove identified patients with dual diagnosis as a group for whom it was difficult to get services.
- A multidisciplinary team approach was considered potentially beneficial for working with his client group. Many of the necessary resources already exist across the system, but they need to work together more effectively. Working with complex needs requires a flexible, well resourced team who can do assertive outreach work with those who are not engaged with services.
- Joint assessment and joint care planning can be of great use but is logistically difficult to arrange, as professionals are based at different sites. However this approach can help to reduce duplication, and prevent clients from being passed between different services.
- Mental health staff are motivated to work with dual diagnosis clients, but are not always confident in doing so. Reasons cited included a lack

of adequate knowledge and training, time pressures, high case loads and a lack of service user engagement.

- Staff in mental health services reported that they had insufficient understanding of the services available for this group, and the roles and responsibilities of each service.
- It was reported that there is not always consistency in terms of the level of substance misuse that would be accepted by mental health services, and clearer referral criteria may help this and aid joint working.
- There is a need for a care pathway for people with Korsakoff syndrome (a brain disorder resulting from thiamine deficiency, usually relating to long term alcohol misuse).

#### Housing:

- Professionals reported that housing is a challenge for this group, as some clients could be very difficult to place.
- People with 'lower level' mental health needs and substance misuse problems often end up in the hostels system, and can be very chaotic and challenging to work with.
- Some hostels have staff specifically trained in working with dual diagnosis clients, but others don't.
- Many hostels staff do not feel confident in working with this client group, and need more support and training in working with clients with complex needs relating to substance misuse, particularly alcohol, and mental health.
- Housing professionals believed that there should be more flexibility in the location of health services, which should be able to come to the client where necessary, so clients may be more likely to engage.
- It was noted that active substance users with mental health needs present a particular challenge, and there is a gap in accommodation provision for this group.

#### **Evidence of effectiveness in addressing needs**

- The Dual Diagnosis Good Practice guide remains the definitive guidance document for the management of dual diagnosis
- The breadth of conditions encompassed by the term dual diagnosis means that studying it is complicated, and evidence is limited in this area.
- Having a policy in place for the management of dual diagnosis has been associated with a 9% reduction in suicide rates
- The available evidence suggests that Integrated Treatment approaches are beneficial for treating patients with dual substance misuse and mental health problems. This involves multidisciplinary working between services, with clinicians working in one setting to provide mental health and substance misuse interventions, rather than in parallel services.

## **1. Introduction**

People with dual diagnosis are a very vulnerable group, and this complex condition is associated with significant clinical, social and legal problems. Developing better services for people with co-morbid mental health and substance misuse problems is a national priority.

It has been ten years since the last comprehensive needs assessment for dual diagnosis was carried out in Brighton & Hove. An Overview and Scrutiny Committee (OSC) review of dual diagnosis services in the city in 2008 recommended a Joint Strategic Needs Assessment for dual diagnosis as a matter of urgency. A city wide action plan for dual diagnosis is being developed and will be informed by this needs assessment.

The OSC made recommendations around several key themes which emerged from the evidence the review heard:

- Supported housing
- Womens' Services including domestic violence, sex work
- Children & Young People
- Integrated Working & Care Plans
- Funding
- Treatment and support
- Data Collection and Systems

Where possible this needs assessment will aim to assess need relating to these key themes.

Dual diagnosis is one of the priority pathways identified in the local Adult Mental Health Programme workplan for 2012/13, along with perinatal mental health and eating disorders. This includes addressing gaps in service provision and lack of co-ordination.

Sussex Partnership NHS Foundation Trust (SPFT) produced a dual diagnosis strategy in 2011.<sup>1</sup> This sets out the vision and framework for the Trust's future work on dual diagnosis. However dual diagnosis is a complex issue affecting a range of services, and this population group often does not access any services at all. It is recognised that a multi-agency approach is needed to address the complex needs of those with mental health and substance misuse problems in the city, and this needs assessment is intended to inform the development of a multi-agency action plan.

The 2002 needs assessment for dual diagnosis in Brighton & Hove and East Sussex comprised a literature review, snapshot audit of Community Mental Health Team caseloads, stakeholder interviews and a stakeholder conference.

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<sup>1</sup> Sussex Partnership NHS Foundation Trust. The Dual Diagnosis Strategy 2011-2016. [www.sussexpartnership.nhs.uk](http://www.sussexpartnership.nhs.uk)

## 1.1 Scope and definition of Dual Diagnosis

The definition of dual diagnosis varies widely. It is not a diagnosis itself, but broadly refers to individuals who have mental health problems which coincide with substance misuse problems. This encompasses a broad spectrum of mental health conditions and problematic use of substances including alcohol and drugs, both licit and illicit. Both mental health and substance misuse exist at varying levels of severity, and deciding at what point an individual has a dual diagnosis is not straightforward. The label of 'dual diagnosis' is believed by many to be inappropriate for describing the multiple and varying needs of people with these problems, which often encompass a wide range of social problems as well as medical conditions.<sup>2</sup> People with 'dual diagnosis' typically have multiple and varied needs rather than two separate problems,<sup>3</sup> and therefore defining the scope of this needs assessment is challenging. The terms 'complex needs' and 'comorbidity' are also used.

The Department of Health produced Good Practice Guidance for dual diagnosis in 2002, which focused on dual diagnosis as "severe mental health problems and problematic substance misuse."<sup>4</sup> This definition was also used for the 2002 needs assessment.

The SPFT strategy uses a broader definition, adapted from the 2002 Department of Health guide: "*A primary psychiatric illness precipitating or leading to substance misuse, substance misuse worsening or altering the course of a psychiatric illness, intoxication and/or substance dependence leading to psychological symptoms or, substance misuse and/or withdrawal leading to psychiatric symptoms or illness.*" The Scrutiny Report did not use a single definition of dual diagnosis but was focused on severe rather than mild comorbidities.

The methodological challenges involved in trying to define dual diagnosis were described by the researchers involved in a large case control study.<sup>5</sup> The researchers asked practitioners from mental health and substance misuse services to identify whether their clients had a single or dual diagnosis, however it became clear that there were important differences in practitioners' understanding of the term depending on their clinical background, the client's primary problem and the agency they presented to. Particular issues included:

- how practitioners defined a 'mental health problem' or 'substance misuse', and the time period in which a client was considered to have

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2 Rethink/Turning Point 2004. Dual diagnosis toolkit.

<http://www.rethink.org/dualdiagnosis/toolkit.html>

3 Banerjee S, Clancy C, Crome I. Co-existing problems of mental health and substance misuse (dual diagnosis). An Information Manual. Royal College of Psychiatrists 2002.

<http://www.dualdiagnosis.co.uk/uploads/documents/originals/PracManualRCpsych.pdf>

4 Department of Health 2002. Mental Health Policy Implementation Guide 27767. Dual Diagnosis Good Practice Guide. London: The Stationery Office.

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalassets/dh\\_4060435.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalassets/dh_4060435.pdf)

5 Todd J, Green G, Harrison M, Ikuesan BA, Self C, Baldacchino A et al. Defining dual diagnosis of mental illness and substance misuse: some methodological issues. Journal of psychiatric and mental health nursing, 2004;11:48-54.

active comorbidity, i.e. if a history of substance misuse but no active use would be considered dual diagnosis. This is important as including previous substance or mental health problems in the definition of dual diagnosis could lead to inflated prevalence estimates. Diagnoses may also change over time.

- Whether a personality disorder constituted a mental health problem. Evidence indicates that personality disorders and substance misuse commonly co-occur; however there was disagreement in this study about whether this would be considered a dual diagnosis in this context.
- Whether being on prescribed antidepressants implicitly constituted a mental health problem. There was disagreement over whether clients under the care of substance misuse services but who were being prescribed antidepressants should be regarded as having a mental health problem.

The authors concluded that understanding and application of the term 'dual diagnosis' may vary between substance misuse and mental health teams, but should be regarded as a general indicator of complexity. The label of 'dual diagnosis' is important because it can and does determine service provision, and the problems encountered in defining it apply to service providers as well.

Kensington and Chelsea Overview and Scrutiny Panel developed the following definition in 2006<sup>6</sup>:

*“Dual diagnosis refers to the negative impact of drug or alcohol use on individuals who experience mental health difficulties. This falls into three categories:*

- *those individuals who self medicate to control their mental illness through the use of non prescribed drugs or alcohol*
- *those individuals who have experienced significant deterioration in their mental health having used drugs or alcohol for enjoyment;*
- *those individuals at high risk of developing mental health problems as a consequence of significant use of or addiction to drugs or alcohol”.*

The term 'dual diagnosis' implies that an individual has a diagnosis of both a serious mental health condition and a severe substance misuse problem. It is clear that this is not always the case and there is a section of the population with mental health needs which for whatever reasons do not meet thresholds for a formal diagnosis or treatment for a mental health condition. Many of these people have co-existing substance misuse problems of varying severity, but are not in treatment for these, in addition to a wide range of other needs. The nature of these problems means that individuals may not engage with

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6 The Royal Borough of Kensington & Chelsea 2006. Report of the Overview and Scrutiny Committees on Health and on Housing, Environmental Health and Adult Social Care. Review of services for adults at the interface between mental health and drugs.  
[http://www.rbkc.gov.uk/PDF/osc\\_review\\_mental\\_health\\_drugs.pdf](http://www.rbkc.gov.uk/PDF/osc_review_mental_health_drugs.pdf)

services and may have chaotic lifestyles. The term 'complex needs relating to mental health and substance misuse' may therefore be more appropriate.

Local service definitions of dual diagnosis vary and it is clear that the formal 'dual diagnosis' as indicated by a clinical diagnosis of a mental health and substance misuse problem does not describe the full extent of the problem associated with co-existing mental health and substance misuse in the city.

A 2002 report produced by the Royal College of Psychiatrists noted some of the problems resulting from the different operational definitions of dual diagnosis used in different clinical and social settings, which can complicate and confuse communication. It concluded that local health, social care, housing, criminal justice and voluntary sector agencies should consider how they operationally use the term dual diagnosis, to identify service roles and capacity, and to ensure that it is not used to exclude people from getting the help they need.<sup>3</sup>

The following definitions are intended to clarify what is meant by mental health problems and substance misuse in this needs assessment<sup>7</sup>:

**Common mental health problems** include problems such as anxiety, depression, phobias, obsessive compulsive and panic disorders.

**Severe and enduring mental health problems** include mental health problems such as psychotic disorders (including schizophrenia) and bipolar affective disorder (manic depression).

**Personality disorder** is defined by the American Psychiatric Association as 'an enduring pattern of inner experience and behaviours that deviates markedly from the expectation of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment.'<sup>8</sup> It is a complex diagnosis which has several variants including borderline personality disorder and antisocial personality disorder. People with more severe forms of personality disorders experience very high levels of emotional distress and have repeated crises, which can involve self-harm and impulsive aggression. They have high levels of comorbidity, including with other mental illnesses and with drug and alcohol misuse, and are frequent users of psychiatric and acute hospital emergency services.<sup>9,10</sup>

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7 London Health Observatory. Mental health overview and definitions. Accessed 1<sup>st</sup> October 2012. [http://www.lho.org.uk/LHO\\_Topics/Health\\_Topics/Diseases/MentalHealth.aspx](http://www.lho.org.uk/LHO_Topics/Health_Topics/Diseases/MentalHealth.aspx)

8 American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), APA: Washington DC.)

9 NICE. Clinical Guideline 78. Borderline personality disorder: Treatment and management. National Institute for Health and Clinical Excellence 2009.

<http://publications.nice.org.uk/borderline-personality-disorder-cg78>

10 NICE. Clinical Guideline 77. Antisocial personality disorder: Treatment, management and prevention. National Institute for Health and Clinical Excellence 2009.

<http://www.nice.org.uk/nicemedia/pdf/CG77NICEGuideline.pdf>

**Substance misuse** refers to the misuse of licit substances including alcohol, or prescription drugs (e.g. benzodiazepines taken in a manner that was not indicated by a medical practitioner); illicit substances such as opiates and opioids (e.g. heroin and ‘street’ methadone), stimulants (cocaine, crack, amphetamines and ecstasy), volatile substances and cannabis; and the misuse of over-the counter drugs such as codeine based products. The use of combinations of substances can also be a problem in people with a dual diagnosis, for example ‘polypharmacy’ (the use of a combination of prescribed and over the counter medications) and polydrug misuse.<sup>23</sup>

The importance of a clear and locally agreed definition of dual diagnosis for integrated services has been emphasised by the Department of Health, and the development of a service definition of dual diagnosis was a recommendation of the 2002 needs assessment. A survey of progress made towards the good practice guide in 2007 recommended that if the local definition of dual diagnosis covers only those with severe mental illness plus substance abuse, the needs of those with less severe mental illness should also be considered in Joint Strategic Needs Assessments.<sup>11</sup>

For the purposes of this needs assessment the SPFT Strategy definition is used, as it does recognise the complexity of the condition, and to include the full spectrum of severity of comorbid mental health and substance misuse problems.

#### **Dual diagnosis**

*“A primary psychiatric illness precipitating or leading to substance misuse, substance misuse worsening or altering the course of a psychiatric illness, intoxication and/or substance dependence leading to psychological symptoms or, substance misuse and/or withdrawal leading to psychiatric symptoms or illness.”*

The term ‘dual diagnosis’ is used interchangeably with ‘complex needs’ and ‘comorbidity’ throughout this document, reflecting the range of terms used in the literature.

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11 Care Services Improvement Partnership. Themed Review Report 07: Dual Diagnosis. National Service Framework for Mental Health.

## **2. Legislation and Policy**

*Key points:*

- *Dual diagnosis has been a priority area in national policy documents for many years*
- *The Dual Diagnosis Good Practice guide 2002 remains the most specific national policy document relating to dual diagnosis*
- *'Mainstreaming' is the key policy for delivering care to people with dual serious mental illness and substance misuse problems; this means that care for this group should be delivered within mental health services, supported by substance misuse colleagues*
- *People with substance misuse problems and mild to moderate mental health conditions should be managed within specialist substance misuse services, and/or primary care, supported by mental health services where necessary.*

Table 1. is a guide to current national policy relating to dual diagnosis. The Dual Diagnosis Good Practice Guide was published in 2002 and remains the definitive national guidance for dual diagnosis. There is no more recent specific national policy for dual diagnosis; it is instead covered in separate strategies relating to mental health, drugs and alcohol. These strategies do not focus on dual diagnosis specifically but do all recognise the close relationship between mental health and substance misuse, and the importance of integrated care.

National policy and guidelines for dual diagnosis tend to focus on people with more severe problems who have been given a formal label of dual diagnosis.<sup>12</sup>

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12 Rethink/Turning Point 2004. Dual diagnosis toolkit.  
<http://www.rethink.org/dualdiagnosis/toolkit.html>

**Table 1: Summary of current national policy framework for dual diagnosis**

	<b>Mental Health</b>	<b>Drugs</b>	<b>Alcohol</b>
<b>Policy/Strategy</b>	No Health Without Mental Health (2011): Cross-government mental health outcomes strategy for all ages. <a href="http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf">http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf</a>	Government Drug Strategy 2010: Reducing demand, restricting supply, building recovery: supporting people to live a drug free life <a href="http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010">http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010</a>	Government Alcohol Strategy 2012 <a href="http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy?view=Binary">http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy?view=Binary</a>
<b>Guidance</b>	Dual Diagnosis Good Practice Guide 2002 <a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009058">http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009058</a>  Guidance for the management of dual diagnosis for prisons: <a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097695">http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097695</a>  Guidance for dual diagnosis in mental health inpatient and day hospital settings: <a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062649">http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062649</a> This aims to encourage integration of drug and alcohol expertise and related training into mental health service provision.		

A new suicide prevention strategy for England has recently been launched. A consultation was launched in 2011 on an updated cross government Suicide Prevention Strategy, which emphasises the importance of a multi-agency approach to suicide prevention. It includes specific actions relating to people with mental health and substance misuse problems, recognising the increased risk of suicide among this group.<sup>13</sup>

Other more recent dual diagnosis resources include a toolkit developed by the community and voluntary sector organisations Rethink and Turning Point, which provides a practical guide for professionals working with clients with dual diagnosis.<sup>12</sup>

PROGRESS, a national consortium of nurse consultants in dual diagnosis, has also been established. The network provides e-learning for health and

<sup>13</sup> HM Government. Preventing suicide in England. A cross-government outcomes strategy to save lives. 2012. <http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf>

social care professionals about dual diagnosis on its website, and is a resource for professionals working with dual diagnosed service users (see [www.dualdiagnosis.co.uk](http://www.dualdiagnosis.co.uk)).

## 2.1 National mental health policy and strategy

Dual Diagnosis has been noted as a priority area in national policy documents for many years. A 10 year plan for mental health was set out in the 1999 National Service Framework for Mental Health. This focused on helping more people to receive treatment in the community, rather than in hospital. The implementation of this was supported by the Dual Diagnosis Good Practice Guide in 2002, which focused on the provision of mental health services to people with severe mental health problems and problematic substance misuse, including legal and illegal drugs, alcohol and solvents. This is discussed further in section 2.4.

Dual diagnosis was highlighted as a priority in a 2004 progress report on the NSF for Mental Health.<sup>14</sup> The plan was updated in 2007 for implementation from 2010. In 2009 the government launched the action plan “New Horizons: a shared vision for mental health”<sup>15</sup>, aiming to improve the mental health and wellbeing of the population, and improve the quality and accessibility of services for people with poor mental health.

The Mental Health Act 2007<sup>16</sup> is largely concerned with the circumstances in which a person with a mental disorder can be detained for treatment for that disorder without his or her consent. It also sets out the processes that must be followed and the safeguards for patients, to ensure that they are not inappropriately detained or treated without their consent. The main purpose of the legislation is to ensure that people with serious mental disorders which threaten their health or safety or the safety of the public can be treated irrespective of their consent, where it is necessary to prevent them from harming themselves or others. Problematic substance misuse would be an example of a threat to the health and safety of an individual, or the public if supply was involved.

The most recent relevant mental health strategy is “No Health Without Mental Health”, a cross-government mental health outcomes strategy for people of all ages which was launched in 2011.<sup>17</sup> The strategy focuses on mainstreaming mental health and emphasises the two-way relationship between social

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14 Appleby L (December 2004). National Service Framework for Mental Health – Five Years On. Department of Health: London.  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4099120](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4099120)

15 Department of Health (December 2010). New Horizons: A Shared Vision for Mental Health. London: Department of Health.  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_109708.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109708.pdf)

16 <http://www.dh.gov.uk/health/2011/07/mental-health-act/>

17 Department of Health (February 2011). No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_123766](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766)

inequalities and mental health. While it does not have a major focus on dual diagnosis, it notes the close relationship between mental illness and drug and alcohol dependence, and states that its approach will “*help to reduce the risk of substance misuse across the population by promoting mental wellbeing, preventing mental illness and early intervention as soon as the problem arises*”. It emphasises the importance of having appropriate services available locally in the right settings including the provision of fully integrated care, when this is appropriate, to meet the broad needs of people with a dual diagnosis, including improving access and take up of mental health services among the homeless. The strategy also includes specific commitments relating to the mental health of offenders, and ex Armed Forces personnel.

An implementation framework for the strategy is currently being developed but is complicated by the changes currently underway to the structure of health and social care. The strategy notes that mental health will be a key priority for Public Health England.

## **2.2 National drug and alcohol policy and strategy**

A new Government drug strategy was published in December 2010.<sup>18</sup> This increased the emphasis on a recovery-led approach to tackle drug dependence, based around three main areas: reducing demand, reducing supply and building recovery in communities. While previous strategies concentrated primarily on reducing harm due to heroin and crack cocaine, this strategy focuses on dependence on all drugs, including prescription and over-the-counter medicines, and severe alcohol dependency. It does not specifically refer to dual diagnosis, but recognises that the approach of the 2011 Mental Health Strategy to prevent mental illness will also reduce the risk of substance misuse, and emphasises the need for services to work together to enable recovery. This strategy represented a national policy shift away from harm reduction, to focus on recovery, and “breaking the cycle of dependence on drugs and alcohol”. This may be particularly challenging for people with a comorbid mental illness.

The 2012 National Alcohol Strategy<sup>19</sup> notes the clear associations between mental illness and increasing risk of alcohol dependence, and the risks to mental health from excessive alcohol consumption. It comments that recovery goes beyond medical or mental health issues to include dealing with the wider factors that reinforce dependence, such as childcare, housing needs, employability and involvement in crime. The alcohol strategy also notes that for children, emotional and mental health problems are associated with the misuse of alcohol, and promoting good mental health in children and adults can help prevent alcohol misuse. It reinforces the principle that mental health takes the lead in dealing with the interface between mental health and

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18 HM Government. Drug Strategy 2010: Reducing demand, restricting supply, building recovery: supporting people to live a drug free life.

<http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010>

19 HM Government. The Government’s Alcohol Strategy. London: The Stationery Office. 2012. <http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy?view=Binary>

substance misuse and comments that the impending implementation framework for No Health Without Mental Health will set out actions for local organisations, Government and national organisations in the promotion of good mental health and wellbeing, as well as in the treatment of mental illness, including dual diagnosis.

### **2.3 Criminal Justice**

The prevalence of substance misuse and mental health problems in the prison population is high and there is specific guidance for the management of dual diagnosis in prisons.<sup>20</sup> The guidance is intended for use by all services within prisons, including primary care, mental health and substance misuse.

### **2.4 The Dual Diagnosis Good Practice Guide**

The Department of Health produced the Dual Diagnosis Good Practice Guide in 2002, as guidance to aid the implementation of mental health policy.<sup>21</sup> The guidance emphasises the importance of local services developing their own focused definitions of dual diagnosis, reflecting local patterns of need. It does not provide a clear definition of what constitutes a client with dual diagnosis, and focuses primarily on people with serious mental illness and problematic substance misuse, proposing different arrangements for service provision depending on the severity of the mental health condition. Key points include:

#### For people with serious mental illness:

- It notes that substance misuse is usual rather than exceptional among people with severe mental health problems, and individuals with dual problems deserve high quality, patient focused and integrated care.
- It emphasises that care for this group should be delivered within mental health services. This policy is known as “mainstreaming”, and an important aspect is that it should not reduce the role of drug and alcohol services in advising on substance misuse issues, and treating the majority of people with substance misuse problems. However it is intended that patients are not be shunted between different services or put at risk of dropping out of care.
- Substance misuse services should provide specialist support, consultancy and training to mental health services to support mainstreaming for those with severe mental health problems.
- Specialist teams of dual diagnosis workers should provide support to mainstream mental health services where possible
- All staff in assertive outreach teams must be trained and equipped to work with dual diagnosis, and adequate numbers of staff in crisis resolution, early intervention, community mental health teams and inpatient services must also be suitably trained.

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20 Ministry of Justice/Department of Health. A guide for the management of dual diagnosis for prisons. London: Department of Health 2009.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_097695](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097695)

21 Department of Health (2002) Mental health policy implementation guide: Dual diagnosis good practice guide, London.

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4009058](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009058)

- All services including drug and alcohol services, must ensure that clients with severe mental health problems and substance misuse are subject to the Care Programme Approach and have a full risk assessment.

For mild to moderate mental health conditions:

- Evidence shows that many people within substance misuse treatment have mild to moderate mental health problems, and it is recommended that this group is managed within specialist substance misuse services and/or primary care.
- Mental health services should provide support, consultancy and training to substance misuse services in caring for people with less severe mental health problems.

## 2.5 Recent developments in Brighton & Hove

The Sussex Partnership NHS Foundation Trust developed a dual diagnosis strategy in 2011, for implementation over the next five years. The strategy has seven key themes and objectives. Key actions include:

**Dual diagnosis champions:** A network of dual diagnosis champions has been established within the trust in Brighton & Hove. (See 'Workforce' chapter).

**Webex pilot:** A pilot is also underway to provide further support for mental health and substance misuse practitioners working with dual diagnosis patients to discuss service users on their caseload with senior colleagues via a 'webex' – a live pre-booked forum for support, guidance, information and signposting.<sup>22</sup>

**Benzodiazepine prescribing:** A programme of local initiatives to reduce benzodiazepine prescribing has been set up recently, and a small decrease in the prescribing rate has been seen in recent months. However for people with dual diagnosis, benzodiazepines can be an important part of care and reducing prescribing for this group may not always be appropriate.

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22 Sussex Partnership NHS Foundation Trust. Webex dual diagnosis peer support and facilitation forum. <http://www.sussexpartnership.nhs.uk/gps/dual/support-forum>

### **3. Who is at risk and why?**

#### *Key points:*

#### *The relationship between mental health and substance misuse:*

- *Mental health and substance misuse problems frequently coincide*
- *Various mechanisms have been proposed to explain the relationship between substance misuse and mental health problems, and the relationship between the two is very complex*
- *Comorbidity can occur at any level of severity; it is not confined to 'serious mental illness'*
- *Substance misuse is most commonly associated with depression, anxiety and schizophrenia, but it also occurs in people with other mental health disorders*
- *Alcohol problems are common among people with bipolar disorders, schizophrenia and personality disorders*
- *People with comorbid mental health and substance misuse problems can have poorer treatment outcomes.*
- *Personality disorder is strongly associated with an increased risk of alcohol or drug dependence*

#### *Mental health and substance use disorders can coexist in several forms:*

- *A primary psychiatric illness precipitating or leading to substance use, misuse, harmful use, and dependent use, which can also be associated with physical illness, and affect social ability.*
- *Substance misuse, harmful use and dependent use may worsen or alter the course of a psychiatric illness, and physical health problems.*
- *Substance use, intoxication, and/or substance dependence may lead to psychological symptoms, which may or may not amount to a diagnosis, and to social problems.*
- *Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses, physical illness and social dysfunction.<sup>4,23</sup>*

#### *Who is at risk and why?*

- *There are no routinely available national or local data available on the prevalence of dual diagnosis*
- *The definition of dual diagnosis varies widely and therefore there are wide variations in prevalence estimates*
- *The prevalence of mental health problems among clients of drug and alcohol services has been estimated at between 50-85%. The most common problems are depression and personality disorder*
- *The prevalence of substance misuse problems among patients in mental health services has been estimated at between 30-80%*
- *The prevalence of comorbid mental health and substance misuse problems has increased in recent years*
- *An estimated 75% of prisoners have a dual diagnosis, and it is particularly common in female prisoners*
- *An estimated 56,000 people in the UK are experiencing multiple needs*

*and exclusions relating to mental illness, drug and alcohol problems, homelessness and offending*

- *Dual diagnosis is more common in deprived areas, but it has been suggested that the rate is increasing more rapidly in affluent areas.*

*People with dual diagnosis are very vulnerable:*

- *They often experience problems relating to education, employment, economic hardship, accommodation, social isolation, and personal relationships*
- *They are at increased risk of experiencing domestic violence and sexual abuse, and women with dual diagnosis are particularly vulnerable*
- *Their general health may be poor and they are at increased risk of poor health outcomes including long term physical health problems, self-harm and suicide*
- *They may decline to readily engage with services and are more likely to be non-compliant with treatment*
- *They have a high risk of contact with the criminal justice system and imprisonment*
- *People with mild learning disabilities have a high risk of mental ill health, particularly anxiety and depression, higher levels of substance misuse than their peers, and are especially vulnerable.*

### **3.1 The relationship between substance misuse and mental health**

It is recognised that mental health problems and substance use often coincide, and the relationship between the two is very complex. There is considerable debate about the influence of substance use on mental illness, and it is difficult to ascertain whether substance misuse is a cause of mental illness, or simply exacerbates or triggers an existing condition. The relationship between the two is very complex; substance misuse, including intoxication, harmful use, dependence and withdrawal can lead to or exacerbate psychiatric or psychological symptoms. Conversely, mental ill health, psychological morbidity and psychiatric disorder can lead to the use of substances, harmful use and dependence.<sup>23</sup>

In practice the diagnosis of psychiatric illness in a person who is misusing substances is difficult, and substance use or withdrawal may result in symptoms similar to those of a psychiatric condition. The mental health condition may only be diagnosed once the patient is substance free unless a clinician knows a patient well.<sup>24</sup> This further complicates the study of comorbidity.

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23 Crome I, Chambers P, Frisher M, Bloor R, Roberts D. Social Care Institute for Excellence. The relationship between dual diagnosis: substance misuse and dealing with mental health issues. Research Briefing 30. January 2009.

<http://www.scie.org.uk/publications/briefings/briefing30/index.asp>

24 Frisher M, Collins J, Millson D, Crome I, Croft P. Prevalence of comorbid psychiatric illness and substance misuse in primary care in England and Wales. J Epidemiol Community Health 2004;58:1036-1041.

Establishing which problem began first is complicated; individuals may present at different stages of intoxication or withdrawal, may be dependent on several substances, and may develop psychiatric symptoms or illness as a result of this. Concerns have been expressed by some authors about the possibility of individuals with comorbidity being excluded from services, for example due to a focus on establishing which condition came first, or the nature of comorbidity leading to exclusion, for example if criteria for accessing mental health services exclude those who misuse substances.<sup>23</sup> This can prevent a difficult-to-engage group from approaching services in the future.<sup>4</sup>

Investigating the temporal relationship between mental health conditions and problematic substance use requires long term data to assess causal relationships. It is important to note that while an increased prevalence of substance misuse may be associated with an increased prevalence of dual diagnosis, this does not mean that there is a causal relationship between substance misuse and mental illness, it may simply mean that more people with mental health problems have access to drugs.<sup>25</sup>

### **Specific associations**

Substance misuse is most commonly associated with depression, anxiety and schizophrenia, but it also occurs in people with eating disorders, post-traumatic stress, attention deficit disorders and memory disorders.

People with severe and enduring mental illness are three times as likely to be alcohol dependent as the general population. Up to 10% of problem drinkers have severe mental illness, 50% have a personality disorder & up to 80% have neurotic disorders.<sup>26</sup>

An estimated 40% of people diagnosed with psychosis have also misused a substance at some point in their lifetime.<sup>27</sup> A recent study investigated the lifetime prevalence of substance dependence among people with schizophrenia in 9 European centres. It found that rates of comorbidity were highest in the UK; 35% of people with schizophrenia reported dependence on a substance, 26% alcohol dependence and 18% drug dependence.<sup>28</sup>

Personality disorder is strongly associated with an increased risk of substance misuse disorders. A recent US study among people with cannabis or alcohol dependence found that those with personality disorders had poorer treatment

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25 Frisher M, Crome I, MacLeod J, Millson D, Croft D. Substance misuse and psychiatric illness: prospective observational study using the general practice research database. *J Epidemiol Community Health* 2005;59:847-850.

26 Safe in the City. Alcohol Intelligent Commissioning Pilot: Alcohol Needs Analysis. Brighton & Hove 2010.

[www.bhlis.org/resource/view?resourceId=1051](http://www.bhlis.org/resource/view?resourceId=1051)

27 National Institute for Clinical Excellence. Clinical guideline (CG120) Psychosis with co-existing substance misuse. March 2011. <http://www.nice.org.uk/guidance/CG120>

28 Carra G, Johnson S, Bebbington P, Angermeyer MC, Heider D, Brugha T et al. The lifetime and past-year prevalence of dual diagnosis in people with schizophrenia across Europe: findings from the European Schizophrenia Cohort (Euro SC). *Eur Arch Psychiatry Clin Neurosci* 2012. PMID 22427152.

outcomes, with an increased risk of the disorder persisting for at least 3 years.<sup>29</sup>

Alcohol problems are frequent among people with bipolar disorders, schizophrenia and personality disorders. People who are dependent on opiates often use other substances, and affective disorders and personality disorders may occur in cocaine users.<sup>23</sup> 'At-risk drinkers' (defined as >20g pure alcohol consumption per day for women and 30 g for men) in a German study had double the risk of psychiatric disorder compared to moderate drinkers and abstainers. The risk was greatest for those with alcohol dependence. Female at-risk drinkers were twice as likely as males to have a psychiatric disorder.<sup>30</sup>

A US study published in 2011 investigated the 'self medication' hypothesis, and reported that people with anxiety who used drugs or alcohol to deal with their symptoms were at up to 5 times greater risk of developing substance use disorders than those who did not self-medicate. The researchers estimated that 10% of new cases of alcohol dependence and 28% of new drug dependence cases were attributable to self-medication of anxiety. In those with mild anxiety, self-medication with alcohol was associated with a doubling of the risk of developing a social phobic disorder.<sup>31</sup> Other studies have suggested that substance use can lead to the development of anxiety disorders, that substance use worsens psychiatric symptoms and the biological effects of withdrawal from substances can mimic anxiety disorders.<sup>32,33</sup>

The primary source of information on the prevalence of both treated and untreated psychiatric disorders in Britain is the Adult Psychiatric Morbidity Survey (APMS). The most recent APMS took place in 2007. This is a structured survey based on interviews with adults living in private households, involving assessments using diagnostic criteria and screening instruments for a range of mental disorders, as well as questions on general health, service use, risk factors and demographics.<sup>34</sup> The results showed that among people with cothymia (comorbid anxiety and depression), there was a high

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29 Hasin D, Fenton M, Skodol A, Krueger R, Keyes K, Geier T et al. Personality disorders and the 3-year course of alcohol, drug and nicotine use disorders. *Arch Gen Psychiatry* 2011;68(11):1158-67.

30 Bott K, Meyer C, Rumpf HJ, Hapke U, John U. Psychiatric disorders among at-risk consumers of alcohol in the general population. *Journal of Studies on Alcohol* 2005;66(3):246-253.

31 Robinson J, Sareen J, Cox B, Bolton J. Role of self-medication in the development of comorbid anxiety and substance use disorders: a longitudinal investigation. *Arch Gen Psychiatry* 2011;68(8):800-807.

32 Tomlinson KL, Tate SR, Anderson KG, McCarthy DM, Brown SA. An examination of self-medication and rebound effects: psychiatric symptomatology before and after drug relapse. *Addict Behav* 2006;31(3):461-474.

33 Schuckit MA. Comorbidity between substance use disorders and psychiatric conditions. *Addiction* 2006;101(suppl 1):76-88.

34 The NHS Information Centre. Adult psychiatric morbidity in England, 2007. Results of a household survey.

<http://www.ic.nhs.uk/webfiles/publications/mental%20health/other%20mental%20health%20publicatio ns/Adult%20psychiatric%20morbidity%2007/APMS%2007%20%28FINAL%29%20Standard.pdf>

prevalence of alcohol (39.7%) and drug dependence (19.9%).<sup>34</sup> There were strong associations reported between antisocial personality disorder (ASPD) and drug or alcohol dependence. Borderline personality disorder was also strongly associated with drug dependence. However this is not surprising because the harmful use of alcohol and drugs contributes to a diagnosis of personality disorder.

The UK General Practice Research database (GPRD) has been used to examine the relationship between substance misuse and mental health.<sup>24</sup> This database includes all significant morbidity recorded by GPs in England and Wales, and has been shown to be a relatively accurate record of psychiatric diagnoses. The GPRD depends on diagnoses of conditions recorded by GPs, and this data therefore represents a minimum estimate of the true burden of dual diagnosis in the community as it does not include cases which do not have contact with primary care.<sup>24</sup> A study of new diagnoses of substance misuse and psychiatric illness made between 1993 and 1998 concluded that while only 0.2% of psychiatric illness was attributable to substance use, a more substantial proportion (14.2%) of substance misuse was attributable to psychiatric illness. Patients with substance misuse were 1.5 (95% CI 1.48-1.62) times more likely to develop psychiatric illness during the 5 year period than without, and those with psychiatric illness were twice (95% CI 1.99 to 2.02) as likely to develop substance misuse. The authors concluded that the increase in prevalence of comorbidity (dual diagnosis) during the period was not attributable to increasing substance misuse.<sup>25</sup> The study took place at a time when the prevalence of substance misuse was increasing, and it found that the prevalence of 'comorbidity' increased by 62% during the study period, and the increase was greater among men (79%) than women (44%). By the end of the study the period prevalence was 80 per 100,000 person years of exposure; the male:female ratio was 1.4:1, and the average age of cases had fallen from 38 years to 34 years.

There were variations in the rate of increase according to the psychiatric diagnosis – the prevalence of comorbid psychoses rose by 147%, while there were also large increases in comorbid schizophrenia (128%) and paranoia (144%). The authors estimated that the rate of comorbidity was increasing by about 10% per year, and the average general practice would encounter 11.3 potentially chronic comorbid cases (defined as comorbidity continuing for the years subsequent to diagnosis) per year by 2003.

### **3.2 The prevalence of dual diagnosis**

Estimating the prevalence of dual diagnosis is difficult and depends on the definition used. Most studies are based on surveys among people who are already in contact with mental health or substance misuse services, and therefore do not tell us about the prevalence of dual diagnosis among the general population. In addition many studies do not include problematic alcohol use in their definition of substance misuse, or focus only on specific mental health conditions and substances.

National estimates suggest that dual diagnosis is common in treatment services: a third of patients in mental health services have a substance

misuse problem, and around half of patients in drug and alcohol services have a mental health problem, most often depression or personality disorder.<sup>35</sup>

There has been an increase in the prevalence of comorbid mental illness and substance misuse problems in recent years. This has been attributed to a range of factors including the de-institutionalisation of patients with serious mental health problems and increasing management within the community, coupled with an increase in substance misuse in the community. As a result there is greater heterogeneity in the presentations of people with dual diagnosis.<sup>3,36</sup>

Nationally, in comparison to drug misuse & treated mental illness, there is more widespread social & regional variation in the prevalence of dual diagnosis. Comorbidity is more common among patients from practices in deprived areas than those in affluent areas. However it has been suggested that the rate is increasing more rapidly in affluent areas.<sup>25</sup>

A study in Bromley in 2002 estimated the prevalence of dual diagnosis in various mental health and substance misuse treatment settings and found that the highest prevalence was in substance misuse services, where 83% of clients had a dual diagnosis (93% in the alcohol service and 91% in the drug service). This was followed by forensic services (56%), psychiatric in-patients (43%), community mental health clients (20%), and primary care settings (8%). Among mental health clients, 48% were assessed as having an alcohol use disorder, and 48% for a drug use disorder, predominantly cannabis and cocaine powder. In terms of mental health problems among substance misuse clients, neurotic disorders were the most prevalent, with 55% of substance misuse clients assessed as having generalised anxiety disorder, 43% agoraphobia and 41% depression. Diagnoses such as psychosis and suicidality were more prevalent among mental health clients, particularly those in forensic or inpatient settings. Compared with others in mental health or substance misuse treatment services, clients with a dual diagnosis had more complex needs relating to increased likelihood of personality disorder, physical health problems, violent behaviour, lower quality of life and overall level of disability, and greater risk profiles. These needs were greatest among those with problematic use of more than one substance. Predictive factors for dual diagnosis included criminal involvement, risk behaviour and poorer quality of life. Those screening positive for dual diagnosis were predominantly young, male and unemployed, and no significant differences in ethnicity were observed. The researchers concluded that the prevalence of mental health and substance misuse problems is such that they must be seen as 'core' needs for any client presenting to the services, rather than unusual needs, and therefore assessment must be routine.<sup>37</sup>

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35 Rethink. Dual Diagnosis Toolkit <http://www.rethink.org/dualdiagnosis/pdfs/Toolkit.pdf>

36 Banerjee S, Clancy C, Crome I. Co-existing problems of mental health and substance misuse (dual diagnosis). An Information Manual. Royal College of Psychiatrists 2002. <http://www.dualdiagnosis.co.uk/uploads/documents/originals/PracManualRCpsych.pdf>

37 Strathdee G et al. Dual diagnosis in a primary care group – a step by step epidemiological needs assessment and design of a training and service response model. Department of Health/National Treatment Agency 2002.

### The 'COSMIC' Study

The "Co-morbidity of Substance Misuse and Mental Illness Collaborative Study" (COSMIC) in 2002 aimed to estimate the prevalence of co-morbid substance misuse and mental health problems among patients of substance misuse and mental health services in four inner-city areas in England. Among substance misuse clients, 75% of those in drug services and 85% in alcohol services had been diagnosed with a psychiatric disorder in the past year.<sup>38,39</sup> The prevalence of specific mental health problems among substance misuse clients in this study is shown in table 2.

**Table 2: COSMIC study: Estimated prevalence of mental health problems among substance misuse patients.**

Condition	% of drug treatment population (95% confidence interval)	% of alcohol treatment population (95% confidence interval)
Psychiatric disorder	75% (68.2-80.2)	85% (74.2-93.1)
Non-substance-induced psychotic disorders	8% (4.7-12.3)	19% (10.4-31.4)
Personality disorder	37% (30.6-43.9)	53% (40.1-66.0)
Depression &/or anxiety disorder	68% (60.9-73.8)	81% (68.6-89.6)
Severe depression	27% (21.1-33.3)	34% (22.3-47.0)
Mild depression	40% (33.7-47.1)	47% (34.0-59.9)
Severe anxiety	19% (14.0-24.9)	32% (20.9-45.4)

Among mental health clients, the study found that 44% of community mental health team (CMHT) patients reported problem drug use or harmful alcohol use in the past year (Table 3).

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38 Weaver T et al, 2003. Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. *British Journal of Psychiatry* 2003;183(4):304–313.

39 Weaver T, Charles V, Madden P, Renton A. Co-morbidity of substance misuse and mental illness collaborative study (COSMIC). Drug Misuse Research Initiative/Department of Health 2002. [http://dmri.lshtm.ac.uk/docs/weaver\\_es.pdf](http://dmri.lshtm.ac.uk/docs/weaver_es.pdf)

**Table 3: COSMIC study: Use of substances by Community Mental Health Team patients**

Substance	Use in the past year by community mental health team patients (%)
Harmful alcohol or drug use	44% (38.1-49.9)
Any drug use	31% (25.5-36.6)
Harmful alcohol use (AUDIT ≥8)	26% (20.5-31.0)
Cannabis	25% (20.2-30.7)
Dependent cannabis use	12.8% (9.1-17.2)
Sedatives/tranquillisers	7% (4.7-11.2)
Crack cocaine	6% (3.3-9.1)
Heroin	4% (2.0-6.9)
Ecstasy	4% (2.0-6.9)
Amphetamines	3% (1.5-6.0%)
Cocaine	3% (1.2-5.5)
Opiate substitutes	1.4% (0.4-3.6)

As shown in table 3, the most commonly used substances among mental health clients were alcohol and cannabis.

There was substantial geographical variation in the prevalence of substance misuse and mental health problems among CMHT and substance treatment populations between the study sites, two of which were based in London and the others in Nottingham and Sheffield. While the study is several years old and based exclusively in inner-city areas it does provide evidence that the burden of comorbidity in these settings is high. They noted that treatment populations were heterogeneous and responding to the range and level of need is challenging.<sup>38,39</sup>

### **Other evidence**

People with mental illness often experience more than one problem, for example anxiety and depression are common among people with schizophrenia, and psychosis. There is some evidence that rates of anxiety and depression among people with psychosis are higher in those who also have substance misuse problems.<sup>40</sup> People with psychosis have much higher rates of alcohol and substance misuse than the general population; the prevalence of substance misuse in the past year among people with psychosis is estimated at 25%, and having dual problems is associated with complications such as increased severity of symptoms, suicide, poorer compliance with treatment, non-adherence to medication, more hospitalisations, violence, homelessness and victimisation.<sup>41</sup>

40 Hartley S, Haddock G, Barrowclough C. Anxiety and depression and their links with delusions and hallucinations in people with a dual diagnosis of psychosis and substance misuse: A study using data from a randomised controlled trial. *Behaviour Research and Therapy* 2012;50:65-71.

41 Barrowclough C, Haddock G, Wykes T, Beardmore R, Conrod P, Craig T et al Integrated motivational interviewing and cognitive behavioural therapy for people with psychosis and comorbid substance misuse: randomised controlled trial. *BMJ* 2010;341:c6325.

An Australian study in 2011 investigated the risk of developing alcohol dependence within five years of a range of mental health diagnoses. It found that a diagnosis of affective disorder was associated with a five-fold increased risk of developing alcohol dependence within 5 years of onset; for bipolar disorder the risk was increased seven-fold; and for generalised anxiety disorder three-fold. In addition, social phobic and post-traumatic stress disorder (PTSD) were associated with an increased risk of alcohol misuse, but not dependence.<sup>42</sup>

### **Risks associated with dual diagnosis**

Compared with others in mental health or substance misuse treatment services, people with a dual diagnosis are at increased risk of a range of poor health outcomes including long term physical health problems, self-harm & suicide. Other risks include homelessness & social isolation, disrupted family relationships, domestic violence, unemployment & imprisonment. The National Audit of Violence, carried out by the Healthcare Commission and the Royal College of Psychiatrists identified drug and alcohol use as the main trigger for violence in mental health services.<sup>43</sup>

People with a dual diagnosis are more likely than those with either a mental health or substance misuse problem to have experienced difficulties with education, employment, accommodation, sexual abuse, personal relationships, general health and neurological damage.<sup>3</sup> They are at risk of homelessness: it is estimated that 18% of rough sleepers have a mental health need combined with a substance misuse issue.<sup>13</sup> They are also more likely to be non-compliant with treatment than others with either a mental health or substance misuse problem, and substance misuse problems have been identified as a major trigger for violence within mental health services. People with severe and enduring mental health problems are more likely than the general population to have significant physical health problems,<sup>47</sup> and having substance misuse problems increases the risk further.

Women with mental health and substance misuse problems are particularly vulnerable. Women who use substances are more likely than men to have a partner with a substance misuse problem, more likely to have experienced trauma related to physical and sexual abuse and more likely to have ongoing mental health problems.

### **Making Every Adult Matter coalition**

The Making Every Adult Matter (MEAM) coalition of third sector organisations Clinks, DrugScope, Homeless Link and Mind estimated in 2009 that there were around 56,000 people living in the UK who were experiencing multiple needs and exclusions relating to mental illness, drug and alcohol problems, homelessness and offending. This estimate was based on extrapolation from

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42 Liang W, Chikritzhs T. Affective disorders, anxiety disorders and the risk of alcohol dependence and misuse. *Br J Psychiatry* 2011;199:219-224.

43 Royal College of Psychiatrists, Healthcare Commission. *The National Audit of Violence (2003-2005)*. May 2005.

<http://www.rcpsych.ac.uk/PDF/OP%20Nat%20Report%20final%20for%20Leads.pdf>

the prison and homeless population, and was intended as a snapshot. The report noted that estimating the number of people in this population is very difficult and no studies have developed a robust estimate of the number of people with multiple needs and exclusions of this nature.<sup>44</sup>

A vision paper published recently by the MEAM coalition and the Revolving Doors Agency suggested a new approach for tackling multiple needs and exclusions. It notes that "...most public services are designed to deal with one problem at a time and to support people with single, severe conditions, and as a result, professionals often see people with multiple needs (some of which may fall below service thresholds) as 'hard to reach' or 'not my problem'."<sup>45</sup> The report focuses in particular on those who are excluded from services because they either have needs which do not quite meet thresholds for services, or because an eligible need is complicated by other problems, and notes that this group is often excluded from adult social care because local teams traditionally targeted at issues such as age, disability and mental health all see the person with multiple needs as someone else's problem. The report recommended that local leaders should make tackling multiple needs and exclusions a priority, and that Council leaders, local authority chief executives and directors and senior commissioners across drug, alcohol, health, housing and criminal justice services all have a role to play.

### **3.3 Criminal justice and prisons**

People with a dual diagnosis are at increased risk of contact with the criminal justice system, both compared to the general population and to others with mental health problems. They are at risk of violent behaviour, and of becoming the subject of violent behaviour including domestic violence, particularly women. They may also become involved in criminal activity or sex work to fund their substance problem.<sup>3</sup>

Consequently, the prevalence of mental health problems is significantly higher among prisoners than the general population, and it has been estimated that 90% of prisoners have a diagnosable mental health problem (including personality disorder) and/or substance misuse problems.<sup>47</sup> Some have very complex problems, such as personality disorder combined with another mental health problem, which is complicated further by alcohol and/or drug misuse. The prevalence of dual diagnosis among the prison population has been estimated at 75%.<sup>46</sup> The prevalence of learning disability among offenders in the UK is estimated at between 1% and 10%.<sup>47</sup>

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44 Making Every Adult Matter. A four-point manifesto for tackling multiple needs and exclusions. 2009. <http://www.meam.org.uk/wp-content/uploads/2009/09/MEAM-report.pdf>

45 Making Every Adult Matter. Turning the Tide: a vision paper for multiple needs and exclusions. 2011. <http://www.revolving-doors.org.uk/policy--research/policy-projects/vision-paper/>

46 Prison Reform Trust. Prison Fact File December 2011. <http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefing%20December%202011.pdf>

47 HM Government 2011. No health without mental health. Delivering better mental health outcomes for people of all ages. [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_124057.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124057.pdf)

An ONS study demonstrated that 10% of male prisoners had a moderate drug dependency and 40% had a severe dependency. Comorbidity was common, and 79% of male remand prisoners who were drug dependent had at least two additional mental health disorders.<sup>4</sup>

It is acknowledged that improvements are needed in the recognition of mental health problems in criminal justice settings, and this is one of the objectives of the 2011 Cross Government Mental Health Strategy.<sup>47</sup> Offenders in custody or under community supervision often have high health and social care needs, but face difficulties in accessing services.

The Bradley review into offender mental health in 2009 noted that the issue of dual diagnosis is a vital component of addressing the issue of mental health and criminal justice, and stakeholders involved in the review strongly felt that no approach to diverting offenders with mental health problems from prison and/or the criminal justice system would be effective unless it addressed drug and alcohol misuse.<sup>48</sup> The report found that mental health and substance misuse services in prisons do not generally work well together, reflecting the separate approach to mental health and substance misuse policy at national level. It noted that instead of supporting access to services, dual diagnosis was used as a reason for exclusion from services. Personality disorder was found to be an important issue, and a lack of formal provision for people with personality disorder was identified as a key problem. The prevalence of personality disorder among the prison population has been estimated at 10-13%, and an evaluation of prison mental health in-reach services in 2009 found that 26% of service users had a dual diagnosis involving serious mental illness and either personality disorder or substance misuse, and 16% had personality disorder alone.<sup>49</sup> The Bradley report concluded that 'despite the recognised high prevalence of dual diagnosis among offenders with mental health problems, services are not well organised to meet this need. In fact, services are currently organised in such a way as to positively disadvantage those needing to access services for both mental health and substance misuse/alcohol problems.'

A review of women and the prison system in 2007 found that while drug addiction is an important influence on offending, this was disproportionately the case for women. Mental health problems are far more prevalent among women in prison than in the male prison population or in the general population.<sup>50</sup>

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48 The Bradley Report. Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. April 2009. [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_098698.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf)

49 Shaw J et al, 2009. A national evaluation of prison mental health in-reach services. Offender Health Research Network. <http://www.ohrn.nhs.uk/resource/Research/Inreach.pdf>

50 The Corston Report. A review of women with particular vulnerabilities in the prison system. London: The Home Office. <http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf>

A study of women in prison in 2006 found that 78% of women in custody had a mental health problem, more than five times the prevalence among women in the general population. 16% had self harmed in the month before imprisonment. Substance misuse was also common; 75% had of female prisoners had used an illicit drug in the six months before prison, and 58% reported daily drug used over that period, most commonly crack cocaine, heroin, cannabis and benzodiazepines. The study also found that women coming into prison had very poor physical, psychological and social health, and this was worse than that of women in social class V, the group within the general population who have the poorest health.<sup>51</sup>

### **3.4 Physical health and dual diagnosis**

Physical health and mental health are closely related and problems frequently coexist. 50% of people with depression or anxiety have long-standing physical disorders, compared with 30% of the general population while 25% of people with long term physical conditions also have mental ill-health. Long term physical conditions are associated with increased risk of mental health problems. For instance, depression occurs in approximately 20% of people with a chronic physical health problem. Studies show that rates of depression are double in diabetes, hypertension, coronary artery disease and heart failure, triple in end-stage renal failure, chronic obstructive pulmonary disease and cerebrovascular disease and seven times more common among those with two or more chronic physical conditions compared to healthy controls.<sup>52</sup>

Chronic physical health problems can both cause and exacerbate depression, and the reverse also occurs, with depression predating physical health problems that go on to become chronic.<sup>52</sup>

### **3.5 Learning disabilities**

Estimates vary widely but the risk of mental ill health for people with mild learning disabilities has been reported at between 35-75%, and anxiety and depression are particularly common. This group also has higher levels of substance misuse than their peers. People with learning disabilities that have these additional problems are very vulnerable and are at risk of abuse and exploitation, and involvement in criminal activity. This can be a challenging group to support and traditional recovery models may not be appropriate for these clients.<sup>53</sup>

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51 Plugge E, Douglas N, Fitzpatrick R. The health of women in prison study findings. University of Oxford; 2006. <http://www.publichealth.ox.ac.uk/research/prison/2007-02-13.6702780065>

52 NICE. Depression in adults with a chronic physical health problem. The NICE Guideline on treatment and management. Royal College of Psychiatrists and the British Psychological Society, 2010. <http://www.rcpsych.ac.uk/files/samplechapter/NICEdepressionCPHP-SC.pdf>

53 NHS Brighton & Hove and Brighton & Hove City Council. Joint Strategic Needs Assessment for Adults with Learning Disabilities. March 2011. <http://www.bhlis.org/needsassessments#L>

### 3.6 Young people

For young people, emotional and behavioural disorders are associated with an increased risk of experimentation, misuse and dependence.<sup>54</sup>

A national survey in 2007 found that 11% of Australian young adults (16-24 years of age) met criteria for an alcohol use disorder (AUD), and those with AUDs were at greater risk of reporting another drug use disorder, an anxiety disorder, risky levels of consumption, and disability. Despite this, mental health services were rarely used by young adults with AUDs.<sup>55</sup> Work in New Zealand suggested that alcohol abuse or dependence increased the risk of major depression in young people aged 17-25 years.<sup>56</sup>

### 3.7 Military veterans

While there is not specific data regarding the prevalence of dual diagnosis among military veterans, they are at increased risk of substance misuse and alcohol misuse compared with the general population.<sup>57</sup> The prevalence of certain mental health problems is higher among veterans than the general population, including depression and anxiety, and Post-Traumatic Stress Disorder (PTSD), particularly among Reservists.<sup>58</sup> Veterans are also at greater risk of homelessness than the general population.<sup>59</sup>

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54 Department of Health. Mental health of children and young people in Great Britain. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH\\_4118332](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4118332)

55 Mewton L, Teesson M, Slade T, Grove R. The epidemiology of DSM-IV alcohol use disorders among young adults in the Australian population. *Alcohol* 2011;46:185-191.

56 Fergusson DM, Boden JM, Horwood LJ. Tests of causal links between alcohol abuse or dependence and major depression. *Arch Gen Psychiatry* 2009;66:260-266.

57 Iversen A, Nikolaou V, Greenberg N, Unwin C, Hull L, Hotopf M et al. What happens to British veterans when they leave the armed forces? *European Journal of Public Health* 2005;15(2):175-184.

58 Fear NT, Jones M, Murphy D, Hull L, Iversen AC, Coker B et al. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. *Lancet*. 2010 May 22;375(9728):1783-97.

59 Royal British Legion Literature review: UK veterans and homelessness. [http://www.britishlegion.org.uk/media/31582/LitRev\\_UKVetsHomelessness.pdf](http://www.britishlegion.org.uk/media/31582/LitRev_UKVetsHomelessness.pdf)

## **4. The level of need in the population of Brighton & Hove**

### *Key points:*

- *Brighton & Hove has a high prevalence of mental ill health, drug and alcohol use, and also has high rates of self harm, suicide and drug related deaths. This suggests that the rate of dual diagnosis in the city is also high.*
- *There is limited recording of dual diagnosis within NHS services in the city, in part due to the complexity of defining the condition.*
- *Data from mental health and substance misuse treatment services give a perspective on the level of dual diagnosis being detected and recorded by services; however this only provides a minimum estimate of the need relating to dual diagnosis in the city.*
- *Between 10-50% of clients within mental health services have a dual diagnosis recorded. This is below national estimates and is likely to reflect issues with data quality. The highest proportion of recorded dual diagnosis is among clients of the Assertive Outreach Team.*
- *At least 15% of people in drug treatment have a dual diagnosis. This has increased from 3% in 2005/06. Again, this is below the number suggested by national estimates and may be due to data quality.*
- *Substance misuse clients with dual diagnosis are more likely to have a risk assessment which considers them at risk of suicide, self neglect, violent behaviour or opiate overdose.*

### *Suicides and drug-related deaths:*

- *Of 26 suicides recorded in Brighton & Hove in 2010, 31% had an alcohol problem and 23% a drug misuse problem, and 77% had a mental health diagnosis, indicating a potentially high number with dual diagnosis*
- *Brighton & Hove has one of the highest rates of drug related deaths in the country*
- *Of 35 drug related deaths in 2010, seven were suicides and fewer than five had recorded mental health issues. However this is likely to represent a minimum estimate of the number of people with mental health, or potential dual diagnosis issues.*

### *Housing:*

- *The rate of homelessness in Brighton & Hove is high, at 3.7 per 1000 population, significantly above the England and South East rates and the rate of rough sleeping is thought to have risen recently*
- *A high proportion of people living in hostels report a need to manage mental health and substance misuse issues – the proportion varies between hostels but is up to 60% in those which take the most chaotic clients*
- *A recent snapshot analysis of referrals for mental health accommodation placements indicated that 73% of clients had a dual diagnosis.*

- *Among people in mental health accommodation placements, it is estimated that over 40% also have problems with substances, in particular alcohol.*
- *A recent review of mental health accommodation concluded that there is an increasing population in the city with dual diagnosis needs, particularly involving multiple drug use with alcohol. It also noted that there is a gap in accommodation provision for people with mental health issues and learning difficulties.*

*Criminal justice:*

- *10% of people detained during a recent Mental Health Court pilot scheme were identified as potentially requiring support for mental health, learning disability or substance misuse problems.*

*Learning disabilities:*

- *Mental health and substance misuse have been identified as significant needs among people with learning disabilities in Brighton & Hove, and it is likely that there is a burden of unmet need among people with learning disabilities and unrecognised mental health or substance misuse problems*
- *A recent JSNA for learning disabilities recommended specialist provision locally for people with learning disabilities and additional needs including mental health and substance misuse problems.*

*Lesbian, Gay, Bisexual and Transgender (LGBT) communities:*

- *A survey among LGBT communities in Brighton & Hove suggested high levels of need for support with mental health issues (39%) and complex substance misuse problems involving both drugs and alcohol (37%).*

There is no routine prevalence data for dual diagnosis available at either national or local level. This is partly due to the complexities of defining dual diagnosis, and the fact that it includes two or more conditions. There are separate prevalence estimates available for mental health conditions, and for substance misuse in our local population, however this does not tell us how many people have both conditions.

We know from treatment services approximately how many people in the city are being treated for a dual diagnosis. However this only gives an impression of met need, and does not provide an insight into unmet need.

#### **4.1 Mental Health in Brighton & Hove**

The Joint Strategic Needs Assessment for 2012 in Brighton & Hove found that emotional health and wellbeing, including mental health, was one of the highest impact social issues in the city.<sup>60</sup>

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60 Joint Strategic Needs Assessment, Brighton & Hove. 2012. <http://www.bhlis.org/jsna2012>

The prevalence of mental illness in Brighton & Hove is generally higher than the average for England. This is true for both common problems and severe mental illness.

**Table 4: Mental health in Brighton & Hove and England**

Prevalence		Brighton & Hove		England
		Number	Rate per 1000 population	Rate per 1000 population
Adults on a GP register for Serious Mental Illness in 2011 <sup>61</sup>		3,230	10.8	7.9
Adults on a GP register for depression in 2011 <sup>62</sup>		29,491	120	110
Any neurotic disorder (16-74)*		36,323	192.4	166
Mixed anxiety and depression (16-74)*		20,493	108.5	89
Generalised anxiety disorder (16-74)*		9,252	49.0	45
Panic disorder (16-74)*		1,859	9.8	6.5
Depressive episode (16-74)*		4984	26.4	
<b>Service use<sup>62</sup></b>				
Adults in contact with NHS inpatient, outpatient and community mental health services (2010)		13,754	68	33
Emergency hospital admissions (2008/09 to 2010/11)	For mental health problems		4.0	2.2
	For unipolar depressive disorders		0.9	0.3
	For schizophrenia, schizotypal and delusional disorders		0.8	0.4
	For self-harm		3.4	2.1
Adults receiving care under a Care Programme Approach (CPA) **			7.8	6.4
Number of patient contacts by Outpatient and Community Psychiatric Nurses/year			230	169
Total patient contacts by mental health staff/year			375	313

\*Data from National Psychiatric Morbidity Survey (2006), among adults aged 16-74 years<sup>63</sup>

\*\* The Care Programme Approach is a way of coordinating community mental health services for people with severe and enduring mental health problems, and involves a comprehensive assessment and care plan for each patient.

61 NHS Information Centre Indicators. Compendium of population health indicators. Mental health and behavioural disorders. Accessed 2012 October. Available at URL:

<https://indicators.ic.nhs.uk/webview/>

62 Community Mental Health Profile 2012, Brighton and Hove, North East Public Health Observatory. Accessed April 2012 at: [www.nepho.org.uk/cmhp](http://www.nepho.org.uk/cmhp)

63 National Psychiatric Morbidity Survey. London: Department of Health; 2006. Accessed 2012 April. Available at URL: <http://www.data4nr.net/resources/1120>

Table 4 shows that Brighton & Hove has a significantly higher proportion of people on GP registers for Serious Mental Illness (SMI) or depression than the England average. The most detailed information about the number of adults affected by specific problems in the city is available from the National Psychiatric Morbidity Survey, which was last carried out in 2006. It also showed that the city prevalence of most mental health conditions was well above that of England.

Brighton & Hove also has very high rates of health service use for mental health problems; it had more than double the England rate of adults in contact with NHS inpatient, outpatient and community mental health services in 2010; has very high rates of emergency hospital admissions for mental health problems; mental health staff have high numbers of patient contacts each year, and the rate of people receiving care under the Care Programme Approach is higher than average.

Brighton & Hove has the second highest rate in England of prescribing for benzodiazepines, and the rate is significantly higher than other nearby or comparator areas.<sup>64</sup> Long term benzodiazepine use is associated with an increased risk of falls and fractures, road traffic accidents, memory loss, confusion, cognitive impairment, ataxia, low mood and insomnia.

### **Self harm**

Brighton & Hove has very high rates of self-harm, which is an indicator of emotional & mental distress. Self-harm is one of the top five reasons for acute hospital admission nationally, most commonly due to self-poisoning. Those who self-harm have a one in six chance of repeat attendance at A&E within a year, & there is a significant & persistent risk of future suicide following an episode of self-harm.<sup>65</sup>

In 2010/11 the rate of emergency hospital admissions for self-harm in Brighton & Hove was 341.6/100,000, significantly worse than the England (211.1) & South East (199.1) rates.<sup>62</sup>

### **4.2 Substance misuse**

The impact of drug misuse on the city of Brighton & Hove is well documented. The Brighton & Hove Drug Treatment Needs Assessment 2012-13 indicates that there are 1,440 clients in drug treatment, of which 557 were new referrals into treatment (figures for October 2010 to September 2011).<sup>66</sup> A third of this client group have been in treatment for over four years. The city has a relatively high number of people in drug treatment compared to the national average; 7.8 per 1000 people in Brighton & Hove were in drug treatment in

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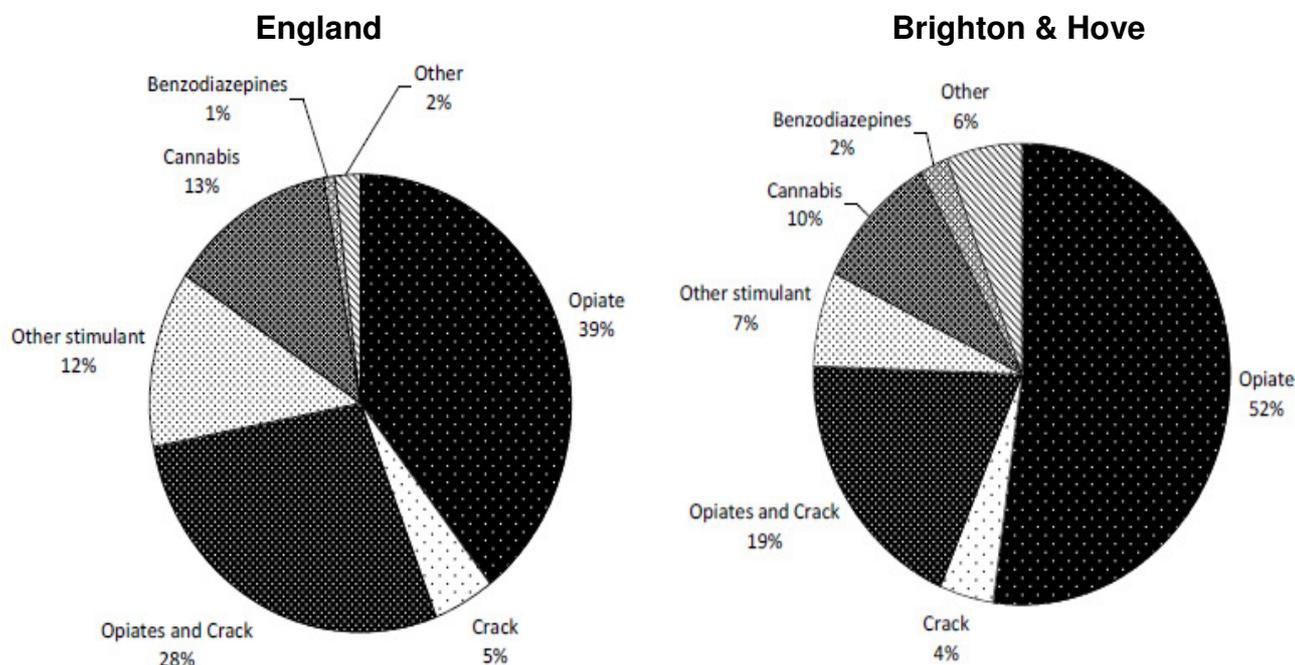
64 Joint Strategic Needs Assessment. Brighton & Hove 2012. <http://www.bhlis.org/jsna2012>

65 Department of Health (2012) Improving outcomes and supporting transparency. Part2: Summary technical specifications of public health indicators. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_132358](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358)

66 Brighton & Hove Drug and Alcohol Action Team. Substance Misuse (Drugs) Needs Assessment 2012-13. [www.bhlis.org/resource/view?resourceld=1111](http://www.bhlis.org/resource/view?resourceld=1111)

2009, which is more than double the South East rate (3.39 per 1000) and significantly above the national rate (5.46 per 1000).<sup>62</sup>

**Figure 1: New presentations to substance misuse treatment during 2011, by substance, England and Brighton & Hove.**



Source: Brighton & Hove DAAT

Figure 1 shows that compared with the national dataset of referrals into treatment, Brighton & Hove has a higher proportion of opiate users, and fewer users of crack, opiates and crack, other stimulants and cannabis.<sup>66</sup>

### 4.3 Alcohol

Alcohol is an important public health problem in Brighton & Hove and for most indicators relating to alcohol, the city is among the worst affected 50 areas in the country, and is significantly worse than the England and regional averages. The rate of alcohol related hospital admissions in Brighton & Hove has been increasing steadily since the beginning of 2010, and for the first 10 months of 2011/12 it increased by 17% compared with the same period in 2010/11.<sup>67</sup>

The 2011 Local Alcohol Profile for Brighton and Hove<sup>68</sup> shows that:

- The number of people requiring treatment for alcohol misuse is high; 4.1 per 1000 people aged 18-75 were receiving treatment for alcohol misuse in 2009/10 compared with 2.5 per 1000 across the South East.

<sup>67</sup> Brighton and Hove Safe in the City Partnership. Strategic Assessment 2011 Alcohol Misuse and Alcohol related crime and disorder. 2012.

<http://www.safeinthecity.info/files/strategic%20assessment%202011.pdf>

<sup>68</sup> LAPE. Local Alcohol Profiles for England 2011. Brighton and Hove City. Accessed 11<sup>th</sup> June 2012. <http://www.lape.org.uk/pctProfile.aspx?reg=q37>

- There are significant social problems relating to alcohol in Brighton & Hove. The alcohol related crime rate was 9.2/1000 population in 2010/11, while regionally it was 5.4/1000.
- Among working age adults, 184.9 per 100,000 were claiming incapacity benefit due to alcoholism in 2010.
- Mortality due to alcohol use in Brighton & Hove is very high; the mortality rate due to alcohol-specific conditions (those which are wholly related to alcohol, such as alcoholic liver disease or alcohol overdose) was 23.7/100,000 for 2007/09, compared to 10.8 at regional level in 2009. This is among the highest in the country, ranking 130<sup>th</sup> of 151 PCTs.
- Alcohol-attributable mortality (which includes conditions that are caused by alcohol in some, but not all, cases, such as stomach cancer) is also high, particularly among women at 26.4/100,000 in 2009, almost double the regional rate of 13, and almost the worst in the country (ranked 150<sup>th</sup> out of 151 PCT areas). Among males the rate is also high, at 48.3/100,000 in 2009, although not significantly higher than the regional rate of 33.1/100,000.
- Hospital admissions due to alcohol are an important challenge for health services in Brighton & Hove; the rate of alcohol-specific hospital admissions is significantly above the regional rate for both men and women. In 2009/10 the rate of alcohol-attributable admissions among men was more than double that at regional level (689/100,000 compared to 329/100,000). The rate for women was also higher (334/100,000 locally vs. 182/100,000 for the South East).
- Among young people under 18, the rate of alcohol-specific hospital admissions is 88.5/100,000, well above the regional rate of 56/100,000 and significantly higher than the national rate.

There are inequalities relating to alcohol use in the city. Alcohol-related attendances at A&E are 50% higher in city residents from the most deprived quintile compared to those in the most affluent quintile of the population. Most alcohol-specific deaths occur as a result of chronic liver disease in adults, rates of which in Brighton & Hove are twice the national average, with most deaths occurring in residents from deprived parts of the city.<sup>67</sup>

The alcohol needs analysis in 2010<sup>69</sup> found that:

- Those living in the most deprived & second most deprived quintiles are most at risk of dying as a direct consequence of their alcohol consumption.
- Longer term alcohol related health problems are seen in increasing numbers of 35-54 year old males being admitted to hospital for conditions such as alcohol intoxication, dependence & harmful use.
- Young men aged 19 to 29 years old were the most frequent group attending A&E for alcohol or assault reasons.

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69 Alcohol Intelligent Commissioning Pilot, Alcohol Needs Analysis, Brighton and Hove Community Safety Partnership, 2010

- those who lived in rented & privately owned property were more likely to drink than those in social housing; LGBT people living in St. James Street & Kemp Town were more likely to drink alcohol than those in other areas
- those who were frequently concerned about their use of alcohol or amount they drank had experienced problems in getting accommodation.

#### **4.4. Service use**

##### **4.4.1 Sussex Partnership NHS Foundation Trust data**

Sussex Partnership NHS Foundation Trust (SPFT) is the main provider of mental health services in Brighton & Hove, and also jointly provides many of the city's substance misuse services, with CRI.

Data on dual diagnosis is not routinely collected within SPFT mental health services. This means that mental health service data for this needs assessment has come from a manual trawl of patient records by staff. However it is recognised within the Trust that data collection should be improved, and a key theme of the recent SPFT Dual Diagnosis strategy is "knowing the dual diagnosis population." There are two outcomes within this theme which are being incorporated into an action plan for SPFT:

- a) Capture, report and analyse dual diagnosis activity data to inform current and future dual diagnosis health and social care provision, training and education requirements.
- b) Clarify the extent of the population across the protected characteristics of those with a dual diagnosis accessing the service to help effectively implement and audit the key priorities and directions identified in the strategy. These should be reviewed regularly with agreed time scales. The information will help the trust maximise effective care provision for dual diagnosis service users and assist in assessing future needs.

The Trust is currently reviewing the mental health and drug/alcohol risk assessment documentation used by inpatient and community service practitioners. It is intended that assessments will include the use of the Alcohol Use Disorders Identification Test (AUDIT) to assess the service user's level of alcohol intake, and drug assessment will provide detailed information about the service user's drug use. Changes are also planned to data collection systems to enable dual diagnosis data to be routinely collected. It is hoped that these developments will improve data collection and aid future needs assessment work in this area.

##### **Snapshot data: Service users in SPFT mental health treatment services from 5<sup>th</sup>-18<sup>th</sup> March 2012**

The data in this section were collected using a combination of methods to determine the number of clients within mental health services with a dual diagnosis.

Health of the Nation Outcomes Scales (HoNOS) are used to measure the health and social functioning of people with severe mental illness. HoNOS is

the most widely used clinical outcome measure within English mental health services.<sup>70</sup> This system is of limited use for dual diagnosis as it was designed to aid mental health assessment, and not for data collection. Secondary diagnoses do not appear on the cluster reports and dual diagnosis may be captured elsewhere with a secondary diagnosis related to dependency or use of substances/alcohol, however this will not be captured by this data source. In addition, the AUDIT tool is currently being introduced for alcohol screening within mental health services, and until it is fully implemented data relating to alcohol misuse will be incomplete.

Data was collected on the number of clients with diagnoses in HoNOS cluster 16, which represents co-existing substance misuse and psychosis, and therefore does not reflect the full spectrum of dual diagnosis within mental health treatment services.

The remaining data was collected through manual trawling of clinical notes by psychiatrists or other qualified mental health professionals and recording dual diagnosis when alcohol and/or substance misuse was negatively impacting on the service user's functioning or wellbeing.

Data may also be collected using ICD-10 codes (a classification system developed by the World Health Organisation for the coding of diseases and other health problems), however these are only completed on discharge from hospital ICD-10 and may only reflect a primary diagnosis. The secondary diagnosis may not have been completed at this stage of assessment and treatment.

Data from these sources was collated for each of the teams within SPFT mental health services.

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70 Royal College of Psychiatrists. What is HoNOS? [accessed 28<sup>th</sup> May 2012]  
<http://www.rcpsych.ac.uk/training/honos/whatishonos.aspx>

**Table 5: Dual diagnosis clients within SPFT mental health services, 5<sup>th</sup>-18<sup>th</sup> March 2012.**

Team	Team Caseload	Co-existing psychosis and substance misuse (HoNOS Cluster 16)	Mental health problems with significant alcohol and drug misuse	Mental health and alcohol	Mental health and drugs	Total 'dual diagnosis'
West Recovery Team	460	25 (5%)	35 (8%)	Not available	Not available	60 (13%)
East Brighton Recovery Team	514	Not available	30 (5%)	50 (10%)	50 (10%)	130 (25%)
Central Recovery Team	663	17 of 395 (4%)	47 of 268 (18%)			64 (10%)
Mental health homeless team	80	<5	Not available	Not available	Not available	11 (14%)
Assertive Outreach Team	116	31 (27%)	22 (19%)	Not available	Not available	53 (46%)
Acute admission wards at Millview**	273	28 (10%)	Not available	Not available	Not available	Not available

\* note rows do not sum as some people will be counted twice within these categories

\*\* Millview inpatient statistics are a snapshot of all inpatients with a HoNOS cluster score of 16 on 27<sup>th</sup> March 2012.

The table shows that the team with the highest proportion of dual diagnosis among their caseload is the Assertive Outreach Team. These proportions are all lower than those suggested in studies of the prevalence of dual diagnosis in treatment services. This may be due to incomplete data, as dual diagnosis is not routinely recorded across all services.

HoNOS statistics were not available for the Mental Health Access team, although anecdotally dual diagnosis is uncommon in this team's caseload.

#### 4.4.2 Substance misuse service data

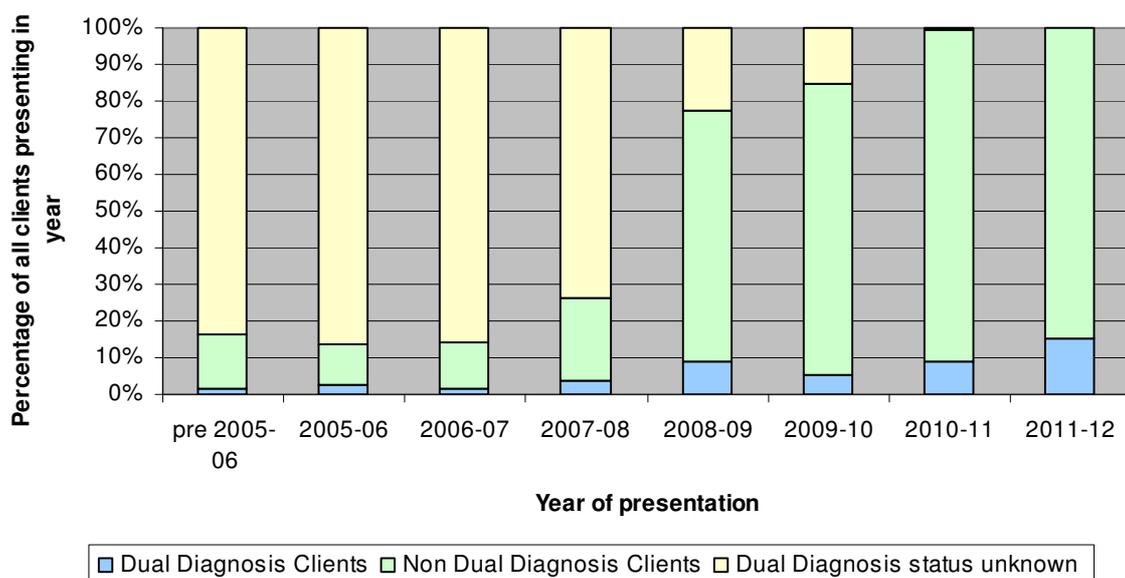
All data in this section were provided by the Brighton & Hove Drug and Alcohol Action Team (DAAT). The DAAT holds the Nebula database, which records details of all clients within the substance misuse treatment system. During the initial Substance Misuse Assessment clients are asked if they are currently receiving care from mental health services for reasons other than substance misuse, and if they disclose this they are recorded on the DAAT's

Nebula system as having a dual diagnosis. This data source therefore relies on a client disclosing this information, and will only include those individuals with a recognised mental health problem receiving treatment. Clients are also asked for permission to share this information with other services, including mental health.

DAAT data shows that between 1<sup>st</sup> October 2010 and 30<sup>th</sup> September 2011 there were 156 clients in substance misuse treatment recorded as having a dual diagnosis, representing 11% of all those in treatment during this period (n=1,440), or roughly 1 in 10 clients. This represents all clients in treatment at any point in the year, so some of these will have been in treatment for several years. This is a much lower proportion than national estimates suggest. There are a number of potential reasons for this. There may be differences in recording practices – national estimates are based on studies carried out in different treatment settings, several years ago, while local service data is collected routinely and may be an underestimate, depending on how different professionals define dual diagnosis. It could also indicate a degree of unmet need among this group, who may either be less likely to access services in Brighton & Hove, or less likely to have their dual diagnosis recognised here.

Figure 2 shows that the proportion of clients in substance misuse treatment with a dual diagnosis recorded has increased from less than 3% of clients in 2005/06 to over 15% in 2011/12. However this data should be interpreted with caution as there have been changes in data collection practices over this period, including the introduction of new assessment forms which explicitly include dual diagnosis, leading to increased recognition and recording of dual diagnosis in recent years. This is shown by the reduction in the proportion of clients with dual diagnosis status unknown. It is therefore difficult to ascertain whether the proportion of clients with dual diagnosis has truly increased or not.

**Figure 2: Proportion of dual diagnosis clients among all clients in substance misuse treatment, 2005-2012.**



**Table 6: Dual diagnosis status of clients presenting to substance misuse treatment services, by year of presentation (2005-2012).**

Year of presentation	Dual diagnosis clients (as % of DD status known)	Non dual diagnosis clients (as % of DD status known)	Dual Diagnosis status unknown (%)	Dual diagnosis (as % of total clients in year)	Total
pre 2005-06	18 (10.0%)	162 (90.0%)	909 (28.9%)	1.7%	1089
2005-06	17 (18.5%)	75 (81.5%)	568 (18.1%)	2.6%	660
2006-07	15 (12.0%)	110 (88.0%)	763 (24.3%)	1.7%	888
2007-08	35 (15.0%)	199 (85.0%)	654 (20.8%)	3.9%	888
2008-09	59 (11.6%)	448 (88.4%)	147 (4.7%)	9.0%	654
2009-10	34 (6.1%)	524 (93.9%)	100 (3.2%)	5.2%	658
2010-11	59 (9.2%)	580 (90.8%)	5 (0.2%)	9.2%	644
2011-12	93 (15.5%)	509 (84.6%)	0 (0.0%)	15.5%	602
	330	2607	3146		6083

An analysis was conducted of the most recent assessment of risk of suicide, neglect, violence and opiate overdose clients within the substance misuse system on 24<sup>th</sup> April 2012. Of 778 clients included 109 clients were recorded as having a dual diagnosis. This risk assessment is carried out as part of the comprehensive overall substance misuse assessment. The data table has been withheld from the published version of the needs assessment because of the small numbers in some categories.

It showed that:

- Although no clients with a dual diagnosis recorded as being at high risk of suicide dual diagnosis clients were significantly more likely to be classed as at medium risk of suicide, with a 1.8 fold greater risk.
- Similarly those with dual diagnosis were more likely to be considered at risk of self neglect, with a 60% greater chance of being at high or medium risk of neglect.
- Fewer than five substance misuse clients were assessed as being at high risk of violent behaviour, and none had a dual diagnosis. However dual diagnosis clients were 70% more likely to be considered to be at medium risk of violent behaviour – although due to the small numbers involved this should be interpreted with caution.

There are several potential explanations for these differences. Dual diagnosis clients in this database are more likely to have a risk assessment which considers them at risk of suicide, self neglect, violent behaviour or opiate overdose. This could be because workers carrying out the risk assessments are more likely to perceive dual diagnosis clients as having these complex problems, or that people with these problems are more likely to be assessed as having a dual diagnosis.

There were 81 clients assessed as being at risk of suicide (6 high risk, 75 medium risk) but who were not recorded as having a dual diagnosis. A dual diagnosis is generally recorded if a client is under the care of mental health services, with a key worker under the Care Programme Approach. The criteria used to assess suicide risk within substance misuse services include previous attempts, having a major psychiatric diagnosis, and suicidal ideation. It is unclear whether this assessment routinely includes liaison with mental health services, and it is possible that some of these clients may have mental health problems which are not identified or recorded within the substance misuse assessment.

**Table 7: Age Distribution of Dual Diagnosis Clients and All Clients in Substance Misuse Treatment 1<sup>st</sup> October 2010- 30<sup>th</sup> September 2011**

Age	Dual Diagnosis Clients		All Clients in Treatment		Proportion with dual diagnosis by age group
	(n)	%	(n)	%	%
<20 years	<5	Withheld	11	0.8%	Withheld
20 – 24 years	10	6.4%	122	8.5%	8.2%
25 – 29 years	25	16.0%	167	11.6%	15.0%
30 – 34 years	35	22.4%	256	17.8%	13.7%
35 – 39 years	23	14.7%	223	15.5%	10.3%
40 – 44 years	26	16.7%	282	19.6%	9.2%
45 – 49 years	21	13.5%	204	14.2%	10.3%
50 – 54 years	13	8.3%	98	6.8%	13.3%
55 – 59 years	<5	Withheld	48	3.3%	Withheld
60 – 64 years	<5	Withheld	18	1.3%	Withheld
65+ years	0	0	11	0.8%	Withheld
	<b>156</b>		<b>1440</b>		<b>10.8%</b>

Table 7 shows that, by age group, the proportion of clients with dual diagnosis is highest among those aged 25-29 years, 30-34 years, and 50-54 years.

**Figure 3: Age profile of clients in substance misuse treatment with and without a recorded Dual Diagnosis, 1<sup>st</sup> October 2010 to 30<sup>th</sup> September 2011**

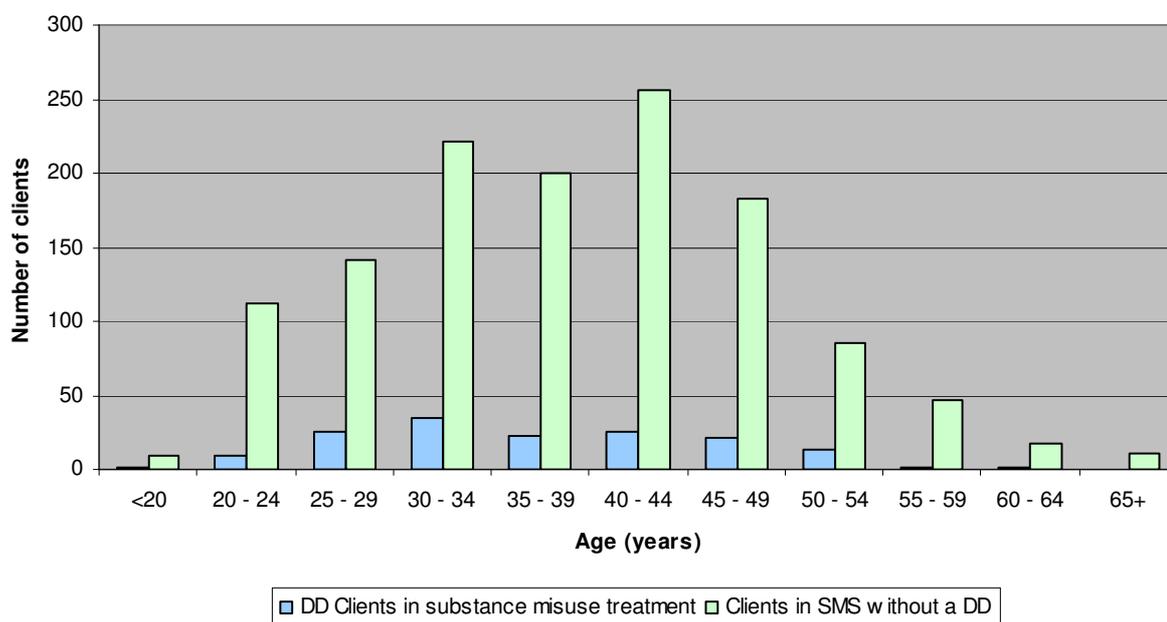


Figure 3 shows that the age profile of clients in substance misuse treatment with a dual diagnosis differs from those without. While the numbers involved are small, clients with a dual diagnosis are on average younger than those without, with a mean age of 36.9 years (median 37 years) compared to a mean age of 38.2 years for the treatment population as a whole (median 29).

### Ethnicity

The majority of dual diagnosis clients in treatment during this period identified as White British (88.5%, n=138), similar to the treatment population as a whole (87.5%). There were very few dual diagnosis clients from other ethnic groups so meaningful comparison cannot be made. However comparing these proportions to the city as a whole shows that the distribution of ethnic groups among those in substance misuse services does not reflect that of the city. In particular only 11.5% of the dual diagnosis population in substance misuse treatment is from a BME group (all ethnic groups except White British), compared to an estimated 16% of the general population of Brighton & Hove (ONS Mid-Year estimates 2007). It is unclear whether this reflects the true ethnic breakdown of those with dual diagnosis needs, or is due to people from BME groups being less likely to access substance misuse services. In addition the small numbers involved mean this proportion is likely to fluctuate each year.

### Sexuality

The number of clients within substance misuse services who identify as homosexual or bisexual is small, however at present the proportion of clients identifying as heterosexual is higher among the dual diagnosis population

than the wider treatment population.<sup>71</sup> Again it is difficult to interpret this due to the relatively small numbers involved.

#### Substances used by people with a dual diagnosis

The Nebula database records the primary drug used by the client. Heroin is the primary drug recorded for 1,006 (72%) clients in substance misuse treatment services, with a slightly lower proportion (66%) among those with a recorded dual diagnosis, although the difference is not statistically significant.

**Table 8: Primary presenting substance, clients in substance misuse treatment between 1<sup>st</sup> October 2010 and 30<sup>th</sup> September 2011.**

Primary substance	Dual Diagnosis Clients		Clients without a dual diagnosis	
	n	% (95% CI)	n	% (95% CI)
Heroin	103	66.0 (58.3 - 73.0)	903	71.6% (69.1-74.0)
Cannabis	16	10.3% (6.4 -16.0)	81	6.4% (5.2 - 7.9)
Other opiates	10	6.4% (3.5 - 11.4)	51	4.0% (3.1 - 5.3)
Crack	7	4.5% (2.2 - 9.0)	34	2.7% (1.9 - 3.7)
Methadone	6	3.8% (1.8 - 8.1)	74	5.9% (4.7 - 7.3)
Benzodiazepines	5	3.2% (1.4 - 7.3)	21	1.7% (1.1 - 2.5)
Cocaine	<5	Withheld	33	2.6% (1.9 - 3.7)
Amphetamines	<5	Withheld	13	1.0% (0.6 - 1.8)
Drug unspecified	<5	Withheld	<5	Withheld
Wines	<5	Withheld	<5	Withheld
Ketamine	<5	Withheld	42	3.3% (2.5 - 4.5)
TOTAL	156		1,261	

Cannabis use as primary presenting substance is more common among those with a dual diagnosis, as are benzodiazepines, crack, and 'other opiates', including buprenorphine and dihydrocodeine. However for all drugs other than heroin the numbers are relatively small so it is difficult to draw conclusions from this. In addition this only includes the substance recorded as the client's primary drug, and clients may be using more than one substance, which is not reflected in this data. There are not clear criteria for determining which substance is a client's primary substance and which is secondary, and there are a number of factors which may influence recording.

#### Time spent in treatment services

Of those clients in substance misuse treatment between 1<sup>st</sup> October 2010 and 20<sup>th</sup> September 2011, 25% of clients with dual diagnosis were discharged from the service, compared to 40% of the wider treatment population. This

71 Brighton & Hove Drug and Alcohol Action Team. Substance misuse (Drugs) Needs Assessment 2012-13.

could suggest that people with a dual diagnosis may remain in treatment for longer.

However comparing the time spent in treatment (Table 9) shows that a higher proportion of dual diagnosis clients have been in the service for less than one year (51.3% vs. 44% among non-dual diagnosis clients).

**Table 9: Total time spent in substance misuse treatment services**

Time in treatment	Clients with dual diagnosis		Clients without dual diagnosis	
	n	%	n	%
<1 year	80	51%	568	44%
1 year	24	15%	188	15%
2 years	<5	Withheld	107	8%
3 years	12	8%	92	7%
4 years	12	8%	92	7%
5 years	8	5%	56	4%
6 to 10 years	14	9%	156	12%
11 to 15 years	<5	Withheld	14	1%
16 to 20 years	0	0%	10	1%
>20 years	0	0%	8	1%
	<b>156</b>		<b>1291</b>	

**Table 10: Housing status of clients in substance misuse treatment services from 1<sup>st</sup> October 2010 and 20<sup>th</sup> September 2011**

Housing status	Dual diagnosis clients		All clients in treatment	
	n	%	n	%
Local Authority (LA) Registered	47	30%	445	31%
Private rented	24	15%	337	23%
Supported housing/hostel	21	14%	121	8%
Direct access short stay hostel	15	10%	82	6%
Social landlord (RSL) rented	12	8%	51	4%
Settled with friends/family	11	7%	105	7%
Live on the streets	9	6%	59	4%
Staying with friends/family as a short term guest	6	4%	91	6%
Sleep on different friends floor each night	<5	Withheld	27	2%
Short term B&B or other	<5	Withheld	14	1%
Owned property	<5	Withheld	63	4%
Missing	<5	Withheld	32	2%
Use night hostels (night by night basis)	<5	Withheld	<5	Withheld
Approved premises	<5	Withheld	7	1%
	<b>156</b>		<b>1,438</b>	

Table 10 shows that the proportion of clients living in Local Authority registered accommodation is similar for those with a dual diagnosis and the wider treatment population. However those with a dual diagnosis are less likely to live in private rented accommodation, and more likely to live in supported housing or hostels, or on the streets. There are several potential explanations for this. The nature of dual diagnosis means that people may struggle to maintain tenancies, and therefore the dual diagnosis population may be less likely to live in privately rented accommodation than others with substance misuse problems. It may be that a dual diagnosis is more likely to be detected and recorded in people receiving statutory support. However again, these numbers are small and represent only a snapshot of the treatment population, and should therefore be interpreted with caution.

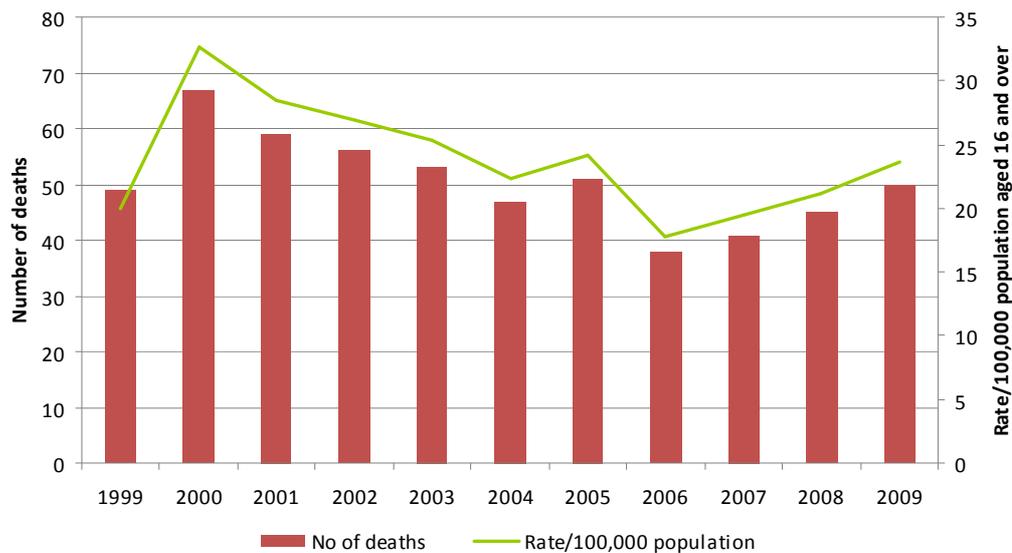
#### **4.5 Drug related deaths**

The recording of drug related deaths is complex and there are several separate datasets where cases in Brighton & Hove may be recorded. Data sources include the National Programme on Substance Abuse Deaths (np-SAD), the Home Office/Office of National Statistics, the South East Observatory (deaths in treatment), and local information from police and substance misuse services. Each uses slightly different case definitions, resulting in variation in the numbers recorded each year in each dataset. There can be a long delay between measurement and publication of the np-SAD and ONS datasets, however these datasets allow comparison to be made with other areas of the country. Locally generated information is available more quickly.<sup>66</sup>

Data from the np-SAD programme consistently show Brighton & Hove as having among the highest rate of drug related deaths in the country. In 2009 there were 50 drug related deaths, or 23.6 per 100,000 people recorded in Brighton & Hove, well above the next highest (East Lancashire 14/100,000). However the prevalence of problematic drug use in Brighton & Hove is not unusually high when compared to other drug and alcohol partnership areas in England (Brighton & Hove is 46<sup>th</sup> highest of 149).

Figure 5 shows that the drug related death rate in Brighton & Hove generally declined from 2000-2006, but subsequently has been increasing steadily in recent years. It remains to be seen whether this trend will continue, however the overall rate remains below the peaks seen in the early part of the decade.

**Figure 5: Drug related deaths in Brighton & Hove, 1999-2009**



Source: National Programme on Substance Abuse Deaths

The np-SAD programme records deaths which are identified as drug related by coroners' reports. These deaths are usually recorded as 'accidental overdose' and generally involve alcohol and sometimes multiple drugs. np-SAD data for 2010 have not been released at the time of writing, but a local audit has been carried out examining reports from the Brighton & Hove coroner, which identified 35 deaths which were identified as drug-related during 2010. This audit found that seven were suicides, of which fewer than five were recorded as suffering from mental health issues. Of the remaining 28, 8 individuals were prescribed psychoactive medication which contributed to their death. While being prescribed psychoactive medication may indicate a mental health problem such as anxiety and depression, there is very little information recorded on mental health in many of these cases. The audit therefore provides a minimum indication of the proportion of drug related deaths among people with mental health problems, because contact with mental health services is not usually recorded on the audit forms, and some mental health problems may not have been recognised.

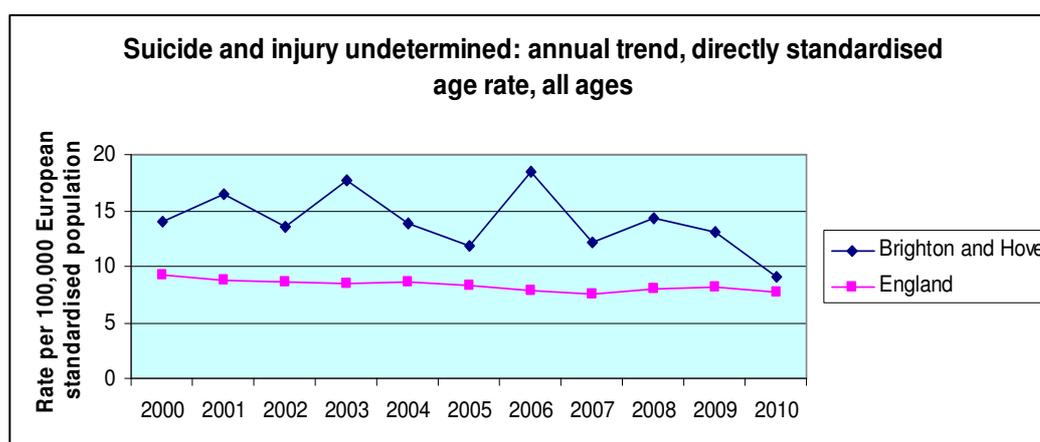
Local police and substance misuse service data are not produced using coroner's reports and do not always correspond with formal data from the np-SAD programme. These local data indicate that there were 25 drug related deaths during 2010 and 30 during 2011. Of these 30, 18 were known to substance misuse services, and 13 were in treatment at the time of their death.<sup>66</sup> It is unclear from this dataset whether any were known to mental health services or had a dual diagnosis recorded.

Deaths that occur in treatment are subject to a Serious Untoward Incident review, and consideration should be given to the role of mental health in this. The 2012/13 Substance Misuse Needs Assessment recommends that information from these reviews is shared across the treatment system.<sup>66</sup> This information sharing should include those working with dual diagnosis clients in mental health services.

## 4.6 Suicides

Brighton and Hove also has one of the highest rates of suicide in the country. Dual diagnosis is a risk factor for suicide, and people with both a mental health & substance misuse diagnosis are particularly vulnerable. Brighton & Hove has had a higher rate of deaths from suicide than the England average for the past century.<sup>72</sup> However, the most recently published data shows a fall in the rate of deaths by 'suicide & injury undetermined' for the city.<sup>73</sup>

**Figure 6: Deaths by suicide and injury undetermined, Brighton & Hove and England rate 2000-2010.**



Based on data for 2008 to 2010, Brighton & Hove is ranked 20<sup>th</sup> among Local Authorities and 7<sup>th</sup> among PCTs in England for deaths by suicide and injury undetermined per 100,000 population (a higher ranking indicates a higher rate of deaths). In 2007-2009 we ranked second among PCTs.

A local audit of suicides which took place in Brighton & Hove found that of 26 suicides recorded in 2010, 31% had an alcohol problem & 23% a drug misuse problem. A high proportion had a mental or physical health problem: 77% had a mental health diagnosis; 69% a history of self-harm; 54% had at least one long term physical condition & 35% were in chronic pain.

## 4.7 Housing

People with a dual diagnosis may experience problems with accommodation, and are at risk of homelessness. People with a dual diagnosis in Brighton & Hove live in a wide variety of accommodation types, from private accommodation to intensively supported housing commissioned by the local authority or the NHS. Some end up homeless, for a variety of reasons, and require support from many different organisations.

The rate of homelessness is high in Brighton & Hove and rates of rough sleeping have risen recently. The rate of homeless households in Brighton &

72 Scanlon T, Memon A, Dorling C, Walker A. 100 years of suicide in Brighton and Hove, England. *J Epidemiol Community Health*. 2011 Aug;65(Suppl 1):A158.

73 NHS Information Centre Compendium. Accessed 2012 Mar 27. Available: <https://indicators.ic.nhs.uk/webview/>

Hove in 2010/11 was 3.7 per 1000 population, nearly three times the South East rate of 1.3 per 1000, and significantly higher than the England rate of 2.0 per 1000.<sup>62</sup> While not all of these people will have a dual diagnosis, many will have substance misuse and mental health issues and these are important risk factors for homelessness.

Substance misuse treatment service data indicates that people with a dual diagnosis are more likely than others in treatment to be homeless. While there are a number of reasons for this, this may contribute to the high rate of homelessness seen in Brighton & Hove, and indicate a need for improved accommodation options for those with mental health and substance misuse problems.

#### **4.7.1. Housing services data**

Outcomes monitoring for the Integrated Support Pathway, April 2008-December 2011

The Integrated Support Pathway (ISP) provides support for single homeless people in Brighton & Hove, and includes a range of accommodation options depending on the support needs of clients. This is covered in detail in section 9 of this document.

When clients enter accommodation via the ISP a Support Plan is developed, which is reviewed at quarterly intervals. Outcomes monitoring records whether the needs identified when the client arrived at the accommodation have been successfully addressed when they leave the service. This information is not collected for all clients: for “Short-Term” services it is intended should be collected for all clients leaving the service, while for “Long Term Mental Health Services” it is recorded for 50% of clients, once a year.

Mental health and substance misuse needs are recorded separately, and dual diagnosis is not routinely monitored. It is important to note that the mental health and substance misuse needs are assessed by a housing professional on entry to the service. Therefore these data do not represent medical diagnoses, and are likely to be an overestimate of the level of dual diagnosis in these settings. In addition, clients with a severe mental health need should be accommodated within mental health services, so those within the ISP are likely to represent those with lower level mental health and substance misuse needs.

**Table 11: Outcomes monitoring for services in the Integrated Support Pathway, April 2008 to December 2011.**

<b>Accommodation</b>	<b>No of Clients</b>	<b>% reporting a need to manage mental health and substance misuse issues</b>	<b>% with a need involving alcohol misuse</b>	<b>% with a need involving drug misuse</b>	<b>% with substance not specified</b>
<b>Band 2</b>					
Glenwood Lodge	149	34%	15%	25%	0%
West Pier Project	158	44%	25%	25%	3%
St Patricks Hostel	82	48%	38%	30%	0%
New Steine Mews	113	58%	33%	37%	4%
All Band 2	867	43%	25%	24%	4%
<b>Band 3</b>					
All Band 3	214	35%	17%	9%	11%
<b>Young People</b>					
Young People's Band 2	235	19%	6%	9%	9%
Young People's Band 3	235	12%	Withheld (<5)	Withheld (<5)	11%
<b>Short Term Mental Health Services</b>					
Short Term Mental Health Services	276	25%	7%	6%	14%
BHT Route 1	67	30%	Withheld (<5)	Withheld (<5)	21%
<b>Long Term Mental Health Services</b>					
All Long Term Mental Health Services	363	11%	3%	2%	7%
<b>All Substance Misuse Services</b>					
Substance Misuse Services	453	41%	30%	32%	0%
BHT SMS	279	42%	24%	37%	0%
St Thomas Fund	128	45%	27%	30%	0%

NB: The percentages in the table do not necessarily sum to 100%, because clients may be recorded as having multiple problems. The table also does not include the YMCA hostels (William Collier House, George William Mews) and Phase 1 – a 52 bed hostel.

Table 11 shows that the Band 2 hostels and the substance misuse services have the highest proportion of clients reporting a need to manage mental health and substance misuse problems. Reporting a need does not necessarily mean that a client has a dual diagnosis, and again this depends on the interpretation and definition of the term dual diagnosis – many of these clients may not have problems which would be considered by mental health or substance misuse services to meet criteria for a dual diagnosis. SPFT mental health clients with a CPN are dealt with by mental health services, and not via the ISP. However this group do present challenges to staff who may not be trained to deal with complex needs of this nature.

## **4.8 Mental health accommodation**

### **4.8.1. Mental health accommodation review** (adapted from ‘Needs Analysis in Brighton & Hove’)<sup>74</sup>

A recent multiagency review of mental health accommodation with support reported on the accommodation pathway and current service provision for service users in Brighton & Hove. The review identified a number of waits and blocks in the system e.g. delayed discharges from hospital and lack of move on to more independent living due to a lack of appropriate accommodation and accommodation with support.

A needs analysis was carried out as part of the review, including a review of the accommodation placements in the city and out of area.<sup>74</sup> Of the 63 residential and nursing home placements in the city, the majority are in residential care homes. A survey among providers of mental health accommodation found that providers felt that 23 (43%) of people within these placements had issues with drugs and alcohol. Of these:

- 18 involved alcohol
- <5 involved illegal drugs, predominantly cannabis
- <5 involved misuse of prescription medication.

In general these clients have a length of stay of under four years, below the average for those in these placements (over 6 years). They are generally representative of the wider residential care population but with additional needs relating to Korsakoff syndrome.

The work also included analysis of referrals to the Mental Health Placement Officer within accommodation services, looking at a snapshot of the caseload on 4<sup>th</sup> October 2011, with the aim of predicting future demand upon accommodation services. This found that of 41 clients, 73% had a dual diagnosis. Of these:

- 57% used multiple drugs including alcohol
- 17% only misused alcohol

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74 Parsonage D. Needs Analysis in Brighton and Hove, January 2012. Brighton & Hove City Council.

- <5 had a learning disability.

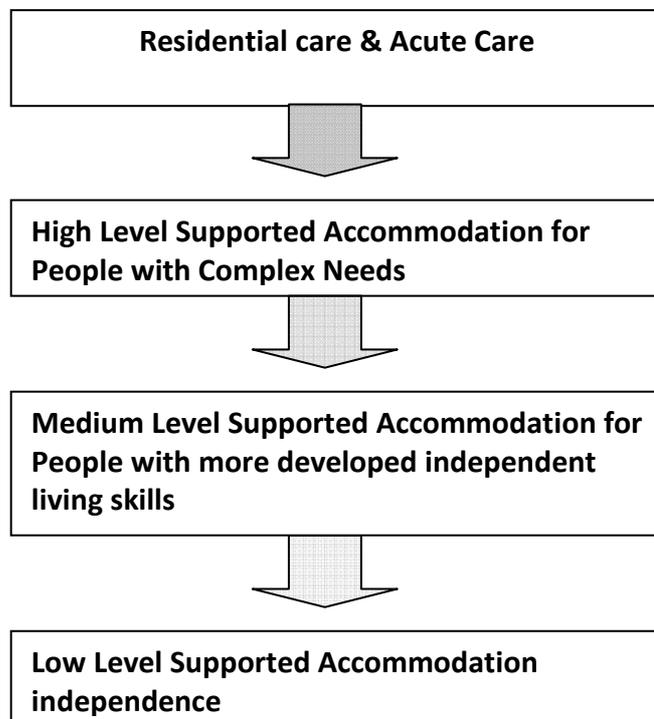
The review concluded that there is an increasing population with significant dual diagnosis, particularly involving multiple drug use with alcohol, and there is a gap in provision for people with mental health issues and learning disabilities.

The review made a number of commissioning recommendations including:

- Increasing capacity through the different tiers of accommodation with support, and as a priority increasing capacity for those with complex needs including dual diagnosis;
- Improving opportunities for move-on through continuing work with providers and providing more floating and tenancy and support services;
- Developing more consistent unit pricing and flexible contracting arrangements to better meet the needs of people in the city.

As a result a strengthened 'tiered mental health accommodation service' is being developed, providing different levels of support depending on service users' needs. This will aim to improve support for people with multiple complex needs including mental health and substance misuse and improve move on within a timeframe specified in an individuals care plan.

**Figure 7: Tiered mental health accommodation pathway**



#### **4.9 Criminal justice**

A Mental Health Court pilot scheme was held across Sussex in 2010. As part of this Sussex Police completed a snapshot of individuals within their custody suites over a week during October 2011, which showed that of 137 people who were detained and screened, 14 (10%) were identified as potentially requiring support for mental health, learning disability or substance misuse problems.<sup>75</sup>

#### **4.10 Learning disabilities**

The Learning Disabilities JSNA in 2011 identified mental health and substance misuse as significant additional needs among people with learning disabilities in the city. It noted that this group may not be sufficiently supported by learning disability or substance misuse services alone and without the right support may be unable to manage or overcome their substance misuse issues, sometimes staying within substance misuse services and temporary accommodation for years.

Of the 798 people in Brighton & Hove receiving adult social care funding from the Learning Disability budget in 2011/12, 15-20% had significant mental health needs, and at least 1.2% had substance misuse problems. This is lower than the national estimates, indicating that it is likely that there are a high number of adults with learning disabilities and mental health problems that are undiagnosed. The needs assessment suggested there is a need for specialist provision locally for people with learning disabilities and additional needs, including mental health or substance misuse problems, to improve support and reduce need for costly, out of area care placements.

Recommendations included:

- expanding the range of supported living options to meet the needs of people with mild learning disabilities and additional needs such as mental health and substance misuse problems.
- reviewing how young people with learning disabilities and mental health problems are identified and supported to reduce the risk of mental health problems in adulthood.
- Continuing to train mental health, primary care and specialist learning disability staff in how to care for people with learning disabilities and mental health problems.
- Improving links between mental health and learning disability teams.

#### **4.11 Lesbian, gay, bisexual and trans (LGBT) communities**

LGBT people surveyed by Supporting People in 2003/4 had high levels of need for support with mental health issues (39%) and complex substance misuse problems involving both drugs and alcohol (37%).<sup>76</sup>

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75 Sussex Health and Criminal Justice Liaison Scheme. Business case – Liaison and diversion service/Alternatives development.

76 Brighton & Hove City Council. Supporting People Strategy 2008-2011.  
[http://www.brighton-hove.gov.uk/downloads/bhcc/SP\\_strategy-Final.doc](http://www.brighton-hove.gov.uk/downloads/bhcc/SP_strategy-Final.doc)

The Count Me In Too research project investigated the experiences of LGBT people in Brighton & Hove during 2006, and included specific research relating to mental health, and drug and alcohol use.<sup>77</sup> It found that of 643 respondents, almost one in five described their mental health over the past year as poor or very poor. Half of respondents had taken illegal drugs, or legal drugs without prescription or medical advice, and 85% said that they drink alcohol.

The survey found that some LGBT people used drugs or alcohol as a 'coping mechanism' in response to discrimination, but that those who didn't drink alcohol were more likely to have experienced difficulties with mental health, suicide and homelessness than those who did drink alcohol. However, those who had used illegal drugs, or legal drugs without a prescription in the past five years were more likely to report mental health difficulties than those who had not (76% vs. 61%).

LGBT people reporting mental health difficulties were more likely to have used illegal drugs or legal drugs without prescription/medical advice, and to be concerned about the amount they drink, than those without mental health difficulties.

Serious thoughts of suicide were more frequently reported among LGBT people who had used drugs than those who hadn't (21% vs. 14%) as was attempted suicide. The use of certain drugs including cannabis, GHB, crystal meth and ketamine was associated with an increased chance of serious suicidal thoughts.

The survey also found that respondents experiencing mental health difficulties were 3.5 times more likely to feel that they wanted more control over their drug use than those without mental health difficulties.

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77 Browne K, McGlynn N, Lim J. Count Me In Too – drugs & alcohol additional findings report. 2009. University of Brighton & Spectrum.  
[http://www.realadmin.co.uk/microdir/3700/File/CMIT\\_DrugAlcohol\\_AF\\_Report\\_August09.pdf](http://www.realadmin.co.uk/microdir/3700/File/CMIT_DrugAlcohol_AF_Report_August09.pdf)

## **5. Projected needs in Brighton and Hove**

There is very limited data available to assess the trend in prevalence of dual diagnosis either nationally or locally, and no recent estimates indicating whether this is changing.

A study in primary care in England & Wales in 2004 estimated that the prevalence of comorbid psychiatric illness & substance misuse was increasing by 10% each year, & at a higher rate among younger patients.<sup>78</sup> However it is unclear whether this occurred, and whether the prevalence is continuing to increase.

National trends show that over the last 20 years there have been large increases in rates of drug dependency, including young people dependent on cannabis. This, coupled with the increasing prevalence of common mental health disorders such as anxiety & depression suggests that dual diagnosis could be increasingly recognised.<sup>79</sup> However quantifying any increase is very difficult with currently available data.

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78 Frisher M et al. Prevalence of comorbid psychiatric illness and substance misuse in primary care in England and Wales. *J Epidemiol Community Health* 2004;58:1036-41.

79 National Mental Health Development Unit. Briefing 189. Meeting the challenge of dual diagnosis. <http://www.nmhd.org.uk/silo/files/seeing-double-meeting-the-challenge-of-dual-diagnosis.pdf>

## **6. Views of service users**

### *Key points:*

- *Dual diagnosis is consistently identified as a priority area of need in consultation with substance misuse service users*
- *Service users consistently report that there is a lack of support for people with dual diagnosis, and care pathways are not clear for this client group*
- *The most recent consultation indicated that these issues continue, and only a third of respondents felt there was good support for dual diagnosis in Brighton & Hove, and that more support was available than had been previously.*

### *Specific issues raised regularly include:*

- *A need for more staff trained specifically in working with dual diagnosis clients, in both substance misuse and mental health services*
- *A lack of awareness of available support and services, among both staff and service users*
- *The need for a clear, accessible care pathway for dual diagnosis in the city*
- *Insufficient support for people with dual diagnosis moving on from treatment services*
- *An absence of partnership working between services.*

An annual service user consultation is carried out by the service user engagement worker for substance misuse services. In addition a regular group is held specifically for service users with a dual diagnosis, to provide peer support and also for consultation about services.

Dual diagnosis is consistently raised as a priority area of need in consultation with substance misuse service users.

### **6.1 Service user consultation: 2009**

In 2009 the consultation included a specific question about dual diagnosis. Participants felt that there should be:

- One keyworker for all services used, instead of several.
- Less personal information sharing between workers and more confidentiality.
- More help and support for dual diagnosis clients within Tier 4 substance misuse services.

When asked specifically about the barriers to accessing dual diagnosis treatment and support, the following points were made by service users:

- There is not enough support for people with dual diagnosis
- Most dual diagnosis clients are taking medication, however some treatment centres will not allow some medications to be taken

- It is difficult to get an accurate diagnosis / statement – there is a lack of clarity which really doesn't help the client in need
- When discussing dual diagnosis clients, services tend to "pass the buck" - each one is reluctant to take full responsibility for the health of the client and this does not help the client.
- Staff in drug treatment services need more training to work with dual diagnosis clients
- Better co-operation and partnership working is needed between mental health and substance misuse services
- There are different levels of support around dual diagnosis and it was felt that there is good support for dual diagnosis from First Base
- Detox time is too quick from diazepam addiction.

When asked about gaps in alcohol service provision the need for effective dual diagnosis support and an effective strategy to tackle dual diagnosis issues was again raised.

Overall in the 2009 service user consultation dual diagnosis was ranked as treatment priority 3: "Increase funding for substance misuse and mental health support and services – improve access to treatment and services for all service users with substance misuse (drug and alcohol) and mental health problems."

## **6.2 Service user consultation: 2010**

Dual diagnosis was identified as the number 1 priority in consultation with substance misuse service users in 2010: "Developed, accessible identified Care Pathways/support for dual diagnosis clients - A robust strategic partnership approach providing support and service provision across all tiers and wraparound services. Safety net for Move On (dual diagnosis)."

A key priority of the 2010 consultation was: "Dual diagnosis: developing and establishing a strategic partnership approach for dual diagnosis, to steer the operational development of local service provision for complex needs. Agreeing robust care pathways and performance measures for dual diagnosis clients."

In terms of assessments, the CRI St Thomas assessment process was considered robust with good access, however clients reported that having complex needs/a dual diagnosis made accessing the service and treatment particularly hazardous. It was commented across all groups that the support and care pathways urgently needed to be improved for clients with a dual diagnosis and although clients were very happy that both St Thomas Fund and BHT accept clients with complex needs, it was reported that there aren't always staff that have been trained to work with dual diagnosis clients. It was noted that joint agency partnership work and follow on services and support for dual diagnosis clients were particularly noticeable by their absence.

When asked specifically about dual diagnosis support and care pathways in 2010, the following comments were made:

- Overwhelming lack of awareness of dual diagnosis support and care pathways across all cohorts
- “Not enough trained staff for dual diagnosis clients”
- “Dual Diagnosis – There is no support”
- “No support for dual diagnosis in Move On – and especially if asked to leave due to lapse”
- “Needs to be clear pathways for dual diagnosis support”
- “Need safety net for dual diagnosis clients after exits from Tier 4 due to lapse”
- More support for dual diagnosis in prison and on release
- Dual diagnosis support available in BHT DSP and RP – “very good”
- “There is no support at all and it is so desperately needed for so many clients”
- “More info needed – lack of awareness”
- “Need to improve care pathways for dual diagnosis urgently”
- “Staff need training to deal with dual diagnosis clients”
- “There has been an ongoing problem with MH and addiction services joint working”
- “Professionals need experience and training in both mental health and substance misuse”

### **6.3 Service user consultation: 2011**

The 2011 consultation found that there had been some improvements in feedback from the preceding year, however only a third of respondents felt that there was good support for dual diagnosis in the city, and recognised that more support was available than had been previously. However many felt that more support was needed, including more staff trained in working with dual diagnosis. A lack of awareness of available support was identified as a key issue, both among service users and staff. Service users recognised that many clients are unaware of the support and appropriate care pathways available for people with a dual diagnosis. Similarly, it was felt that staff should be more aware of the options available so that they can provide the best advice, information and support to their clients. Dual diagnosis was service users’ priority number 2 for the 2012/13 treatment plan.

Recommended actions from the 2012 consultation were:

- Improve access to treatment and services and available support for all service users with substance misuse (drug and alcohol) and mental health problems.
- Continued work through the Brighton & Hove dual diagnosis steering “project” group to develop dual diagnosis care pathways in the city, dual diagnosis champions training and role, and the implementation of the dual diagnosis strategy action plan.
- Continued access to the Mind dual diagnosis peer support and consultation group and development of other similar groups across the city.

## **7. Views of professionals**

### **Key points**

- *Professionals strongly agreed that there is an urgent need to develop closer working relationships between the range of agencies working with dual diagnosis clients in Brighton & Hove.*
- *Many staff felt that the term 'dual diagnosis' was not appropriate, as this client group generally have a range of complex problems but may not be dually diagnosed, and 'complex needs' was a more appropriate term.*
- *A general lack of joint working between substance misuse and mental health services was noted by many professionals across all services as a barrier to working with this client group, although they believed that joint working was very beneficial for clients.*
- *Staff often have different perceptions of what constitutes a dual diagnosis, and this complicates work with this client group.*

### **Health services:**

- *Most professionals agreed that there are generally clear systems in place for working with people with a serious mental illness and substance misuse problem, with good communication and joint working; however there is less clarity for the quite significant group of people with complex needs involving common mental health problems, and these people are at risk of 'falling through the gaps' between services.*
- *A frequently identified problem was the need for improved information sharing between mental health and substance misuse services. At present neither service can access the other's patient record systems. Staff felt strongly that enabling shared access to information systems, where appropriate, would greatly aid joint working between services.*
- *GPs in Brighton & Hove identified patients with dual diagnosis as a group for whom it was difficult to get services.*
- *A multidisciplinary team approach was considered potentially beneficial for working with his client group. Many of the necessary resources already exist across the system, but they need to work together more effectively. Working with complex needs requires a flexible, well resourced team who can do assertive outreach work with those who are not engaged with services.*
- *Joint assessment and joint care planning can be of great use but is logistically difficult to arrange, as professionals are based at different sites. However this approach can help to reduce duplication, and prevent clients from being passed between different services.*
- *Mental health staff are motivated to work with dual diagnosis clients, but are not always confident in doing so. Reasons cited included a lack of adequate knowledge and training, time pressures, high case loads and a lack of service user engagement.*
- *Staff in mental health services reported that they had insufficient understanding of the services available for this group, and the roles*

*and responsibilities of each service.*

- It was reported that there is not always consistency in terms of the level of substance misuse that would be accepted by mental health services, and clearer referral criteria may help this and aid joint working.*
- There is a need for a care pathway for people with Korsakoff syndrome (a brain disorder resulting from thiamine deficiency, usually relating to long term alcohol misuse).*

#### *Housing:*

- Professionals reported that housing is a challenge for this group, as some clients could be very difficult to place.*
- People with 'lower level' mental health needs and substance misuse problems often end up in the hostels system, and can be very chaotic and challenging to work with.*
- Some hostels have staff specifically trained in working with dual diagnosis clients, but others don't.*
- Many hostels staff do not feel confident in working with this client group, and need more support and training in working with clients with complex needs relating to substance misuse, particularly alcohol, and mental health.*
- Housing professionals believed that there should be more flexibility in the location of health services, which should be able to come to the client where necessary, so clients may be more likely to engage.*
- It was noted that active substance users with mental health needs present a particular challenge, and there is a gap in accommodation provision for this group.*

## **7.1 Primary care**

A survey of Brighton & Hove GPs in 2010 identified patients with dual diagnosis as a group which it was difficult to get services for, and for whom services are not currently being provided for.<sup>80</sup> A new primary care mental health service is being introduced in the city from summer 2012 and will replace the current system for access to mental health services. It is hoped that this will help to address these concerns.

## **7.2 Secondary care mental health services**

A survey was carried out among SPFT Recovery Mental Health team staff in 2010 investigating their experience, knowledge and attitudes regarding substance misuse in service users.<sup>81</sup> In general the survey found that mental health staff felt that understanding the relationship between substance misuse

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80 GP and Primary Care Mental Health Service redesign. GP survey. 2010.

<http://www.brightonhovacitypct.nhs.uk/healthprofessionals/generalpractice/psc/documents/MentalHealthGPsurveyresults.pdf>

81 Eaton S. An investigation into the experience, knowledge and attitudes of recovery team members around service users' problematic drug and alcohol use. MSc thesis, Middlesex University, 2010.

and mental health was vital to their role, and were motivated to work with this client group, but were not always confident in doing so. Participants also highlighted the problems that can arise from not having a clear definition of dual diagnosis, meaning that professionals' views may differ over whether an individual patient has a dual diagnosis.

Participants were asked to highlight barriers that they perceived to be preventing them from achieving an appropriate standard of care for this client group:

- Almost half of respondents reported that time pressures were the main barrier to providing effective care for this group.
- Many staff also cited high case loads, lack of time to reflect adequately on their work, and general work pressures and target levels.
- Communication with, or availability of, the substance misuse services and a general lack of joint working was noted as a further barrier.
- A third of respondents reported that a lack of adequate knowledge or training had an impact on their confidence in working with this client group.
- Lack of engagement from the service users themselves.
- A recurring theme was a lack of understanding of the roles and responsibilities of other statutory and non statutory services for this client group, or difficulty in accessing them,

Respondents suggested a number of opportunities for improvement:

- developing closer working relationships with other agencies through joint meetings;
- more opportunity for discussion of referrals and advice from specialist services;
- Further training, including raising awareness of other services, their roles and responsibilities and referral criteria.

### **7.3 Interviews with professionals**

Semi-structured interviews were carried out during 2012 with a range of professionals involved in working with clients with dual diagnosis in Brighton & Hove. There were some generic issues which arose from the stakeholder interviews. The majority of the professionals interviewed felt that "complex needs" was a more appropriate way of describing clients with problems relating to substance misuse and mental health, as there are many people who have these dual problems but may not be dually diagnosed. In addition it was frequently noted that the complexity of defining dual diagnosis within services, and the differing perceptions of staff within services of what constitutes a dual diagnosis could lead to problems in dealing with this client group. While most professionals agreed that those with a serious mental illness and substance misuse problem fell within the 'dual diagnosis' group, there was less clarity over how to classify people with less severe mental health problems, or transient problematic substance misuse, while recognising that this group could be very challenging for services to work with. There was

confusion from most services over what to expect from other services in relation to working with this group of 'complex needs' clients.

#### Information sharing

The issue of information sharing was a common theme raised by professionals who were interviewed. In particular, access to clinical information for patients being cared for by separate services was an issue.

Mental health services use the Electronic Care Programme Approach (ECPA) system to record all relevant information relating to a client's treatment. The substance misuse services record information on clients in treatment on the Nebula database. There is very limited sharing of information between these systems – staff within substance misuse services are generally not able to access the ECPA system, and those within mental health services cannot access the Nebula system. This makes joint working and a holistic approach to caring for this client group very difficult. However if a number of staff within each service were able to access the other's systems, this could aid the development of joint care planning and prevent duplication of work.

#### **7.3.1 Substance misuse service representatives**

Dual diagnosis within substance misuse services is generally considered to be that which meets the Department of Health definitions i.e. a mental health condition which has met the threshold for secondary mental health treatment, so the mental health service is leading the individual's care. Clients who are under the care of mental health and substance misuse services, and have a CPA, would definitely be considered to have a dual diagnosis. However it was felt that the term dual diagnosis is not always useful and there are many people who have mental health and substance misuse issues outside this definition.

Particular issues were identified with data collection: data from the treatment system includes only those who are recorded as having a dual diagnosis at their initial assessment, however this does not necessarily reflect all of those with true dual diagnosis, or with joint mental health and substance misuse needs.

It was suggested that a pathway is needed from substance misuse back to the Access team, so that people can move from Access into substance misuse while still able to access their mental health service.

Anecdotally there are reports of difficulties dealing with some cases involving more common mental health problems, which may not be classical serious mental health diagnoses, but nonetheless may require mental health support. For the most severe cases, a substance misuse Psychiatrist can determine whether specialist mental health input is required, however there are cases where this is less clear cut and these can be more difficult to manage. However the new primary care mental health service may help to address these issues. It is important that there are staff within this new service that understand complex needs.

### 7.3.2 Substance misuse psychiatry

It was agreed that within substance misuse services, the classic definition of dual diagnosis is clear: it includes those with major psychiatric illness and substance misuse problems. The proportion recorded on the Nebula database as having a dual diagnosis (10-15%) is considered to be quite accurate for this definition. However it was reported that there are a large proportion (70-80%) of substance misuse clients who have mental health problems such as anxiety, phobias, sleep disorders, self harm, reactive mood problems, borderline learning disability and general vulnerabilities. Similarly it is likely that within mental health services, a similar proportion will be casual users of substances such as cannabis and stimulants, or drink too much alcohol.

In general, it was felt that there is good communication and joint working between substance misuse and mental health services for those with classic dual diagnosis involving severe and enduring mental illness. Similarly, mental health services would be unlikely to have problems getting a substance misuse service for this group, and clients can generally be seen quickly. It was felt that there is an area of unmet need among people outside this group i.e. the group that falls outside the strict definition of dual diagnosis but has dual problems, and this is an important issue for GPs.

Referral criteria were raised as an important issue. It was reported that while mental health services in general are good at assessing substance misuse, in terms of management, there is not consistency between the different mental health teams regarding what level of substance misuse they will work with. Some teams will see people who are actively using substances, others require clients to have been stable and off substances for 6 months. The lack of consistent criteria affects referral behaviour. The availability of psychiatrists within substance misuse services can lead to a perception that they should deal with mental health problems within this client group. This can mean that the substance misuse service see people who would be within mental health services if they were not on methadone, for example. However substance misuse services cannot manage mental health risk in the same way as specialist mental health services, and there is not CPN provision, or the ability to oversee mental health medication.

Mental health assessments are carried out within substance misuse service, and patients would be referred to mental health services if necessary. However waiting times can be an issue, and lack of clarity of the referrals that services will accept compounds this. The service may try to refer someone early, to get them onto a waiting list, but there have been instances where referrals are not accepted until the client is stable and have stopped using substances. This has meant that clients can face a long wait if they are unable to join a waiting list until they are stable and off substances. We need a more consistent approach and clarity over referral criteria.

It was noted that dealing with dual diagnosis should include consideration of other needs, such as housing, homelessness, learning disabilities or children in care. A multidisciplinary team approach was considered potentially beneficial for working with his client group, including a social worker,

psychologist, nurse and others. Some of these resources already exist in other teams, for example the Assertive Outreach team, the homelessness and the hostels alcohol nurse, and these could be components of a model to work with this client group. Working with complex needs requires a flexible, well resourced team who can do assertive outreach work with those who are not engaged with services.

In terms of joint assessment and joint care planning, it was noted that this does happen on occasion but is logistically difficult to arrange, as professionals are based at different sites. In practice this would be difficult to do regularly. However this approach can help to reduce duplication, and the issues of 'ping pong' between the different services. Resources would be needed to free up staff to attend CPA meetings, but it was suggested that some of this work could be done remotely, via webinar or WebEx.

Issues relating to data sharing were again noted: very few staff in substance misuse services have access to the ECPA system used to record clinical information in mental health services. Where appropriate, access to this system would be of great use for staff in substance misuse services, to enable them to see what medication clients are on, and share information relevant for joint care. Similarly, mental health staff should have access to the Nebula system where necessary.

### **7.3.3 Mental health professionals**

Staff from secondary care mental health reported that in general these services work to the classic definition of dual diagnosis i.e. severe and enduring mental illness and substance misuse.

There are currently service changes underway in mental health services and these are likely to impact on the way that the service works with substance misuse services. The service is structured into Assessment and Treatment, and a Recovery service, which would see the majority of patients with dual diagnosis.

It was noted that while mental health leads the care of individuals with SMI, if a patient had a serious substance problem they would generally co-work with substance misuse services. The level of co-working depends on the client's willingness to engage with substance misuse services.

Referrals: It was noted that there are currently no specific criteria for the severity of substance misuse which would be accepted by mental health services, or that would prompt a referral to substance misuse services. In some cases this has led to inappropriate referrals from substance misuse services, in particular from CRI workers, who generally have less mental health training than SPFT staff. There are instances where mental health services do not accept referrals for clients who are actively using substances, and this is generally due to clinical need, for example psychological interventions are unsuitable for people who are actively using substances and can increase their risk level. Clearer referral criteria or joint training between mental health and substance misuse professionals may help to address this.

IT issues: Information sharing was noted as an important issue and it was felt that mental health professionals should be able to access the substance misuse computer system where necessary, to aid joint working. Similarly mental health staff agreed that substance misuse professionals should be able to access the mental health ECPA system where necessary. Staff agreed that consideration should be given to improving information links with primary care, including the new primary care Wellbeing service, and potentially also the social care Care First system.

Joint working: Joint working with substance misuse services was seen as very beneficial for clients, but it was reported that generally the services could work more closely with one another. Joint assessments are carried out occasionally and generally work very well. However they can be difficult to arrange when required urgently, but could be done more regularly for less urgent cases. A protocol for joint assessment of people with mental health and substance misuse problems is currently being developed.

One reported barrier to joint working was a general lack of awareness among staff of the basics of how other services work: for example who to contact, the range of services available, and any new initiatives that have been developed. Staff on both sides are very busy and this can also hinder efforts to work together.

Housing was noted as a particular challenge for this group in Brighton & Hove, and they can be very difficult to place in accommodation. Some are frequently evicted from temporary accommodation due to their behaviour and have very limited options once this has happened, so remain in mental health services.

Korsakoff syndrome was raised as an issue for services. Korsakoff syndrome is a brain disorder resulting from thiamine deficiency, usually relating to long term alcohol misuse.

Many clients with Korsakoff syndrome are still drinking heavily and so dementia services are generally unable to see them. They regularly present to A&E and many do not access secondary mental health services. It was reported that there is a need for a clear Korsakoff syndrome care pathway. This affects a relatively small, but growing, number of people.

It was noted that the dual diagnosis champions are a useful initiative as they understand both services, but staff would welcome a more specialist dual diagnosis presence within the mental health teams. In general staff wanted more regular training in working with dual diagnosis clients, as there are frequent changes to services. Increased training in motivational interviewing in particular would also be of benefit for working with this client group, both for dual diagnosis champions and other mental health staff.

Several suggestions were made:

- The development of a 'virtual' dual diagnosis team comprising staff in mental health and substance misuse services, with access to the necessary IT systems.
- Regular multidisciplinary meetings would be very useful, and joint training where appropriate, to build an informal network. However it was reported that time pressures on staff may make this difficult, and would require an individual to lead it.
- Senior staff could be asked to lead on issues relating to dual diagnosis within their service.

### **7.3.4 Housing commissioning representatives**

The lack of joint assessment of an individual's need was identified as a gap in the current system, and it was reported that there should be better links between mental health and substance misuse services, including joint assessments. Anecdotally, there have been instances where inflexibility in the location where mental health assessments may be carried out has been a problem. Mental health assessments carried out in a healthcare setting are may not be accessible for rough sleepers or others within the Integrated Support Pathway. Problems have included health services communicating appointment times to patients by post. Letters sent to hostels may not reach people, and if given a specific appointment time in a healthcare setting clients may not attend. This can result in clients being discharged from the service due to not attending appointments. If mental health assessments could be carried out in a place which is appropriate for the person, for example on the street or in a hostel, clients may be more likely to engage. Health professionals may be reluctant to carry out an assessment on the street for a number of reasons, however other settings such as hostels would be more appropriate than hospital. There are precedents for this type of work – certain health services are already provided at the First Base day centre (BHT), including visits from a GP, nurse and sexual health. A protocol could be developed whereby mental health and substance misuse workers can carry out a joint assessment in an appropriate setting. At present this relies on individual professionals working together to join up the dots.

Most of the mental health supported housing would be very reluctant to take a chaotic substance user as they wouldn't be able to support them. The most chaotic clients usually go to the West Pier project, via the Integrated Support Pathway, but this is based on homeless need not mental health need, so others with a greater homelessness need may take priority. A tiered mental health service has recently been developed to address this.

### **7.3.5 Housing provider representatives**

It was recognised that outcomes monitoring data provides a snapshot of the need among hostel clients but there is a difference between how many clients have a dual diagnosis problem, and how many people tell staff that they have mental health and substance misuse problems. Alcohol was perceived to be an increasing problem in hostels, among both the general hostel population and people with a dual diagnosis.

Work on dual diagnosis in housing has so far remained very separate from the work relating to the SPFT strategy, which is limited to the Trust. Some hostels have staff specifically trained in working with dual diagnosis clients, but others don't.

It was noted that substance misuse services have changed dramatically in the last year and have become more accessible. However there can still be issues with dual diagnosis clients if services believe that mental health issues should be dealt with first. Similarly if mental health services are unable to work with someone due to their chaotic substance use, there isn't a clear plan for where they should go. Hostels end up dealing with people who are very chaotically unwell and need accommodation.

People with a substance misuse and mental health problem who also have a housing need can be challenging to work with. They may be reluctant to engage with services, and if services make it difficult for them to engage the problem worsens. Services for this group have to be taken to the client, some clients will declare that they need help but often people do not acknowledge they have a problem. The hostels alcohol nurse has been a very successful initiative in this respect, working intensively with a small number of clients in each hostel, and people who have been chaotically drinking for decades have engaged with this. Having a clinician available to work with these clients is important, as hostel key workers may not have the expertise to approach these issues with the most problematic, non-engaged clients, and can feel caught in the middle.

There are good models of multiagency working in Brighton & Hove for complex rough sleepers, where rough sleeping is very entrenched and who are not engaging with services. Some, but not all, of this group will have problems relating to dual diagnosis, but not necessarily recognised and diagnosed. A "Safeguarding Hub" made up of a multidisciplinary group of professionals is held weekly, and services can discuss any particular clients they are particularly concerned about. It is intended to work as a 'pre-alert' system to assess the level of risk for the client and develop new approaches to work with them before an alert is raised. This has identified individuals who are not in the substance misuse treatment system and led to referrals.

There can be issues with people potentially developing substance misuse problems while living in Band 2 hostels where there is a high level of substance misuse, and it is important to keep people moving through the Integrated Support Pathway to prevent this. However the goals required to move on from Band 2 may not be sustainable for some people when they move onto a lower level of support in Band 3.

Suggested initiatives included:

- If there are issues with getting mental health assessments in an appropriate environment for rough sleepers it may be possible to use a hostel space for this, for example the First Base day centre.

- Pilot a scheme in which workers trained in mental health and substance misuse go and see clients in hostels.
- Pilot of a hostels dual diagnosis nurse working in a similar way to the hostels drug nurse, with the most complex clients.

### 7.3.6 Hostel managers

General issues which arose from discussion with the managers of hostel accommodation in Brighton & Hove included:

#### 1. Access to services:

- Getting clients into services in the first place can be very difficult. Services generally are reluctant to take this client group on and this discourages clients from addressing their issues. If someone doesn't respond well to treatment they are particularly challenging, sometimes nobody will take responsibility for them and they slip through the net.
- It is often difficult to establish whose responsibility it is to deal with this client group. Services need to respond more quickly, take ownership of a client's care, and work together to progress their care rather than batting them onto another service.
- It can be difficult to get mental health assessments for clients who are actively using substances.
- There were concerns about the response time for services in general. Getting extra support for clients can take several weeks, when a rapid response is needed. An example given was that arranging one to one support for a client can take weeks to arrange so by the time the service starts it is too late.
- It was agreed that ideally services should go into hostels, as this is a difficult group to engage and making them go to the service makes engagement more difficult.

#### 2. Specific problems/vulnerable groups:

- Managers reported that personality disorder is a big problem, and is the "ultimate door closer" for services.
- This client group can be chaotic with a high risk of challenging behaviour and violence, and it is important that services can respond quickly. Sometimes the only option is to call the police, but once the client is released the cycle starts again.
- Within this client group, people with learning disabilities are particularly vulnerable. This group is challenging for specialist learning disability services because they are very different from their main client group. Older people with complex needs are also very vulnerable.
- It is particularly difficult for people with Asperger's and autism to access services. They may not meet criteria for learning disabilities or mental health services, and it is not clear who should support them. Those with a forensic history are generally more likely to get support, and those who have not had criminal justice contact fall through the gaps.

### 3. Issues relating to health services:

- Hostels don't generally have any involvement in joint care planning for clients, and this would be beneficial in some cases.
- The level of partnership working with other services is not formalised and depends on individual workers' motivation.
- Hostel staff are often not aware which services are available and what can be expected of them.
- It was generally agreed that there should be better links between mental health and substance misuse services. Managers suggested that a dedicated link worker or advocacy service would help in this regard.
- Managers felt that this group of clients needs ongoing assessment, as they are too complex for a one off assessment to capture their issues and their capacity. It isn't clear what is needed to get someone a reassessment if required.

It was felt that staff in hostels generally don't have enough training to deal with this client group, particularly in relation to personality disorder and substance misuse. Most have some mental health and substance misuse training but they need training in the basics of how to deal with this group, for example how to approach someone who is delusional.

#### **7.3.7 Oasis Project representative**

The Oasis Project provides specialist support and treatment for women with alcohol and substance misuse problems in Brighton & Hove. The project provides psychosocial interventions and works alongside mainstream substance misuse services provided by SPFT.

There are also specialist services for women offenders, and for children and young people (of any gender) who are at risk due to their mother's substance use. An outreach service is provided to visit women in a variety of settings, including sex workers and the most vulnerable women. Women with a dual diagnosis could access the Oasis project via any of these services.

Approximately 400 women access the Oasis Project's services each year, of which staff estimate that 90% have a mental health need, the majority due to depression and anxiety. Staff would generally see dual diagnosis as involving 'serious mental illness' and not consider this to be the case in clients with depression and anxiety, which may be perceived to be related to their substance misuse. If a client's mental health appears to be deteriorating, they are referred to the Consultant Psychiatrist within the substance misuse service.

Most women with a dual diagnosis will be living in an insecure environment, and are vulnerable, but do not necessarily present as vulnerable, due to a 'survivor mentality'. The experience of domestic violence among women with dual diagnosis is high. Some women who are in violent relationships will move on to another relationship to get away from an abusive partner, often ending up with another violent partner.

Gaps identified are:

- A lack of a joined up approach for dual diagnosis – clients may have a mental health worker but substance misuse staff may not be aware of this or how to work with them. Liaison with mental health services is not routine, and is generally limited to responding to problems when they occur.
- There is a lack of housing provision, particularly temporary accommodation for women. There is no women-specific hostel provision in the city, and this is an issue for substance misuse in general, not just dual diagnosis.
- There should be more grassroots activity to bring people working in different settings together, to discuss issues and learn from each other. Staff may not know what they can expect from other services or what is available.
- For women with complex needs, often the person who has the most contact with them is their hostel worker, and this group of staff often have the least training. The CPN service is a very high level, professional service but it doesn't see clients very often. CPNs should be more accessible to the people who see the clients regularly, for example it would be beneficial to have a CPN attached to a hostel where there are lots of vulnerable people, to provide support to staff.

### **7.3.8 Probation service representative**

Historically, investment in health in the criminal justice system has been in drug and alcohol services, not mental health. Assessments in people with alcohol or substance problems wouldn't focus on mental health; generally the substance problem would be dealt with in isolation. This meant that unless people had a very clear serious mental health problem which would come under the MAPA system (high risk of harm cases) they would not have access to a mental health service at all. The aim of the new Liaison and Diversion scheme is to assess mental health, substance misuse and learning disability needs and intervene early before offending behaviour becomes more serious.

The assessment system seems to be working well; the challenge now is how to get people from the assessment stage into services. There are generally good links with the substance misuse treatment system. For mental health, the process for serious mental illness is more obvious, but there is a lack of a clear pathway for other mental health problems such as depression and anxiety. The threshold for learning disabilities services is very high. Personality disorder is a particular challenge to deal with, clients are very complex and chaotic and tend to move around the system. Access to services is particularly challenging for offenders, who don't engage well.

People on a drug rehabilitation requirement (DRR) or alcohol treatment requirement (ATR) go through the treatment system and have dedicated probation officers who pick up on these issues. They will develop a plan which includes mental health and substance misuse intervention where appropriate – this is where the links with other services are needed.

There is access to primary care treatment through Sussex Partnership NHS Foundation Trust, links with MIND and a specialist women's mental health worker through Brighton Housing Trust. Health Trainers are also involved with the Probation service and can help people to access services where necessary.

The main presenting mental health issues for people coming into court are depression and anxiety, and for substance misuse there are fewer opiate users and more users of other drugs such as casual cocaine users.

Working with dual diagnosis clients involves many organisations, and trying to coordinate provision is challenging. Engaging offenders in services can be difficult, and many are not registered with a GP, limiting access to secondary services. Issues with housing and other complex needs compound these problems.

### **7.3.9 Old Age Psychiatry**

It was reported that there is generally good joint working with substance misuse and Old Age Psychiatry locally. There is generally good information sharing with substance misuse where cases require joint working. If an inpatient needs substance misuse assessment the team will see them on the ward, assess them, attend discharge planning meetings and offer support on discharge. The substance misuse psychiatrist attends weekly case discussions, and can therefore be easily accessed for advice. There can be a delay in accessing substance misuse services in the community.

It was noted that older people may be 'invisible addicts', presenting to hospital with falls or collapse, and their substance problem may not be detected and referred to services. Services need to be aware that assessing elderly people with a dual diagnosis requires an increased awareness of physical health problems, the role of carers and housing, and that lower levels of drugs or alcohol will equate with harm. We need to ensure that assessing older people is included in dual diagnosis training.

## **8. Services working with dual diagnosis clients in Brighton & Hove**

### **8.1. Adult mental health services**

The city performs poorly compared to average for several indicators of provision of mental health care:

- 89% of adults on GP depression registers in 2011 received an initial severity assessment, compared to the national average of 92%.<sup>82</sup> 67% received a follow-up assessment, compared to the national average of 74%.<sup>83</sup>
- 82.5% of patients included on GP Severe Mental Illness registers in 2011 had a comprehensive care plan, compared to 89% for England.<sup>84</sup>

#### **Primary care**

A new primary care mental health and wellbeing service was launched during 2012 across seven GP practices within Brighton & Hove. The service is provided by the Mental Health Partnership, which comprises Brighton and Hove Integrated Care Service (BICS), Sussex Partnership NHS Foundation Trust, and community and voluntary sector organisations Turning Point and MIND. The service will refer to secondary care for assessment and treatment where necessary.

Primary healthcare services for homeless people are provided by Brighton Homeless Healthcare at the Morley Street Practice.

**Secondary care mental health services** in Brighton & Hove are provided by Sussex Partnership NHS Foundation Trust. There are a wide range of different services and teams within SPFT mental health services.

Inpatient mental health services are provided at Millview Hospital.

### **8.2 Adult substance misuse services**

There are four main providers of substance misuse services in Brighton & Hove: SPFT, CRI, Oasis Project and BHT. Drop in assessment clinics are carried out by substance misuse workers, and clients are assigned to one of the services based on their needs. The Care Coordinator role within substance misuse services is similar to a key worker; if a mental health need is flagged up at the assessment then the services will endeavour to assign a care coordinator with experience of dealing with mental health problems, such as a Psychiatric Nurse. These clients would generally be seen by a doctor the

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82 NHS Compendium/illness or condition/mental health and behavioural disorders/ depression/ depression severity at outset of treatment. Accessed April 2012 at:

<https://indicators.ic.nhs.uk/webview/>

83 NHS Compendium/illness or condition/mental health and behavioural disorders/ depression/ further assessment of depression severity. Accessed April 2012 at:

<https://indicators.ic.nhs.uk/webview/>

84 NHS Compendium/illness or condition/mental health and behavioural disorders/mental healthcare and support/ comprehensive care plans for patients on mental health registers. Accessed April 2012 at: <https://indicators.ic.nhs.uk/webview/>

same day, who would assess whether specialist mental health input is required.

There are mental health professionals within the substance misuse services and so the threshold for referral to mental health services is quite high. The threshold for referral from mental health services to substance misuse services is much lower. The assessment process is changing, and the AUDIT tool to assess alcohol use has now been introduced as part of the mental health assessment process. A new care pathway has just been launched involving a feedback loop - whereby if mental health workers in the Access team assess a client who they believe has a drug or alcohol problem, they liaise with substance misuse instead of immediately referring. This is intended to prevent clients from being referred on to substance misuse and potentially being lost in the system.

**Acute substance misuse services** are delivered mainly through a partnership of CRI and the Substance Misuse Service of Sussex Partnership Foundation Trust.

Services include:

No. 11: Open Access Service; Harm Reduction Service

The Open Access service is the main point of contact for initial assessment in order for people to enter the treatment system. It is an open access service providing needle exchange, paraphernalia, condoms and advice and information on any substance issue. Abstinence time is provided on four mornings a week to ensure there are facilities for those who have stopped using and are in need of ongoing support and those who have stopped using and feel they are tempted to use again. Brief interventions are provided for these clients. Friends, families and carers of substance misusers are also encouraged to utilise this service.

Medical intervention is provided daily for people to have their drug injuries treated; to access Hepatitis B vaccinations; and to receive harm reduction advice.

Other services integrated into Open Access include:

- a holding group for those waiting for treatment, filling a gap for alcohol users
- a relapse prevention group
- a peer support group for those leaving treatment
- PATCHED (advice, information and support for friends, families and carers)
- Drug Interventions Programme
- community substance misuse workers, ensuring that those living in the most deprived areas have easy access to mainstream services
- Satellite sessions, provided by the Rough Sleepers Team, Pathways to Health and Working Links

- Outreach sessions, provided to some of the high support hostels to offer Needle Exchange and harm reduction advice. A Needle Exchange service goes out with the Rough Sleepers Team on an early morning street shift, providing an out of hours service to one of the groups at high risk of drug related overdose.
- A training package is offered by the Harm Reduction Team to accommodation providers rolled out through Supporting People services

The Recovery Project, provided by Brighton Housing Trust (BHT)  
<http://www.bht.org.uk/index.php?dir=services/addiction/recovery>

This is a residential drug and alcohol service, providing a therapeutic 12 step programme.

Route 1, provided by BHT

Route 1 provides supported accommodation for people with mental health problems, and works closely with statutory mental health services. Some clients have substance misuse problems, but the service only accepts clients who also have a recognised mental health problem.

<http://www.bht.org.uk/index.php?dir=services/mental%20health/route%201>

St Thomas Fund

The St Thomas Fund provides residential substance misuse treatment, and a structured day programme to prepare people for residential treatment.

A Hostels Alcohol Nurse has recently been introduced to provide intensive support for hostel residents with serious alcohol problems, to try and reduce A&E attendances and hospital admissions due to alcohol.

### **8.3 Women's services**

The Oasis Project provides psychosocial interventions and support for women affected by alcohol and substance misuse. Case studies discussed in the Oasis project's annual reports indicate a high level of mental health need among their clients.<sup>85</sup>

The Inspire network is made up of specialist organisations working together to provide a women-only project where information, support and advice is available on a range of issues including substance misuse problems, mental health, domestic violence and criminal justice. The network includes the Oasis Project, Brighton Housing Trust, Rise, the Survivor's Network and Brighton Women's Centre.

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85 Brighton Oasis Project. Annual reports. <http://www.oasisproject.org.uk/annual-reports.html>

## **8.4 Young people Substance misuse services**

**RU-OK?** is commissioned to provide specialist support for young people with substance misuse problems.

**Young Oasis** is commissioned to provide support for children and young people aged 5-18 years with a family member who is using drugs.

### **Young People's Mental Health services**

Mental health services for young people in Brighton & Hove are provided by CAMHS: Child and Adult Mental Health Service.

Early Intervention in Psychosis is a service for people aged 14 to 35 years old who have had an experience that could be a symptom of psychosis. It is a stand alone multi-disciplinary team comprised of doctors, nurses, social workers, occupational therapists, psychologists, support workers and administrative workers. Anyone can refer to the team: the young person themselves, their family, carer or a concerned acquaintance.

Bridging the Gap: a team of Teen to Adult Personal Advisors (TAPA) is based in Youth Centres in Brighton & Hove. These advisors are trained mental health professionals who provide support for young people who are not accessing mental health services. The service is intended to act as a bridge into adult services, providing a transition service for young people aged 14-24 years. It is not intended to provide long term support, but to provide support for those in transition into adult services. One worker specialises in services for lesbian, gay, bisexual, and transgender (LGBT) young people and one worker has a special interest in Black and Minority Ethnic (BME) young people. Young people can walk into the TAPA service or be referred by another team.

## **8.5 Criminal justice**

Brighton & Hove is a pilot area for the National Pathfinder Offender Health programme, implementing the recommendations of Lord Bradley's report on offender mental health.<sup>48</sup> A Liaison and Diversion service has been developed, to divert offenders away from the Criminal Justice System where appropriate. A single assessment process has been developed to cover suspected mental health, learning disability and/or substance misuse. The aim is to provide early assessment for people detained in custody in Brighton, and nurses are based at Hollingbury Custody suite and Brighton Magistrate's Court to do this. The pilot began on 1<sup>st</sup> April 2012. Diversion pathways are being developed so that vulnerable individuals can be diverted away from the criminal justice system and supported to address their offending behaviour and reintegrate back into the local community.

## **8.6 Housing services and accommodation with support**

People with dual diagnosis may access housing via several routes. General access to Council and Housing Association accommodation is via the Home Move system, in which prospective tenants are assessed according to their housing need and given a priority banding which determines the type of accommodation they may bid for. Need is assessed according to a range of factors, including medical need. Simply having a mental health or substance misuse problem would not be considered a reason for priority access to housing, unless an individual's current accommodation was affecting their health.

Supported accommodation is accessed through:

- Housing options at Brighton & Hove City Council: people with a dual diagnosis who are assessed as having a housing need and a support need are then placed in accommodation via the Allocations Team as appropriate
- The Rough Sleepers Team
- Probation services

People with mental health issues would be placed via the mental health placement officer into supported accommodation after being assessed by Housing Options.

People with substance misuse issues enter supported accommodation (BHT Addiction Services or CRI St Thomas Fund) via the SPFT Substance Misuse Service.

People who are experiencing homelessness and have support needs would be placed in hostel accommodation (Band 2 of the Integrate Support Pathway).

### **8.6.1 Supporting People Programme**

BHCC Housing Commissioning Unit commissions housing related support to a range of people including those with a dual diagnosis, and aims to enable people to achieve and maintain independence. It includes short term services based on an NHS recovery model or a re-ablement model of adult social care, working towards time-limited outcomes to improve independence and enable move-on from services. There are also longer term services based on maintaining life skills and retaining independence for as long as possible.

One of the objectives of the 2008/11 Supporting People Strategy for Brighton & Hove<sup>86</sup> was to enable people living in hostels to tackle alcohol and substance dependence and misuse problems. When the Strategy was written there were 481 people with substance misuse problems living in supported accommodation, 35% of whom also had problems with their mental health. In addition, 38% were single homeless, 19% were ex offenders and 14% had

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86 Brighton & Hove City Council. Supporting People Strategy 2008 – 2011.  
[http://www.brighton-hove.gov.uk/downloads/bhcc/SP\\_strategy-Final.doc](http://www.brighton-hove.gov.uk/downloads/bhcc/SP_strategy-Final.doc)

learning disabilities. The aim of the Strategy was for all hostel residents with a substance misuse problem to be referred for an assessment, to increase the proportion in treatment. It also aimed to reduce homelessness due to mental ill health by developing specialist skills in staff teams to provide dual diagnosis services and ensure services are able to meet the needs of people who have both a substance misuse and mental health problem. Part of this work involved the development of the Integrated Support Pathway to support people at risk of homelessness and this work is ongoing.

The Supporting People Strategy for 2011-15<sup>87</sup> builds on this work and has a number of key priorities and actions relating to mental health and substance misuse. These include:

1. Improving access to services by:
  - developing greater personalisation and choice by reviewing how clients can access different approaches to substance misuse in hostels
  - working with Sussex Partnership NHS Foundation Trust to ensure that clients in the Integrated Support Pathway are able to access psychological interventions available in the community;
2. Flexible services with positive outcomes:
  - supporting the implementation of an alcohol pathway across services so that 'revolving door' clients can receive personalised and specialist support with alcohol issues;
  - enable people with multiple needs such as mental health, substance misuse, learning disabilities, forensic history, physical needs etc. to get the support and housing they need
3. Working towards greater independence:
  - Implementation of the multi agency commissioning plan for a strengthened mental health tiered model of accommodation support with additional support to those with complex needs, including those with a dual diagnosis
  - Establish a multi-agency panel to deliver move-on solutions for older people and clients with complex needs.

### **8.6.2 The Integrated Support Pathway**

The Integrated Support Pathway provides support for single homeless people in Brighton & Hove, with services arranged in bands which describe the type of support they provide. The intention is that as people progress through the pathway they receive a lower level of support, recognising that people may move backwards as well as forwards due to changing support needs. This pathway is currently under review, and a longer term needs assessment of

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87 Brighton & Hove City Council. Supporting People Commissioning Strategy 2011-2015. [http://present.brighton-hove.gov.uk/Published/C00000139/M00003464/AI00022439/\\$SupportingPeopleStrategy20112015HousingCabinet.doc.pdf](http://present.brighton-hove.gov.uk/Published/C00000139/M00003464/AI00022439/$SupportingPeopleStrategy20112015HousingCabinet.doc.pdf)

homeless in planned. This will include a review of current provision and the balance of abstinence and harm reduction service models.

Within the Integrated Support Pathway there are many people with a very wide range of complex needs, including mental health and substance misuse needs, which may not be severe enough to meet thresholds for statutory support. These people would be less likely to be recognised as having a dual diagnosis by the substance misuse or mental health services as they may not have met thresholds for diagnosis of a specific condition. Rough sleepers with mental health and substance misuse problems are unlikely to appear in the statistics from Drugs and Alcohol Action Team or SPFT locally as they are unlikely to be engaged with mental health or substance misuse services.

### **Services in the Integrated Support Pathway**

There are five 'bands' in the Pathway, each offering different levels of support. Service users are expected to move on to the next band within the timeframes shown in figure 8.<sup>88</sup>

Within this pathway there are many different services and service providers. The main services which would be accessed by people with a dual diagnosis are:

#### ***Band 2:***

Brighton & Hove City Council Glenwood Lodge Project  
West Pier Project: This is a 39 bed unit with 25 mental health beds, which generally takes chaotic clients with a history of substance misuse, homelessness, or forensic contact.

#### ***Band 3:***

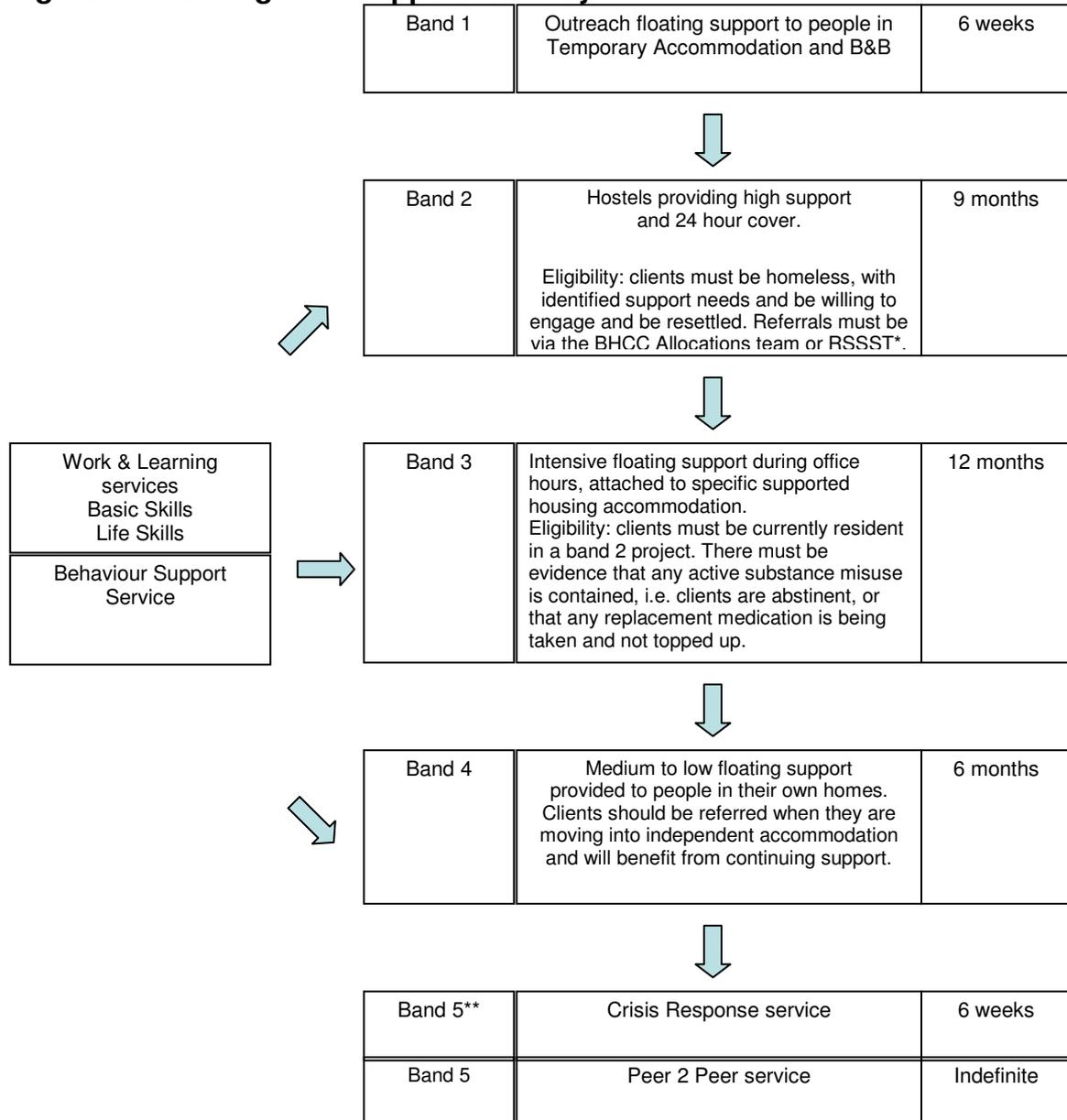
CRI St James Avenue  
Equinox Stanley Road  
Supplementary services: CRI St Thomas Fund.

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88 Adapted from:

[http://www.supportingpeopleinbrightonandhove.org.uk/downloads/spibah/integrated\\_support\\_pathway/ISP\\_summary\\_for\\_service\\_users\\_adult\\_services\\_June\\_07.doc](http://www.supportingpeopleinbrightonandhove.org.uk/downloads/spibah/integrated_support_pathway/ISP_summary_for_service_users_adult_services_June_07.doc)

**Figure 8: The Integrated Support Pathway**



\*Rough Sleepers, Street Services & Relocation Team.

\*\* Band 5 services work to sustain tenancies and prevent homelessness through tenancy crisis intervention, peer support, and support to those returning to work.

### 8.7 The Pathway Project

The London Pathway Project is a model of integrated primary and secondary healthcare for homeless people, focusing on improving care for this group and in so doing, reducing emergency attendances and admissions. This model has been successful at University College Hospital in London, where it led to a reduction in emergency admissions of 3.2 days per homeless person, and a fall in the proportion staying in hospital for more than 30 days, from 14% to 3%, saving an estimated £300,000.

A research study evaluating the effectiveness of the scheme in Brighton & Sussex University Hospital Trust is underway. The model involves training hospital staff in the identification and treatment of homeless patients; improving communication between hospital and community services, weekly multi-disciplinary meetings, and a specially trained GP and nurse working with community and mental health teams.<sup>89</sup>

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<sup>89</sup> Vital. Annual Report of the Director of Public Health Brighton & Hove 2011.  
<http://www.bhllis.org/PHAR2011>

## **9. Evidence of effectiveness in addressing needs**

### *Key points:*

- *The Dual Diagnosis Good Practice guide remains the definitive guidance document for the management of dual diagnosis*
- *The breadth of conditions encompassed by the term dual diagnosis means that studying it is complicated, and evidence is limited in this area.*
- *Having a policy in place for the management of dual diagnosis has been associated with a 9% reduction in suicide rates*
- *The available evidence suggests that Integrated Treatment approaches are beneficial for treating patients with dual substance misuse and mental health problems. This involves multidisciplinary working between services, with clinicians working in one setting to provide mental health and substance misuse interventions, rather than in parallel services.*

A recent literature review of the management of patients with dual diagnosis noted that the breadth of the condition means it encompasses a wide range of potential combinations of diagnoses, and therefore generic approaches to treatment must be broad. It noted that there is relatively little research on dual diagnosis in patients with obsessive compulsive or panic disorder.<sup>90</sup>

The National Institute for Health and Clinical Excellence (NICE) has not produced specific guidance for dual diagnosis, however there is relevant condition specific guidance, including the 2011 clinical guidelines for the management of psychosis with co-existing substance misuse.<sup>27</sup> The guidance includes the following main recommendations:

1. **Healthcare professionals in all settings** should routinely ask adults and young people with known or suspected psychosis about their use of alcohol and/or prescribed and non-prescribed (including illicit) drugs.
2. **Secondary care mental health services** should consider seeking specialist advice and initiating joint working arrangements with specialist substance misuse services for adults and young people with psychosis being treated by community mental health teams, and known to be: severely dependent on alcohol or dependent on both alcohol and benzodiazepines or dependent on opioids and/or cocaine or crack cocaine.
3. **Substance misuse services:** Healthcare professionals in substance misuse services should be competent to recognise the signs and symptoms of psychosis and undertake a mental health needs and risk assessment sufficient to know how and when to refer to secondary care mental health services.

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90 Baigent M. Managing patients with dual diagnosis in psychiatric practice. *Curr Op Psychiatry*. 2012;25(3):201-205.

4. **Inpatient mental health services:** All inpatient mental health services should ensure that they have policies and procedures for promoting a therapeutic environment free from drugs and alcohol that have been developed together with service users and their families, carers or significant others. These should include: search procedures, visiting arrangements, planning and reviewing leave, drug and alcohol testing, disposal of legal and illicit substances, and other security measures. Soon after admission, provide all service users, and their families, carers or significant others, with information about the policies and procedures.
5. **Specific issues for young people with psychosis and coexisting substance misuse:** Those providing and commissioning services should ensure that age-appropriate mental health services are available for young people with psychosis and coexisting substance misuse and transition arrangements to adult mental health services are in place where appropriate.

### 9.1 Suicide prevention and dual diagnosis

The report of the National Confidential Inquiry into suicide and homicide by people with mental illness in 2001<sup>91</sup> included twelve key recommendations for safer mental health services, one of which specifically addressed dual diagnosis:

*“Strategy for dual diagnosis covering training on the management of substance misuse, joint working with substance misuse services, and staff with specific responsibility to develop the local service”*

These twelve recommendations also formed part of the English Suicide Prevention Strategy in 2002.<sup>92</sup> A recent study investigated the implementation of these recommendations in mental health services across England and Wales, and their impact on suicide rates. It found that implementing a local policy for patients with dual diagnosis was associated with a statistically significant 9% decline in suicide rates. The only other policies associated with greater declines were the provision of 24 hour crisis care, and post-suicide multidisciplinary review.<sup>93</sup>

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91 Appleby L, Shaw J, Sherratt J et al. Safety first. Five year report of the National Confidential Inquiry into suicide and homicide by people with mental illness. London: Stationery Office, 2001.

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalassets/dh\\_4058243.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalassets/dh_4058243.pdf)

92 Department of Health. National Suicide Prevention Strategy for England. London, Department of Health, 2002.

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalassets/dh\\_4019548.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalassets/dh_4019548.pdf)

93 While D, Bickley H, Roscoe A, Windfuhr K, Rahman S, Shaw J, Appleby L, Kapur N. Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: a cross-sectional and before-and-after observational study. *Lancet* 2012;379(9820):1005-1012.

## 9.2 Screening for dual diagnosis

The use of screening instruments in healthcare settings has been recommended by a range of authors as an aid to the identification of coexisting substance misuse and mental health problems. There is a wide range of screening tools available and studies have been carried out in a variety of settings including alcohol and drug treatment units in Australia, and emergency departments in the USA, and their findings have generally supported the use of screening tools for the identification of patients requiring further assessment for mental health and substance misuse problems. However a recent review noted that further research is required to fully evaluate their use for this purpose.<sup>94</sup> Local services use a range of different screening tools to assess clients' mental health condition and use of substances, but their use is not standardised across the services.

## 9.3 Psychosocial interventions

A Cochrane Review in 2008 compared the effects of psychosocial interventions such as motivational interviewing, cognitive behavioural therapy and skills training in people with dual diagnosis. It concluded that there was no compelling evidence to support any one psychosocial treatment over another for reducing substance use or improving mental state in this group.<sup>95</sup> The researchers identified flaws in the quality of the evidence base, including small heterogeneous samples, flawed experimental designs, high attrition rates, and short follow-up periods. These differences in study designs made comparison of the various trials difficult, and the review concluded that there was a need for further research in this area.

A more recent trial among people with psychosis and substance misuse found that integrated motivational interviewing and cognitive behavioural therapy had only limited benefit: while it was associated with a reduction in the amount of substance used for at least a year after completion of therapy, there was no improvement in outcome in terms of hospitalisation, symptoms or functioning.<sup>41</sup>

## 9.4 Evidence relating to services for people with dual diagnosis

The Co-morbidity of Mental Illness and Substance Misuse (COSMIC) study reported in 2002 that most patients with comorbidity were ineligible for cross referral between services; large proportions were not identified by services and received no specialist intervention. The researchers recommended that models of collaborative working should be developed with local general practitioners and psychotherapy services (in addition to general adult psychiatry). They also recommended that CMHT staff should be able to implement basic management of comorbidity, and should be trained in the assessment of drug and alcohol problems and motivational techniques to improve patient engagement with substance misuse treatment. They concluded that mental health and substance misuse services should begin

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94 Assanangkornchai S, Edwards JG. Clinical and epidemiological assessment of substance misuse and psychiatric comorbidity. *Current Opinion in Psychiatry* 2012;25:187-193.

95 Cleary M, Hunt GE, Matheson SL, Siegfried N, Walter G. Psychosocial interventions for people with both severe mental illness and substance misuse. *Cochrane Database of systematic reviews* 2008, Issue 1. Art No: CD001088.

work to develop joint policies around assessment, intervention and management of comorbidity.<sup>38,39</sup>

The Government's drug strategy<sup>96</sup> emphasises a recovery-led approach to tackle drug dependence, which is particularly challenging in individuals with a dual diagnosis. For people with comorbid alcohol misuse and depression or anxiety, NICE recommends that the alcohol misuse is treated first, as this may lead to significant improvement in the depression and anxiety symptoms, and referral considered if it continues after 3-4 weeks of abstinence.<sup>97</sup> However this can be a challenge for substance misuse services without the appropriate support of mental health services.

A study in Bromley in 2002 carried out focus groups with a range of professionals involved in the care of people with a dual diagnosis. It found that there was a willingness to manage mild to moderate dual diagnosis cases within 'mainstream' mental health and substance misuse services, but for more complex cases with serious mental illness, management by specialist teams such as Assertive Outreach or Dual Diagnosis teams was advocated.<sup>98</sup>

There is no specific NICE guidance for dual diagnosis, however there is a range of relevant NICE guidance relating to specific mental health conditions, and also substance misuse <http://www.dualdiagnosis.co.uk/NICE.ink> There is also NICE guidance for psychosis with co-existing substance misuse in adults and young people aged 14-60 years. This notes that there is limited specific evidence for effective psychosocial or pharmacological interventions, or for the integrated service model for this condition, and recommended further research. Due to a lack of evidence relating to young people, its recommendations for this group are based mainly on the adult evidence base. However the guideline endorses the recommendations of the 2002 Good Practice guide, and advocates for a shared care model between general mental health and specialist substance misuse services.<sup>99</sup>

## 9.5 Integrated treatment approaches

Integrated Treatment is increasingly proposed as a model for treating patients with dual substance misuse and mental health problems,<sup>100</sup> and the National Consortium of dual diagnosis nurse consultants note that the emerging evidence suggests that components of an 'Integrated Treatment Approach' have better outcomes.

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96 HM Government. Drug Strategy 2010. Reducing demand, restricting supply, building recovery: supporting people to live a drug free life. <http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010>

97 NICE. Alcohol use disorders. Diagnosis, assessment and management of harmful drinking an alcohol dependence. NICE Clinical Guideline 115: February 2011. <http://www.nice.org.uk/nicemedia/live/13337/53191/53191.pdf>

98 Strathdee G et al. Dual diagnosis in a primary care group – a step by step epidemiological needs assessment and design of a training and service response model. Department of Health/National Treatment Agency 2002.

99 Saleh M, Crome I. National Institute for Health and Clinical Excellence (NICE) guideline: psychosis with coexisting substance misuse. *Addiction* 2011;107:1-3.

100 Burnett R, Porter E, Stallings K. Treatment options for individuals with dual diagnosis. *Journal of Human Behavior in the Social Environment* 2011;21(7):849-857.

Services are generally designed to deal with either mental health or substance misuse, and therefore think about these conditions separately. In assessing clients, professionals may wish to ascertain whether mental health problems predate or result from drug use, and vice versa, and reviews have noted that there is a possibility that staff from mental health services may be more likely to attribute presenting problems to substance use and vice versa, so shifting responsibility for the case onto the other service.<sup>3</sup>

Integrated treatment approaches are designed to remove some of the problems associated with having entirely separate mental health and substance misuse services, where patients are assessed and treated in parallel by two different services. This can delay initiation of appropriate interventions and is resource intensive. An integrated approach involves multidisciplinary working, with clinicians working in one setting to provide mental health and substance misuse interventions for patients with dual diagnosis. This can include medication, coordinated psychotherapy, psychosocial treatment for mental illness and substance misuse, to suit the patient's motivation.<sup>101</sup> A recent study compared an integrated treatment approach with usual care in patients with schizophrenia and comorbid substance misuse, and found that after 3 months those receiving integrated treatment had greater improvements in drug and alcohol use and addiction severity, psychiatric symptoms, and reported better quality of life, social and community functioning. There were also fewer patients dropping out of treatment in the integrated care group, and the authors concluded that an integrated approach should be considered as the treatment of choice for this patient group.<sup>102</sup>

A recent randomised controlled trial compared the effectiveness of integrated motivational interviewing and cognitive behavioural therapy with standard care, among patients with psychosis and substance problems. Its findings were mixed; while outcomes were similar between the two study groups in terms of hospitalisation, symptoms outcomes and functioning, the integrated approach reduced the amount of substance used for at least one year after completion of therapy, and the authors noted that CBT and motivational interviewing were of partial benefit in the treatment of dual diagnosis.<sup>103</sup> Similar findings have been reported in patients with comorbid substance use disorders and other psychiatric diagnosis, and the authors of a recent review concluded that integrated models of intervention are likely to be beneficial and reduce treatment costs.<sup>101</sup>

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101 Murth P, Chand P. Treatment of dual diagnosis disorders. *Curr Op Psychiatry* 2012;25:194-200.

102 Morrens M, Dewilde B, Sabbe B, Dom G, De Cuyper R, Moggi F. Treatment outcomes of an integrated residential programme for patients with schizophrenia and substance use disorder. *Eur Addict Res* 2011;17:154-163.

103 Barrowclough C, Haddock G, Wykes T, Beardmore R, Conrod P, Craig T et al. Integrated motivational interviewing and cognitive behavioural therapy for people with psychosis and comorbid substance misuse: randomised controlled trial. *BMJ* 2010;341:c6325.

## 9.6 Work in other areas

### Housing projects

The below examples of initiatives relating to dual diagnosis in other areas are taken from a Department of Health report on housing support for substance users.<sup>104</sup>

#### **Specialist floating support to preventing repeat homelessness: North East**

Byker Bridge Housing Association runs the Under the Bridge Project in South Tyneside in partnership with South Tyneside's Anti Social Behaviour Unit and Homeless Unit. This is an intensive Supporting People-funded specialist floating support service, working with clients with complex needs to prevent repeat homelessness; 95% have substance misuse issues.

#### **Specialist floating support for people with complex needs and forensic issues: London**

Threshold Support provides a range of floating support and tenancy sustainment services in central London. The Safer Communities floating support project is a multi-agency partnership for people with substance misuse and/or mental health and/or forensic issues and behaviour that challenges. Referrals come through the housing department and the Multi-Agency Public Protection Panels (MAPPs).

#### **PCT and local authority partnership: specialist floating support for dual diagnosis clients: London**

A partnership was developed between a London Local Authority, PCT and Threshold Support to provide a specialist floating support service to maintain tenancies of people with substance misuse issues and dual diagnosis. The aim was to maintain tenancies and enable clients to continue to access health services for their substance misuse and mental health issues. Floating support works with people who have moved on into their own tenancies after a period in homeless hostels, supported housing or residential rehab. It can also be preventative, helping those vulnerable to homelessness remain in their existing housing, by tackling the causes before they lead to eviction or abandonment.

Specialist floating support services have a substance misuse remit, and some are specifically for dual diagnosis (mental health and substance misuse) or for ex-offenders. Support staff help people to access and remain in contact with treatment and detox services, and to avoid losing their tenancies through behaviour linked to their substance misuse (for example through anti-social behaviour or rent arrears). Unlike mainstream floating support services provided by generic services:

- specialist services have staff trained in substance misuse;

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104 Substance users and supported housing: What's the score? Report Two. Lessons and Learning Points.

[http://www.dhcarenetworks.org.uk/library/Resources/Housing/Support\\_materials/Reports/Substance\\_users\\_report2.pdf](http://www.dhcarenetworks.org.uk/library/Resources/Housing/Support_materials/Reports/Substance_users_report2.pdf)

- they use interventions such as motivational interviewing to encourage substance users to address their misuse;
- they may receive funding from the PCT or DAT as well as, or in place of, SP funding;
- they often working very closely with staff in partner agencies (depending on the project this may include mental health or probation, as well as other Health colleagues for substance misuse issues); and
- support staff generally have a much smaller caseload.

### **Other initiatives**

The Making Every Adult Matter coalition recently released a vision paper which describes a 'multiple needs service' which was developed to better coordinate the response of existing services to working with adults with multiple needs and exclusions. The service had a small number of staff working intensively with very chaotic clients who had been excluded from other services due to their behaviour or lack of engagement. Staff could accompany clients to assessments and help them to work with existing services. The service was supported by multi-agency meetings.

<http://www.revolving-doors.org.uk/policy--research/policy-projects/vision-paper/>

## **10. Funding**

Research has shown that service users with a dual diagnosis typically use NHS services more and cost more. A study in 2000 in South London psychiatry services found a greater proportion of the patients with dual diagnosis used the support of community psychiatric nurses, inpatient care and emergency clinics than those without dual diagnosis. Their analysis found that dual diagnosis patients had significantly higher 'core' psychiatric service costs (a difference of £1,362) and non-accommodation service costs (a difference of £1,360) than patients without a dual diagnosis.<sup>105</sup>

There is not a specific funding stream for dual diagnosis in Brighton & Hove. People with a dual diagnosis are clients of a range of services, funded from various budgets, and therefore it is very difficult to ascertain the proportion of funds spent on dual diagnosis clients. There are specific budgets for mental health and substance misuse services.

### **Substance misuse funding in Brighton & Hove**

Substance misuse services are funded from several different budgets:

- Preventive and Acute Services Commissioning Budget
- Alcohol and Substance Misuse Young People Budget
- DAAT Budget
- Communities Against Drugs Budget

Funding for substance misuse services for 2012/13 comes from the following streams:

<b>2012/13 Budget</b>	<b>Amount</b>
Pooled Treatment Budget	£2,609,379
PCT Substance Misuse Budget	£1,420,064
Alcohol Budget	£887,590

In addition, some substance misuse preventative and treatment services are funded from the Public Health budget (e.g. naloxone use), the Communities Against Drugs Team, the Police, Probation Trust and Children and Young People commissioner.

### **Mental Health funding**

The cost of mental health problems to the economy in England have been estimated at £105 billion, and it is predicted that treatment costs could double in the next 20 years.

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105 McCrone P, Menezes PR, Johnson S, Scott H, Thornicroft G, Marshall J et al. Service use and costs of people with dual diagnosis in South London. *Acta Psychiatr Scand* 2000;101(6):464-72.

In 2011/12, an estimated £197.19 was spent on mental health services per head of the population in Brighton & Hove. This was higher than, but not significantly different to, the England average of £182.95 per head.<sup>62</sup>

### **Housing related support**

The recent needs analysis carried out for clients with mental health needs in community care placements found that clients with drug or alcohol issues were significantly higher cost compared with the general residential care population.

## **11. Workforce**

The Dual Diagnosis Capability Framework<sup>106</sup> outlines the core skills needed to deliver dual diagnosis interventions (as outlined in the Dual Diagnosis Good Practice guide). It is intended to be used to identify and develop individual's capabilities to work effectively with people with serious mental illness and combined substance use problems.

The framework is separated to describe core skills at three levels of expertise:

	<b>Level 1: Core</b>	<b>Level 2: Generalist</b>	<b>Level 3: Specialist</b>
<b>Service user needs</b>	Service users who are at risk of developing long term problems with substance use and mental health. People with more severe problems who come into contact with these agencies and workers as first point of contact. People engaged with other agencies and for whom the worker plays a specific role in their care.	People with moderate problems with a range of problems relating to substance use and mental health problems, also including potential physical and social needs.	People with chronic long term and complex physical psychological and social needs.
<b>Aimed at</b>	All workers who come into contact with this service user group especially as first contacts to care.	generic post-qualification workers who work with dual diagnosis regularly, but don't have a specific role with this group.	Aimed at people in designated senior dual diagnosis roles who have a responsibility to manage and train others in dual diagnosis interventions.
<b>Example of staff who should have these skills</b>	Primary care workers, A & E staff, police, criminal justice workers, housing, support workers, health care assistants, nonstatutory sector employees, volunteers, service users, carers, and friends	Mental health social workers, mental health nurses, psychologists, psychiatrists, substance use staff, occupational therapists, probation officers.	Dual Diagnosis Development workers

At each level of expertise there are capabilities relating to values, utilising knowledge and skills, and practice development. The framework notes that all

106 Hughes L, 2006. Closing the gap. Dual Diagnosis Framework. Department of Health/CSIP. <http://www.nmhd.org.uk/silo/files/closing-the-gap-pdf>

dual diagnosis training at any level should be able to map its contents to the capabilities framework, and include various methods of assessment of those capabilities within the training course.

### **Workforce in Brighton & Hove**

There is a specialist Dual Diagnosis Nurse Consultant post at Sussex Partnership NHS Foundation Trust (SPFT) for Brighton & Hove.

There is a network of “Dual Diagnosis Champions” within SPFT mental health and substance misuse services. The champions are provided with bi-annual training events which take place in Brighton & Hove and focus on updates, training and networking with other dual diagnosis champions. On occasion partner organisations and service user representatives attend these events.

Each team or ward within SPFT has a Dual Diagnosis champion who is a qualified practitioner and has completed the DD essential training. Dual diagnosis champions within the city meet regularly as a local network group to share experience of practice. The Dual Diagnosis Nurse Consultant also trains DD Trainers to provide DD essential training for the Trust. There are three trainers (including the DD Nurse Consultant) who are now able to address the DD essential training for SPFT in Brighton and Hove.

However due to the high prevalence of dual diagnosis among clients of mental health and substance misuse clients, staff in each service will regularly encounter clients with dual diagnosis and therefore require the knowledge to work with this group effectively. In addition staff report that they require further training to work confidently with dual diagnosis clients (see section 8).

### **Training**

A recent editorial noted that there have not been many studies relating to the training needs of staff working with dual diagnosis clients. Two studies were identified as part of the literature search for this needs assessment.

The COMO study examined the effect of specific training in dual diagnosis interventions on the work of community mental health team staff in South London. The training package was a 5 day course and treatment manual, based on a longer specialist accredited course, which aimed to increase skills and competencies to detect, assess and intervene in cases with comorbid substance use problems. It found that training significantly improved staff perceptions of their own knowledge and skills, but had limited effect on their attitudes towards working with drinkers and drug users in mental health settings. The authors concluded that it is unlikely that brief training courses are sufficient to meet the needs of this client group, without other service developments such as specialist dual diagnosis workers providing intensive support and supervision, and multi-agency strategies.<sup>107</sup>

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107 Hughes E, Wanigaratne S, Gournay K, Johnson S, Thornicroft G, Finch E et al. Training in dual diagnosis interventions (the COMO study): Randomised controlled trial. *BMC Psychiatry* 2008. Doi:10.1186/1471-244X-8-12.

The COMPASS project in Birmingham evaluated the impact of a short training course in cognitive behavioural integrated treatment for dual diagnosis, delivered to assertive outreach teams.<sup>108</sup> The authors concluded that training and supporting assertive outreach staff to use an integrated treatment approach is well received and produces lasting changes in confidence and practice, but further research was needed to demonstrate the impact on client outcome.

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108 Graham H, Copello A, Birchwood M, Orford J, McGovern D, Mueser K et al. A preliminary evaluation of integrated treatment for co-existing substance use and severe mental health problems: impact on teams and service users. *Journal of Mental Health* 2006;15:577-591.

## **12. Key issues and gaps**

Dual diagnosis is a complex issue and presents many challenges to services and commissioners. It is an important issue in Brighton & Hove, where the prevalence of mental health problems and substance misuse problems is high. Dual diagnosis clients can be very vulnerable, while at the same time very chaotic and challenging to services, and this means that they are frequently passed between different services, or fall through the gaps between services.

The evidence gathered from interviews with professionals indicates that for clients with 'classic' dual diagnosis, involving serious mental health problems, there are quite clear systems in place in the city and services available. There seems to be a gap in services for people who fall outside this classic definition of dual diagnosis but nevertheless present a challenge to services and require support. The hostels system may encounter these clients regularly and staff do not always have the knowledge or skills to work with them effectively.

Interviews with stakeholders indicated that many feel that they have problems getting assessments from other services. This client group is very complex to work with, and there may be a natural tendency to refer clients on to other services where possible, however this approach is not constructive and results in clients being passed between services without necessarily achieving improvement. At present services work in a fragmented way, and a solution is needed which enables services to work together to develop a care plan for individual clients, in which each service can commit to specific areas of work.

There are a wide range of agencies working with dual diagnosis clients in Brighton & Hove, but joint working is lacking and services are not coordinated effectively. There is motivation among staff to work with this client group but many are not confident in doing so, and this could be improved by ensuring that staff are able to build supportive working relationships with colleagues from other services. Evidence suggests that an integrated approach to treatment is important in providing care for people with dual diagnosis. Services in Brighton & Hove operate separately and joint working seems to rely on motivated individual staff rather than being standard practice.

It is clear that dual diagnosis requires a coordinated multiagency approach and the development of a clear care pathway including all of the services involved in working with this client group. This would be of benefit to clients, but also to staff, as both report a lack of awareness of the services available in the city.

### **13. Recommendation for further needs assessment**

An updated dual diagnosis needs assessment should be carried out when data collection issues have been resolved, and a clearer picture of need relating to dual diagnosis in Brighton & Hove can be established.

Further needs assessment work in relation to dual diagnosis and suicide could be of use, including detailed analysis of coroner's reports of narrative verdicts to ascertain whether unaddressed mental health or substance misuse needs are a factor.

This needs assessment has not fully considered the needs of young people in transition to adult services, and future needs assessment should address this.

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