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Mental ill health and substance misuse: Dual Diagnosis

This paper has been compiled in response to an MLA request on the complex issue of 'dual diagnosis' in the context of service provision. Specifically, the paper provides the following:

- An overview of dual diagnosis.
- Estimated prevalence rates.
- The impact of dual diagnosis on people's lives.
- Types of services available and challenges in terms of accessibility.
- Recommendations for service delivery.
- The policy context in Northern Ireland and neighbouring jurisdictions.

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Key points

- Dual Diagnosis (DD) is a broad term used to describe the co-occurrence of a mental (psychiatric) disorder alongside substance misuse. Mental disorders include a variety of illnesses such as depression, bipolar disorder, schizophrenia and other psychoses. Substance misuse is the use of alcohol, illicit drugs, or over-the-counter or prescription medicines in a way that can cause harm.
- People with a DD are not a homogeneous group and often have multiple needs. It is not known why a person may develop a DD, but it is thought to stem from a combination of factors.
- The nature of the relationship between these disorders is complex. Likewise, diagnosis and treatment can be particularly challenging for healthcare professionals.
- DD is a significant health and societal issue. People with a DD are at increased risk of physical health problems, early death, unemployment, poverty, social isolation, homelessness, suicide and contact with the criminal justice system.
- Many jurisdictions have separate services for mental health and substance misuse, often with different philosophies, staff, and locations. Evidence suggests siloed and fragmented care, with little in the way of multi-agency working.
- In turn, people with a DD can be overlooked or passed between services – with neither mental health nor substance misuse services taking overall responsibility for care. Barriers like stigma or stringent service criteria can exclude service users and lead to high levels of unmet need.
- There is no one-size-fits-all model regarding service delivery. Integrated services which address both disorders concurrently are considered best practice for reducing barriers and leading to better outcomes.
- This requires a collaborative, holistic and person-centred approach between health care and other relevant agencies (such as housing, employment and justice).
- In terms of Northern Ireland, levels of mental ill health are substantial. Despite improvements in mental health services since the Bamford review, literature outlines a number of shortcomings. Furthermore, it is estimated that the Department of Health spends over £900 million each year tackling drug and alcohol misuse.
- Costs and demands for care for people with a DD are projected to rise. The need for care will be exacerbated by the COVID-19 pandemic, and place even more pressure on services and already lengthy waiting times.
- There is no healthcare policy for DD in Northern Ireland, however the issue being considered in two draft strategies. Neighbouring jurisdictions also have various policy and guidance frameworks that consider the issue of DD. Nevertheless, evidence shows practical implementation has lagged behind policy intentions. Challenges remain as to how services should be appropriately designed to address the often complex needs of people with a DD.

1. What is a Dual Diagnosis?

Dual Diagnosis (DD) is a broad term used to describe the co-occurrence of a mental (psychiatric) disorder alongside substance misuse. Yet there is no consensus about this terminology.¹ As a recent systematic review (2020) suggests, “*there are many areas where there is no scientific agreement on DD, starting from the definition itself*”.² For example, the World Health Organisation defines DD disorders as:

“...comorbidity or the co-occurrence in the same individual of a psychoactive substance use disorder and another psychiatric disorder.”

However, the European Monitoring Centre for Drugs and Drug Addiction defines DD as:³

“The temporal co-existence of two or more psychiatric disorders as defined by the International Classification of Diseases, one of which is problematic substance use.”

Whereas in the UK, the National Institute for Health and Care Excellence (NICE) refers to DD disorders as:⁴

“...people with a *severe* mental illness combined with misuse of substances in a way that causes mental or physical damage.”

Also rather confusingly, alternative names have been given to the term “Dual Diagnosis” in other jurisdictions. These include “co-occurring disorders”, “concurrent disorder”, “comorbidity”, and “dual pathology,” amongst others.⁵

People with DD disorders are not a homogeneous group. Although the term *dual* diagnosis implies that there are two issues (a mental disorder and a substance misuse disorder), this is somewhat misleading as numerous forms of DD can co-exist.⁶

¹ There are two main clinical interpretations of the term ‘dual diagnosis’. This can include having a mental illness along with a substance abuse disorder, or the co-existence of intellectual, developmental or physical disability with a mental illness.

² Fantuzzi, C. and Mezzina, R. (2020) Dual diagnosis: A systematic review of the organization of community health services. *International Journal of Social Psychiatry*, Vol. 66(3) 300-310.

³ European Monitoring Centre for Drugs and Drug Addiction website. https://www.emcdda.europa.eu/topics/pods/comorbidity-substance-use-mental-disorders-europe_es

⁴ NICE (2015) Severe mental illness and substance misuse (dual diagnosis): community health and social care services: Draft Review 1: The epidemiology, and current configuration of health and social care community services for people in the UK with a severe mental illness who also misuse substances <https://www.nice.org.uk/guidance/ng58/documents/evidence-review>

⁵ Get connected website. Get a clear understanding of Dual Diagnosis <https://www.getconnected.org.uk/dual-diagnosis/>

⁶ The Alcohol Forum / Health Service Executive (2015) Dual Diagnosis: A report on prevalence, policy and management. https://www.drugsandalcohol.ie/26423/1/AlcoholForum_Report_DualDiagnosis.pdf p7.

Furthermore, substantial diversity exists in the combinations of disorders, their severity, and individual treatment needs.

At a high level, these disorders can be described as follows:

- **Mental disorders** – include a variety of illnesses and presentations⁷ such as depression, bipolar disorder, schizophrenia and other psychoses, dementia, and developmental disorders.⁸ They are generally characterised by a combination of abnormal thoughts, perceptions, emotions and behaviours.
- **Substance misuse** (abuse) is the use of alcohol, illicit drugs, or over-the-counter or prescription medicines in a way that can cause harm.⁹ Dependence on, or addiction to either alcohol or drugs (or both) can lead to a substance use disorder.

1.2 How does Dual Diagnosis occur?

It is not known why a person may experience a DD, but it is thought to stem from a combination of factors like genetics, the environment and behaviours, which can overlap and interact at one time in a person's life. The triggers for the development of a DD are also diverse and may include a range of adverse life events such as homelessness, relationship breakdown or bereavement.¹⁰ It is also difficult to establish if alcohol and drug use causes mental health problems, or vice versa. For example:

Common risk factors (such as trauma) can contribute to both mental disorders and substance misuse.

A mental disorder may contribute to substance misuse.

Substance use and addiction can contribute to the development of mental disorder.¹¹

People suffering from a mental disorder are at increased risk of developing a substance use disorder.¹² Similarly, people with a substance use disorder are known to experience high rates of mental ill health.¹³ This can exacerbate or lead to mental health problems, for example, alcohol abuse is associated with depression and anxiety. People may use substances for a multitude of reasons; to self-medicate or cope with mental health challenges, trauma, stress, difficult emotions, to temporarily change their

⁷ See further information from: Royal College of Psychiatrists <https://www.rcpsych.ac.uk/mental-health/problems-disorders>

⁸ World Health Organisation website. Mental Disorders <https://www.who.int/news-room/fact-sheets/detail/mental-disorders>

⁹ See 'Progress' website 'Drug and Alcohol Information' for a more complete list. Available at:

<http://www.dualdiagnosis.co.uk/DrugAlcoholInfo.ink>

¹⁰ Turning Point: Dual diagnosis toolkit: Mental health and substance misuse. https://www.turning-point.co.uk/_cache/614e/content/dualdiagnostoolkit%20%282%29-5090910000025924.pdf p6.

¹¹ National Institute on Drug Abuse (2020) Common Comorbidities with Substance Use Disorders Research Report, pp6-11.

¹² Szerman N., et al (2019) Dual Disorders: Addiction and other Mental Disorders. Integrating mental health. p4.

¹³ UK Guidelines on drug misuse and dependence (2017) Coexisting problems with mental health and substance use.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2_017.pdf p232.

mood, or to manage pain. Likewise, withdrawal of substance misuse can produce psychiatric symptoms or illness. Substances can also interact with mental health medication and reduce their effectiveness, thus delaying recovery.

1.3 Complexities with diagnostic terms

In addition to the numerous names and definitions for DD, there are also complexities in terms of classifying these disorders, which can cause disagreement amongst practitioners.¹⁴ Firstly, there is no universally agreed definition of what constitutes a severe mental illness.¹⁵ Secondly, inconsistencies with the interpretation of substance abuse and substance dependency also exist. As NICE (the National Institute for Health and Care Excellence) highlights:¹⁶

“In terms of psychiatric disorder, definitions include any mental health problem, severe mental illness (which sometimes includes personality disorders and/or severe depression), psychosis broadly defined (including bipolar disorder) and schizophrenia. While the definition of substance misuse is no less problematic and has included inconsistent definitions, for example, diagnostic classifications of substance misuse (DSM-IV and ICD-10), and operational definitions (generally scores above threshold on standardized measures of alcohol and drug misuse). Moreover, there is an important distinction between substance abuse or dependence and use of substances including non-harmful or nondependent use, however, both have been included under the ‘dual diagnosis’ term.”

These broad definitions present challenges for healthcare professionals and clinical judgement must be applied through a careful assessment process. Furthermore, multiple factors need to be considered in relation to a diagnosis, such as the type of mental disorder, the amount of substance used and the severity of the substance disorder, the presence of co-existing physical conditions, and other relevant social issues.¹⁷

In addition, symptoms of DD can be wide ranging and change over time. The symptoms of drug or alcohol misuse can be remarkably similar to the symptoms of mental illness, and vice versa, and they frequently co-exist. There can be further difficulties distinguishing between substance-induced mental disorders and those that pre-existed. Likewise, patients may not disclose substance abuse when asked; or they

¹⁴ Turning Point: Dual diagnosis toolkit: Mental health and substance misuse. https://www.turning-point.co.uk/cache_614e/content/dualdiagnostoolkit%20%28%29-5090910000025924.pdf p25.

¹⁵ Welsh Government (2015) Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem <https://gov.wales/sites/default/files/publications/2019-02/service-framework-for-the-treatment-of-people-with-a-co-occurring-mental-health-and-substance-misuse-problem.pdf> p6.

¹⁶ NICE website <https://www.nice.org.uk/guidance/ng58/documents/evidence-review> p27.

¹⁷ McLellan A. (2017) Substance Misuse and Substance use Disorders: Why do they Matter in Healthcare? *Transactions of the American Clinical and Climatological Association*, 128, 112–130.

may not view it as problematic.¹⁸ Diagnostic overshadowing can also occur, where the substance misuse may mask an underlying severe mental illness, or vice versa.

2. Impact of Dual Diagnosis

Literature suggests that people with DD disorders can experience some of the worst health, wellbeing and social outcomes.¹⁹ Young people are particularly at risk, and are more likely to experience poorer outcomes.²⁰

Depending on the severity, DD can hinder people's ability to cope with difficulties, to function at work, school or homelife, and in their relationships. This may lead to family breakdown and unemployment; and feelings of stress, being disconnected, low self-esteem and guilt.

In the most extreme cases, people with a DD are more likely to experience higher rates of poverty, social isolation, stigma and they have an increased risk of suicide and self-harm.²¹ They are also more likely to be homeless, which can exacerbate mental ill health, and fuel addiction.²² Having a DD is also associated with considerable health problems and higher mortality rates (a reduction in life expectancy of around 15-20 years in people with mental health problems, and 9-17 years in those with alcohol and drug misuse disorders).²³

Misuse of alcohol and drugs can also lead to risky behaviour and violence.²⁴ People with a DD may struggle to detach from peers who engage in drug use or excessive drinking. This increases their likelihood of engaging in other illegal activities to support their dependency, which may inadvertently lead to a continuous cycle of contact with the police service and the criminal justice system.^{25,26}

Those with chaotic or transient lifestyles are also more likely to miss medical appointments and have difficulties accessing services (such as counselling or mental

¹⁸ Pierre, J. (2018) Real-world challenges in managing 'dual diagnosis' patients. *Current Psychiatry*. 17, (9):24-30

¹⁹ NICE Severe mental illness and substance misuse (dual diagnosis): community health and social care services <https://www.nice.org.uk/guidance/ng58/documents/severe-mental-illness-and-substance-misuse-dual-diagnosis-community-health-and-social-care-services-final-scope2>

²⁰ For example, early onset of substance misuse is linked with higher rates of major depressive disorders and it is estimated that a third of young people committing suicide are intoxicated with alcohol at the time of death.

²¹ Hayes R. et al. (2011) Associations between substance use disorder sub-groups, life expectancy and all-cause mortality in a large British specialist mental healthcare service. *Drug and Alcohol Dependence*. Vol. 116 Issue 1.

²² The Irish Times (2018). O'Donnell, C. Plight of those with 'dual diagnosis' most evident in the homeless. <https://www.irishtimes.com/life-and-style/health-family/plight-of-those-with-dual-diagnosis-most-evident-in-the-homeless-1.3566974>

²³ Department of Health (NI) (2020) Mental Health Strategy Draft 2021-2031 <https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-mhs-draft-2021-2031.pdf> p37

²⁴ Turing Point (2016) Dual Dilemma: The impact of living with mental health issues combined with drug and alcohol misuse https://www.turning-point.co.uk/cache_96dc/content/dual_dilemma-509091000020596.pdf p.4.

²⁵ UK Guidelines on drug misuse and dependence (2017) Coexisting problems with mental health and substance use. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

²⁶ Homeless Link (2019) <https://www.homeless.org.uk/sites/default/files/site-attachments/Single%20Homelessness%20Support%20in%20England%20-%20Annual%20Review%202019.pdf> p27.

health/addiction services), especially if intoxicated.²⁷ They are more likely to disengage with services along the way²⁸ and be non-compliant with medication.

Research shows that those with a DD also have higher attendances at A&E²⁹ (which is often not the most appropriate gateway to treatment) due to a crisis or relapse, and higher hospital admission rates.³⁰

The impact of DD on the individual, their families and wider society is significant.³¹ Evidence shows that the costs of treating this group are disproportionately higher than for those with mental illness alone; most likely due to the high utilisation of services, and the long timeframe needed to successfully recover. Evidence also suggests there is much unmet need, not only in relation to DD, but individuals' wider needs such as housing, other health conditions, and finances/debt. Moreover, the costs associated with unmet needs are substantial and projected to increase in the future.³²

2.1 How many people are estimated to be affected?

As well as terminological and diagnostic complexities, there is a lack of robust data and reporting on the prevalence of DD.³³ Part of the difficulty involves methodological challenges, for example, small sample sizes, population characteristics and selection bias.³⁴ Nevertheless, DD is thought to be highly prevalent yet under-reported.³⁵ The following data is taken from a range of studies which suggest:

- Up to 75% of people with a serious mental illness or mental disorder have a DD.³⁶
- Up to 70% of people in drug services and 86% of alcohol services users experience mental health problems.³⁷

²⁷ Personal correspondence with author and EXTERNs Dual Diagnosis Street Team on 12.1.21.

²⁸ Ibid

²⁹ Care Quality Commission (2015) Right here, right now -

http://www.cqc.org.uk/sites/default/files/20150611_righthere_mhcrisiscare_summary_3.pdf

³⁰ NICE Severe mental illness and substance misuse (dual diagnosis): community health and social care services

<https://www.nice.org.uk/guidance/ng58/documents/severe-mental-illness-and-substance-misuse-dual-diagnosis-community-health-and-social-care-services-final-scope2> p10.

³¹ Social Care Institute for Excellence SCIE (2009) Research briefing 30: The relationship between dual diagnosis: substance misuse and dealing with mental health issues. <https://www.scie.org.uk/publications/briefings/briefing30/>

³² Fantuzzi, C. and Mezzina, R. (2020) Dual diagnosis: A systematic review of the organization of community health services. *International Journal of Social Psychiatry*, Vol. 66(3) 300–310.

³³ NICE (2016) <https://www.nice.org.uk/guidance/ng58/documents/severe-mental-illness-and-substance-misuse-dual-diagnosis-community-health-and-social-care-services-final-scope2> pp9-10.

³⁴ See for example: <https://www.nice.org.uk/guidance/ng58/documents/evidence-review>

³⁵ Public Health England: Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf p14.

³⁶ Temmingh, H. et al. (2018) Risperidone versus other antipsychotics for people with severe mental illness and co-occurring substance misuse. Cochrane Library <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD011057.pub2/full>

³⁷ Delgado J. et al. (2013) Depression, anxiety and comorbid substance use: association patterns in outpatient addictions treatment. *Mental Health and Substance Use* Vol. 6, Issue 1.

- Many people with a DD are young. Between 64% and 88% of adolescents with substance use disorders have at least one co-existing mental disorder.³⁸
- An audit of the homeless in England showed 80% of people had mental health issues and 41% had a substance misuse problem. 12% had a dual diagnosis.³⁹
- Substance misuse increases the risk of suicide.⁴⁰ A national study across the UK in 2016 found that around 54% of all suicides in people experiencing mental health problems had a drug or alcohol misuse history. Only 11% were in contact with alcohol or drug services at the time of death.⁴¹
- Co-existing alcohol and drug misuse and mental ill health are the “norm rather than the exception” amongst most offenders.⁴²

Without a more complete picture of prevalence, it will continue to be difficult for policy makers and service providers to develop appropriate and evidence-based services.⁴³

3. Access to services

Effective management of DD is challenging. Experts agree that the earlier an individual gets into treatment, the more likely they are to engage with services and achieve better outcomes. Yet factors influencing good outcomes can be highly dependent upon the individual’s motivation, the severity of their dependence and problems, the extent that their social care needs (e.g. housing, income) are met, and the level of supportive social networks.

Treatment requires input from an array of services that may be delivered in community, outpatient and inpatient settings. The first point of contact for a person with DD may be through health or social care, housing, criminal justice settings or the voluntary and community sector.

Given its diverse nature, there is no single treatment option and no *one-size-fits-all* model of care. Literature commonly refers to three service models. They include: 1) the ‘parallel’ model, where mental health and addiction services are delivered simultaneously by different providers; 2) the ‘sequential’ model, where one treatment

³⁸ Brewer, S. et al. (2017) Treating mental health and substance use disorders in adolescents: What is on the menu? <https://pubmed.ncbi.nlm.nih.gov/28120255/>

³⁹ Homeless Link (2014) The unhealthy state of homelessness: health audit results 2014.

⁴⁰ MHFA England <https://mhfaengland.org/mhfa-centre/research-and-evaluation/mental-health-statistics/#alcohol-drugs>

⁴¹ The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2016: England, Northern Ireland, Scotland and Wales. University of Manchester.

⁴² Turning Point (2016) Dual Dilemma. The impact of living with mental health issues combined with drug & alcohol misuse.

p3. Huges Report suggest at least 70% of prison population have a DD. <http://eprints.lincoln.ac.uk/id/eprint/729/1/uoal2eh05.pdf>

⁴³ NICE Severe mental illness and substance misuse (dual diagnosis): community health and social care services https://www.nice.org.uk/guidance/ng58/documents/severe-mental-illness-and-substance-misuse-dual-diagnosis-community-health-and-social-care-services-final-scope2_p10.

follows the other; and 3) the ‘integrated’ model, where treatments for mental disorders and substance misuse are delivered simultaneously by an integrated treatment team.

3.1 Treatment interventions

A wide range of health and social care staff may be involved in providing care and treatment, such as psychiatrists, mental health nurses, psychologists, social workers, GPs, pharmacists, occupational therapists, addiction counsellors, and cognitive behavioural therapists. Treatment options are discussed in the literature elsewhere⁴⁴ but might include some of the following:

Stabilising mental health problems, with prescribed medication and psychosocial therapies, such as counselling, cognitive-behavioural therapy or anxiety management.

Detoxification and / or substitute prescribing.

Providing information to individuals, carers and families as to the effects of alcohol and drug use on mental and physical health.

Supporting and developing skills to help to manage or reduce alcohol and drug use.

Increasing motivation to change. Providing support to develop alternative social networks and other interests and activities.

3.2 Barriers to treatment

Despite the range of treatments, many barriers can occur in terms of accessing support services as described below:⁴⁵

“Mental health and drug/alcohol services operate separately from each other and have different philosophies, and there is little coordination of services and few formal systems for multi-agency working. Lack of communication between services has led to duplication of assessments and complex referral systems. In addition, many agencies are operating without the skills and resources to provide appropriate help for service users with a dual diagnosis.”

These barriers exist because:

⁴⁴ Turning Point: Dual diagnosis toolkit: Mental health and substance misuse. https://www.turning-point.co.uk/cache_614e/content/dualdiagnostoolkit%20%28%29-5090910000025924.pdf pp33-48.

⁴⁵ Shelter (2007) Good practice briefing: Service without substance https://england.shelter.org.uk/data/assets/pdf_file/0003/48090/Briefing_Service_Without_Substance_Jul_2007.pdf

- Historically, statutory and non-statutory agencies have worked independently from each other. This, in addition to policy silos, has led to a lack of joined-up working regarding service provision.⁴⁶
- Many treatment facilities and practitioners do not have the broad spectrum of expertise required to treat both conditions. The relationships between the two problems may not be recognised or addressed, thereby leading to gaps in provision. Unmet need can lead to relapse and can impact on physical health.⁴⁷
- Stringent access criteria for services can lead to a narrow interpretation of need and exclude those whose conditions are deemed to be “not serious” enough. One report states: “*People with a DD are in effect a kind of mental health underclass. They find that their needs are not severe enough to meet the criteria of any single agency, so they can fall just below the threshold of all helping services.*”⁴⁸ Furthermore, in practice, there is a sense that a formal diagnosis of DD is generally given if a person has severe mental health problems (mainly psychotic disorders) and severe substance misuse problems that meet the criteria for specialist services.⁴⁹
- Stigma makes it difficult to seek treatment. Research shows people with a DD have been excluded from support if for example, their behaviour is perceived as difficult. They have also been refused access to mental health treatment unless they can abstain from drugs/alcohol for a set timeframe beforehand;⁵⁰ which may be a near impossible task given the addictive nature of substances.
- There is a disparity in access to services in vulnerable groups like prisoners and those that are harder to reach - such as the homeless.⁵¹
- People with a DD may have had previous negative experiences of services, or perhaps felt coerced into a certain treatment.⁵² They may lack trust in those services, which can act as a barrier for seeking future interventions.
- Pressure on waiting lists and funding constraints can exacerbate adverse outcomes for those waiting for help.

⁴⁶ The Recovery Partnership (2017). State of the Sector: Beyond the tipping point http://www.recovery-partnership.org/uploads/5/1/8/2/51822429/state_of_the_sector_2017_-_beyond_the_tipping_point.pdf p8.

⁴⁷ NICE guidance (2016) Coexisting severe mental illness and substance misuse: community health and social care services <https://www.nice.org.uk/guidance/ng58/chapter/Recommendations>

⁴⁸ Turing Point: Dual Dilemma The impact of living with mental health issues combined with drug and alcohol misuse https://www.turning-point.co.uk/_cache_96dc/content/dual_dilemma-5090910000020596.pdf

⁴⁹ Turning Point: Dual diagnosis toolkit: Mental health and substance misuse. https://www.turning-point.co.uk/_cache_614e/content/dualdiagnostoolkit%20%28%29-5090910000025924.pdf p2.

⁵⁰ BBC news NI (Connolly, M-L) September 2019. Mental health: ‘Services must include dual diagnoses’ <https://www.bbc.co.uk/news/uk-northern-ireland-49599787>

⁵¹ St Mungos website: St Mungo’s evidence to the NICE Public Health Advisory Committee: severe mental illness and substance misuse (dual diagnosis) (2016) <https://www.mungos.org/app/uploads/2017/07/St-Mungo%E2%80%99s-evidence-to-the-NICE-Public-Health-Advisory-Committee-severe-mental-illness-and-substance-misuse-dual-diagnosis.pdf>

⁵² NICE <https://www.nice.org.uk/guidance/ng58/chapter/Recommendations>

As highlighted, different models of care can mean that people with a DD can be overlooked, or passed between services (mental health, addiction services) – with neither service taking overall responsibility for care, as well as different staff, policies, views on treatment, and different locations. This has led to a lack of co-ordinated care and significant unmet need. Continuity in regard to aftercare has also been identified as problematic, as many people with a DD require a long-term approach to recovery.⁵³

4. Best practice

Current best practice indicates that **integration** of mental health and addiction services, which addresses both disorders concurrently (for example using a combination of psychotherapy and pharmacotherapy medication),⁵⁴ can reduce barriers and lead to better outcomes.⁵⁵ Integration of these services requires providers to have a thorough understanding of needs - from early identification and treatment, to ongoing management.⁵⁶ Literature also suggests it is important to evaluate possible traumas experienced and to better contextualise the conditions from a psychosocial perspective.⁵⁷ It is also recommended that services are person-centred, holistic, and have a focus on recovery, whilst taking account of other agencies that may be required to support the individual (such as housing, training, employment, social security, social services and so forth).

4.1 Integrated model examples

Despite recommendations for integrated services, both national and international evidence indicates that the majority of healthcare systems have been slow to adapt to a more collaborative way of working.⁵⁸ Change in practices takes time and can present significant challenges for organisations on multiple levels. Issues frequently cited include staff training and culture, siloed funding, and a wide difference in practices, policies and procedures.

Two examples of integrated service models taken from international literature include:

⁵³ Public Health England. Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf p11.

⁵⁴ Pharmacological treatment-the main drug treatment of psychiatric illness include use of appropriate mood stabilizers, anti-psychotics and anti-depressants. Non-pharmacological treatment (psychosocial treatments) including family interventions, motivational interviewing, motivation enhancement therapy, relapse prevention counselling, cognitive behaviour therapies and other behaviour therapies (such as Assertive community treatment), either alone or in combination that have been conducted individually or in group format; and somatic treatments such as electroconvulsive therapy (ECT), and biofeedback for anxiety.

⁵⁵ Peterson, A (2013). Integrating mental health and addictions services to improve client outcomes. *Issues in Mental Health Nursing*, 34(10), 752–756.

⁵⁶ Health Research Board Ireland (2019) Evidence Review: Treatment Services for people with co-occurring substance use and mental health problems

https://www.hrb.ie/fileadmin/user_upload/HRB_Evidence_Review_Alcohol_and_Evidence_Review_FINAL_PROOF_11.6.19.pdf

⁵⁷ Nexus Model. St Vincent's Hospital Melbourne website <https://www.svhm.org.au/our-services/departments-and-services/n/nexus/our-services>

⁵⁸ See: Fantuzzi, C. and Mezzina, R. (2020) Dual diagnosis: A systematic review of the organization of community health services. *International Journal of Social Psychiatry*, Vol. 66(3) 300-310.

- 1) The **NEXUS Model**⁵⁹: Nexus was established in 2002 as part of the Victorian Dual Diagnosis Initiative in Australia. Key features of this model include:

An integrated approach to DD treatment, delivered in both specialist mental health and drug and alcohol services.

Care is accessed through either sector – through a “no wrong door” approach.

Co-ordinated response to levels and complexity of need, linked by clear referral pathways.

A balance of direct care and the provision of consultation and support to primary care and with other sectors (such as housing, employment, education, community organisations).

Individuals with a DD and families and or carers are included in supporting policy and service development.

- 2) The **Housing First** model was designed in New York in 1992 to specifically serve chronically homeless individuals with co-existing serious mental illness and substance use disorders. The model has since been widely adopted in homeless strategies in the USA, Canada, Denmark, Finland and France. It is well documented that many hostels are not adequately equipped to deal with homeless people with a DD; they may for example, lack privacy, and have high turnover of staff - who may not be suitably trained to deal with some of the more complex needs a person with a DD may have.⁶⁰ As stable housing is considered the linchpin for good mental health, this model uses permanent housing as a starting point rather than the end goal. Individuals with a DD are not required to accept treatment or complete a series of ‘steps’ to access housing (such as sobriety or treatment compliance). Instead, Housing First services enable the individual to leap over these steps to immediately access housing, which is delivered using a holistic and person-centered model.⁶¹ Research suggests this approach has had demonstrable success and can end homelessness in around 70-90% of cases.⁶²

5. DD in Northern Ireland

5.1 Mental health and substance misuse – a picture of need

It is well documented that Northern Ireland experiences 20-25% higher levels of mental health illness when compared to the rest of the UK. Around 1 in 5 adults are reported

⁵⁹ <https://www.svhm.org.au/our-services/departments-and-services/n/nexus/our-services>

⁶⁰ Personal correspondence with Externs' Dual Diagnosis Street Team.

⁶¹ Housing First England Website <https://hfe.homeless.org.uk/>

⁶² Ibid

to have a diagnosable mental health condition at any given time.⁶³ The legacy of the Troubles is also recognised as having a considerable impact on mental health. There are also significantly higher levels of depression here than in the rest of the UK,⁶⁴ and higher levels of antidepressant prescription rates and incidences of self-harm.^{65,66} Moreover, the ongoing COVID-19 pandemic has increased levels of psychological distress among the population; with research suggesting that significant mental health consequences are likely to be present for longer, and peak later than the actual pandemic.⁶⁷

Notwithstanding high mental illness rates and levels of need, the proportion of spend on mental health in Northern Ireland remains the lowest in the UK, at around 8% of the total healthcare budget. This is reported to be 27% less than in England and 20% less than the Republic of Ireland.⁶⁸

In terms of mental health services in Northern Ireland, there have been considerable positive developments and reshaping of services since the completion of the Bamford Review.⁶⁹ Nevertheless, many shortcomings have been highlighted. For example, a recent report (2018) on stakeholder views about mental health services describes service variations, a void in leadership and lack of focus for service improvement, resource constraints, poor communication, and a disconnect between hospital and community services, and child to adult mental health services.⁷⁰ Likewise, the latest draft mental health strategy from the Department of Health (the Department) in 2020 acknowledges public concerns around long waiting lists for psychological therapies, crisis support being unavailable when required, exclusion criteria from services, and the need for a more preventive approach - with earlier interventions that can mitigate against the onset of more serious illness.⁷¹

⁶³ Department of Health (NI) (2014) Making Life Better, p 18. Available online at: https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/making-life-better-strategic-framework-2013-2023_0.pdf

⁶⁴ Donnelly, K.J. (2014). Primary Care Prescribing. Northern Ireland Audit Office: Belfast. Available online at: http://www.niauditoffice.gov.uk/primary_care_prescribing-2.pdf

⁶⁵ Northern Ireland Registry of self-harm. Annual Report 2017-18 (p20). Available online at https://www.publichealth.hscni.net/sites/default/files/2019-07/NIRSH%20Annual%20Report%202017.18%20final%20for%20publication_0.pdf

⁶⁶ Prevalence and variation in antidepressant prescribing across Northern Ireland: a longitudinal administrative data linkage study for targeted support, p38. Available online at https://www.ulster.ac.uk/_data/assets/pdf_file/0007/307816/SDAI-ESRC-report.pdf

⁶⁷ HSC (2020) The Mental Health Impact of the COVID-19 Pandemic in Northern Ireland <https://www.health-ni.gov.uk/sites/default/files/publications/health/mh-impact-covid-pandemic.pdf>

⁶⁸ Mental Health Strategy Draft 2021-2031: Department of Health (NI) 2020 <https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-mhs-draft-2021-2031.pdf> p10.

⁶⁹ A review of the law, policy and provisions affecting people with mental ill-health or a learning disability in Northern Ireland which was conducted between 2002-2007. The review proposed significant changes to the delivery of mental health services.

⁷⁰ Montgomery, L. et al. (2018). An Evaluation of Mental Health Service Provision in Northern Ireland. Health and Social Care in the Community. <https://doi.org/10.1111/hsc.12627> Methodology involved the completion of semi-structured interviews and focus groups with a wide range of stakeholders.

⁷¹ Department of Health (NI) (2020) Draft Mental Health Strategy 2021-2031: Consultation Draft <https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-mhs-draft-2021-2031.pdf>

The high level of mental ill health is even more concerning given the increasing rates of substance misuse in Northern Ireland. A recent report by the Northern Ireland Audit Office (2020) paints a bleak picture. Findings show:⁷²

- The Department of Health in Northern Ireland spends over £900 million each year tackling drug and alcohol misuse.
- A small budget is allocated to address this issue; £8 million for implementing its alcohol and drug strategy and £8 million towards statutory addiction services.
- The number of bed days occupied where there was a primary diagnosis of mental and behavioural issues due to substance misuse has increased by over 35% in the last five years.
- Those seeking treatment for drug misuse have increased significantly and drug misuse deaths in Northern Ireland have increased by more than 200%.
- Addiction services are facing significant pressures, including complexity care needs, an ageing cohort of service users and co-existing mental health issues which make management of treatment more complicated.
- Waiting lists for some services have been in excess of a year.
- Monitoring the performance of substance misuse services is limited. Data collected is not reliable nor complete. There is no evidence to show if public funds for addiction services provides value for money, or whether service users are getting the best possible outcomes.

5.2 Current service provision and pathways

Northern Ireland has an integrated health and social care system. In relation to DD services, a response to an Assembly Question from the Department states: *“It is accepted that sometimes people with dual diagnosis experience difficulties accessing services.”*⁷³

When asked about access to DD services for the purposes of this research paper, the Department responded by stating that Northern Ireland does not have a DD service, but rather, services are delivered based upon clinical need:

“Patients with a DD are provided with access to the same mental health and addictions services as those with a single diagnosis. In both mental health and addiction services, the level and kind of care and treatment are professional decisions based on the clinical needs of the patient.... Those with DD are treated by

⁷² Northern Ireland Audit Office (2020) Addiction Services in Northern Ireland. https://www.niauditoffice.gov.uk/sites/niao/files/media-files/235243%20NIAO%20Addictions%20Services%20Report_NEW%204.pdf

⁷³ Assembly Question 8046/17-22 Ms Cara Hunter (SDLP - East Londonderry) To ask the Minister of Health for his assessment of the treatment of dual diagnosis in Northern Ireland. Answered on 14/10/2020.

*the service which is most appropriate for them at that point in time with input from other services and disciplines as required.*⁷⁴

Yet given some of the issues already highlighted, these disparate services inevitably present challenges. In response to several other Assembly Questions posed, there was no information available from the Department about the number of people with DD awaiting treatment, or the types of services provided:

*“...It is therefore not possible to list specific dual diagnosis services, as these are provided in line with all mental health and addiction services.”*⁷⁵

There was also incomplete data reported about the numbers of staff who had received training in DD each HSC Trust.⁷⁶

Mental Health Services

In terms of how mental health services are configured in Northern Ireland, the Health and Social Care Board, in partnership with the Public Health Agency, plans and develops services for people with mental health needs. Although it is not possible to detail all the types of provision available in this paper, a directory of services for mental health and emotional wellbeing in each HSC Trust area has been published by the Public Health Agency for reference.⁷⁷

Depending on the level of need, mental health services are guided by several pathways detailed on the Board’s website, such as the five stage “stepped care model” within the *You in Mind Regional Mental Health Care Pathway* (2014).⁷⁸

⁷⁴ Personal correspondence with author and DoH Adult Mental Health Unit on 25.1.21.

⁷⁵ Ms Órlaithí Flynn (SF - West Belfast) To ask the Minister of Health, pursuant to AQW 4713/17-22, to list the current dual diagnosis services for addictions and mental health, broken down by catchment area. Answered on 16/09/2020.

⁷⁶ Assembly Question 8623/17-22 Ms Órlaithí Flynn (SF - West Belfast) To ask the Minister of Health how many staff in each Health and Social Care Trust have a recognised qualification or specific training in dual diagnosis. Answered on 30/10/2020 and QW 6438/17-22

⁷⁷ PHA website. Directory of services to help improve mental health and emotional wellbeing

. <https://www.publichealth.hscni.net/publications/directory-services-help-improve-mental-health-and-emotional-wellbeing>

⁷⁸ For various pathways see HSC Board Mental Health <http://www.hscboard.hscni.net/our-work/social-care-and-children/mental-health/>



Figure 1 Stepped Care Model - *You in Mind* Regional Mental Health Care Pathway

More recently an *Acute Mental Health Care Pathway* (2018) has been developed. Acute mental health services provide intensive treatment for those who are most acutely unwell; those often in crisis, vulnerable and at high risk of self-harm or suicide. (this pathway focuses on steps 4 and 5 of the *You in Mind* Stepped Care Model shown in Figure 1).

The Acute Mental Health Care Pathway details the types of services available under several categories: 1) treatment at home, 2) inpatient services, 3) acute day services, and 4) a crisis beds service – for those unable to receive treatment at home because of for example, a relationship breakdown with carers. The pathway contains a number of service standards; with a focus on recovery and opportunities for peer support, family interventions and access to appropriate behavioural therapies. The pathway also highlights the importance of working with community mental health services, specialist mental health teams (such as forensic, personality disorder services), early intervention services, drug and alcohol services, liaison services and supported housing. Although not part of the pathway, it is recognised that those services:

*“are essential components of support for people with mental health needs. It is also acknowledged that there is a continuing need to focus on prevention, wellbeing and community services. Depending on the local context, other services will interface with the Acute Care Pathway including prisons, courts, mental health liaison service to Emergency Departments, and other acute wards in general hospitals and primary care services.”*⁷⁹

⁷⁹ HSC Board Acute Mental Health Pathway (2018) http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you_in_mind/acute-mental-health-pathway.pdf p11.

Drug and alcohol services

A list of services and supports for drug and alcohol (addiction) services in Northern Ireland are documented via the *Alcoholanddrugsni* website which provides links to Drug and Alcohol Co-ordination Teams in each HSC Trust area and signposting to various other non-statutory support services.⁸⁰ In Northern Ireland, drug and alcohol services operate within a four-tiered model as follows⁸¹:

Tier 1 interventions include provision of alcohol / drug-related information and advice, screening and referral to specialised drug treatment. They are usually provided in primary care, education and criminal justice settings.

Tier 2 interventions include provision of information and advice, triage assessment, referral to structured alcohol / drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare.

Tier 3 interventions include community-based specialised alcohol / drug assessment and co-ordinated care planned treatment and specialist liaison. They are typically delivered in specialised alcohol and drug treatment services, with their own premises in the community or on hospital sites.

Tier 4 interventions include provision of residential specialised drug treatment, which is care planned and care coordinated to ensure continuity of care and aftercare. Detoxification and stabilisation are provided in specialised inpatient or residential substance misuse units or wards.

5.3 Strategic Direction

In relation to the Department's strategic direction, in May 2020 the Minister for Health Robin Swann, published a Mental Health Action Plan with Covid-19 Mental Health Response Plan in its Annex.⁸² Two actions are linked to DD under the themes "Improved transitions" and "Better mental health care and treatment in primary care."⁸³

The Department is also considering the issue of DD in two forthcoming strategies, both of which have been recently subject to public consultation.

⁸⁰ See *Drugsandalcoholni.info* website <http://services.drugsandalcoholni.info/treatment-support> for a list of services.

⁸¹ *Drugsandalcoholni.info* website. Explanation of Tiered approach to service provision <http://services.drugsandalcoholni.info/node/13>

⁸² Department of Health (NI) Mental Health Action Plan (May 2020) <https://www.health-ni.gov.uk/sites/default/files/publications/health/mh-action-plan-plus-covid-response-plan.pdf>

⁸³ See Objectives 7.1 and 10.1 Department of Health (NI) Mental Health Action Plan (May 2020) <https://www.health-ni.gov.uk/sites/default/files/publications/health/mh-action-plan-plus-covid-response-plan.pdf>

The first is the *Draft Mental Health Strategy*,⁸⁴ (consultation closes 26 March 2021). It sets out a new ten-year vision for mental health services. It includes 29 high-level actions, of which, Action 20 seeks to: “*Create a managed care network, with experts in DD supporting and building capacity in both mental health and substance use services, to ensure that these services meet the full needs of those with co-occurring issues.*”⁸⁵ According to the Department, a review of service interfaces will be conducted in 2021/22 which will include service interfaces with DD. This review work will need to be completed before a clear picture emerges about the details of the “managed care network”.⁸⁶

With regards to DD services, the draft strategy also states that:

“The creation of a dedicated dual diagnosis service is not the answer. Such a service would be at risk of receiving “difficult” referrals that mental health and substance use services do not feel able to treat. Instead, the most effective approach is likely to be mental health and substance use services that work together. In practice, to achieve this vision, support will be provided to ensure services work collaboratively and that existing pathways are followed.”

The second strategy which also considers DD is the substance misuse framework *Making Life Better: Preventing Harm & Empowering Recovery*.⁸⁷ The framework states:

*UK Guidelines on the Clinical Management of Drug Dependency*⁸⁸ are clear – no matter where the individual with co-occurring issues is first referred to, whether mental health or substance use services, they should work collectively together to address the issues and clients should not be referred back and forward between services unnecessarily.⁸⁹

Following the proposals outlined in the two strategies above, the Department was asked how it envisaged gaps in services would be addressed for individuals with a DD, the response was somewhat limited:

The Minister has committed to publishing the Mental Health Strategy in July 2021 and it is expected that this commitment will be met. It is envisioned that gaps in services will be met either through a reconfiguration of services or through provision of additional funding identified in the 10-year funding plan which will accompany the Mental Health Strategy. The upcoming strategies will consider

⁸⁴ Department of Health (NI) Draft Mental Health Strategy 2021-2031: Consultation Draft <https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-mhs-draft-2021-2031.pdf>

⁸⁵ Department of Health (NI) Draft Mental Health Strategy 2021-2031: Consultation Draft <https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-mhs-draft-2021-2031.pdf> p6.

⁸⁶ Personal correspondence with author and DoH Adult Mental Health Unit on 25.1.21.

⁸⁷ Department of Health (NI) Making Life Better – Preventing Harm & Empowering Recovery. <https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-sus-consultation.pdf>

⁸⁸ These guidelines are shared across the UK

⁸⁹ Making Life Better – Preventing Harm & Empowering Recovery. A Strategic Framework to Tackle the Harm from Substance Use <https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-sus-consultation.pdf> p65.

*the issue of dual diagnosis to ensure that those with dual diagnosis of mental health and addiction get the best care and treatment available.*⁹⁰

It is likely to be some time yet before there is more clarity on how these local services will be designed and delivered.

6. Neighboring Jurisdictions

This section of the paper provides a brief overview of the policy direction regarding DD in Ireland, England, Scotland and Wales. It is also noteworthy that each health care system is structured, operated, and funded differently.

6.1 Ireland

DD services in Ireland are generally managed between separate mental health and addiction services.⁹¹ Access to support and treatment can be further complicated as people may have to pay for some services - depending on medical card and insurance exemptions, and this can delay some people from seeking, or, being able to afford care. Further details on the types of services are documented elsewhere.⁹²

Different government departments are responsible for mental health and substance misuse policy. To date, no national guidelines on service provision for DD in Ireland exist. In 2016, the National Service Plan published by the Health Service Executive (HSE) highlighted the need for investment in DD.⁹³ Following this, the National Drugs Strategy (2017-2025)⁹⁴ published by the Department of Health (Ireland), set a goal to improve treatment and outcomes for individuals with a DD because of the lack of access to appropriate services. The strategy states:

Ensuring that people with a DD receive an assessment, an onward referral and timely access to appropriate treatment is extremely important. They may be dealing with the impact of trauma or a psychiatric disorder as well as experiencing problems as a result of alcohol and/or drug use. These individuals may also have physical and psychological health problems, disabilities, or problems with housing, employment and relationships or have a history of offending.

The strategy also sets out two actions to address the issue of DD namely:

- 1) Supporting a new Mental Health Clinical Programme.

⁹⁰ Personal correspondence with author and DoH Adult Mental Health Unit on 25.1.21.

⁹¹ https://alcoholforum.org/wp-content/uploads/2016/11/AlcoholForum_Report_DualDiagnosis.pdf p16.

⁹² See the types of services and how they are accessed in this report https://www.dualdiagnosis.ie/wp-content/uploads/2011/05/A-Z_mental_Health_2013.pdf.

⁹³ Health Service Executive National Service Plan 2016 <https://www.drugsandalcohol.ie/24939/1/HSEnsp16.pdf> p66.

⁹⁴ Department of Health (Ireland) Reducing Harm, Supporting Recovery (2017) http://www.drugs.ie/downloadDocs/2017/ReducingHarmSupportingRecovery2017_2025.pdf p45.

- 2) Developing joint protocols between mental health services and drug and alcohol services.

In 2017 the HSE established a steering group to implement the Mental Health Clinical Programme mentioned above.⁹⁵ Its aims were to facilitate the development of a regional model for access to more timely treatment, as well as evidence-based approaches to the identification, assessment and treatment of DD. But correspondence with the HSE (January 2021) has confirmed that the Programme has been subject to delays and challenges, and the model has yet to be rolled out.⁹⁶

A recent research report (2019) on DD in Ireland describes several community-based DD programmes operating in Ireland (in Cork, Tipperary, Clondalkin, Dublin City, Kilkenny, Limerick and Waterford). The aim of this research was to examine the level of service provision in two urban communities in North Dublin, and the barriers experienced for people with a DD and their families. Many issues were identified which echo some of the issues already discussed in this paper, as well as notable frustrations with the lack of progress, despite efforts for change:

“So far, we have seen from the literature that there has been a limited response to what is a huge complex need in communities across Ireland due to the fragmented government policy. Even where a process for developing a clinical programme was started, it emerged into nothing and presently there are no guidelines for any services in Ireland to provide a Dual Diagnosis service. This is not to say that communities and services are not trying to respond effectively.”

In addition to the findings, a number of recommendations (and a conceptual model) were developed for service improvements. These are presented in Figure 2 overleaf.

⁹⁵ National Clinical Programme for Mental Health (Health Service Executive, 2017). The aim of this Programme is to develop a standardised evidence-based approach to the identification, assessment and treatment of co-morbid mental illness and substance misuse. This includes increasing awareness of the frequent co-existence of mental illness and substance misuse; ensuring there is a clear clinical pathway for management of people with such a dual diagnosis, including when they present to Emergency Departments; ensuring a standardised service is provided across Ireland; and ensuring adolescents are also included within the scope of this Clinical Programme.

⁹⁶ Personal correspondence with author and Clinical Lead, Mental Health. Health Service Executive, January 2021.

DOMAIN	WHAT IS NEEDED	HOW CAN IT BE ACHIEVED
Community Response	Interagency Collaboration	Networking, Improved Communication, Identify Liaisons & Establish Community Groups
	Integrated Services	Agreements between mental health and addiction services & Implement Integrated Practices
	Information Sharing	Protocol for Information Sharing, Directory of Services & Improved Record Keeping
	Develop Referral Pathways	Standardised Referral Pathway, Improve Screening & Establish an Online Portal
	Develop Supports	Online forum and Resources, Phone Support & Access and Outreach Teams
	Family Support	Develop Family Support Services, Social Events & Support Groups
	Partnership Approach	Collaborative Approach between service users, families and service providers
Organisational Requirements	Training	Staff could attend a Dual Diagnosis programme & upskill in deficient areas
	Response to Trauma	Raise Staff Awareness, Training in Trauma Informed Care & Respectful Approach
	Develop Assessment Tool	Develop an Evidence-Based Tool
Governmental Responsibility	Care Pathway	Re-establish National Clinical Programme & Mimic Similar Policy Documents
	Change of Policies	Amend Mental Health Act and Clinical Governance Policies & Adopt 'No Wrong Door Approach'
	Improved Case Management	Online Database, Co-Working & One Case Manager per Service User
	Changes to Education	Develop Training and Education Programmes Which Can Incorporated Into Interdisciplinary Academic Programmes

Figure 2. Proposed DD service improvement framework.⁹⁷

In terms of further reading, research also conducted in 2019 by the Health Research Board, provides an in-depth review of the literature regarding how integrated systems

⁹⁷ Proudfoot, D, et al (2019) Dual Diagnosis: A Community Perspective <https://www.dualdiagnosis.ie/wp-content/uploads/2019/12/Final-Report.pdf> p47.

can be built using evidence-based models of care to improve outcomes for individuals with a DD.⁹⁸

6.2 England

Much of the policy on DD in England stems from the *Dual Diagnosis Good Practice Policy Implementation Guide* published in 2002.⁹⁹ It stipulates that care for DD should be high quality, patient focused and integrated, and that this should be delivered within mental health services. This type of model is referred to as “mainstreaming”¹⁰⁰ wherein the mental health (and substance use) workforce should be equipped to integrate substance use and mental health into their routine care plans; and that patients should not be shunted between different sets of services or put at risk of dropping out of care.

Since the original guidance was published, a number of subsequent guidance documents have been published on treatment approaches,¹⁰¹ service delivery for commissioners, providers and practitioners¹⁰² as well as UK-wide policy guidelines in relation to *Drug misuse and dependence* (2017).¹⁰³ England has also adopted a Care Programme Approach (CPA) which is a framework for inter-agency working. It seeks to ensure that individuals have a proper assessment and that services are co-ordinated and integrated in line with their needs.¹⁰⁴

Current policy in England sets out two key principles regarding DD care and treatment:

- 1) **Everyone’s job** – that commissioners and providers of services have a joint responsibility to work collaboratively to meet the needs of people with co-occurring conditions.
- 2) **‘No wrong door’** - that service providers have an open-door policy for individuals with DD. Commissioning enables services to respond collaboratively, effectively and flexibly offering compassionate and non-judgemental care centred around the person’s needs, which is accessible from every access point.

⁹⁸ Minyard K, et al. (2019) Treatment Services for people with co-occurring substance use and mental health problems. A rapid realist synthesis. HRB Drug and Alcohol Evidence Review 6. Dublin: Health Research Board.

⁹⁹ Mental Health Policy Implementation Guide Dual Diagnosis Good Practice Guide (2002) https://www.drugsandalcohol.ie/17764/1/DOH_Dual_diagnosis_good_practice_guide.pdf

¹⁰⁰ The rationale for this is that mental health services may be better placed to offer services such as assertive outreach, crisis management and long-term care than substance misuse services.

¹⁰¹ NICE (2016) Coexisting severe mental illness and substance misuse: community health and social care services <https://www.nice.org.uk/guidance/ng58>

¹⁰² Public Health England (2017) [Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers](https://amhp.org.uk/app/uploads/2017/08/dualdiagnostoolkit.pdf) (2017) See also Turning Point’s Toolkit <https://amhp.org.uk/app/uploads/2017/08/dualdiagnostoolkit.pdf>

¹⁰³ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group: Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2_017.pdf

¹⁰⁴ Rethink.org. website. The Care Programme Approach <https://www.rethink.org/advice-and-information/living-with-mental-illness/treatment-and-support/care-programme-approach-cpa/>

NICE guidance currently does not recommend a specialist DD service, as all services should to be competent to respond to these needs (i.e. Everyone's job),¹⁰⁵ and that this could exclude people further. The guidance also suggests that care need not be delivered in the same location, although people with co-occurring conditions reported positively on co-located services.

Despite the various policy recommendations, evidence collated by Public Health England (2017) suggests they have not been widely implemented¹⁰⁶ and that "*people are frequently unable to access the care they need from services, including when intoxicated or experiencing mental health crisis.*"

In response, the Five Year Forward View for Mental Health (and its implementation plan) and the Crisis Care Concordat have established national action plans in an attempt to address this unmet need.

6.3 Scotland

In 2003, the Scottish Executive identified the many problems associated with the needs of people with a DD and the need for improved service provision in its report *Mind the gaps: meeting the needs of people with co-occurring substance misuse and mental health problems*.¹⁰⁷ This was followed by *A Fuller Life* in 2004.¹⁰⁸ Findings from these reports resulted in a number of commitments for more joined-up DD services in the publication of *Closing the Gaps - Making a difference* in 2007.¹⁰⁹

Since then, there has been ongoing work in the area of DD. More recently Scotland's ten-year Mental Health Strategy (2017-2027) has two actions amongst 40 which relate specifically to DD that suggest gaps still exist:

Action 27: Test and learn from better assessment and referral arrangements in a range of settings for dual diagnosis for people with problem substance use and mental health diagnosis.

¹⁰⁵ Public Health England (2017) [Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers](#) (2017) p24.

¹⁰⁶ Ibid https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf p10.

¹⁰⁷ Scottish Executive (2003) *Mind the Gaps* <https://www.webarchive.org.uk/wayback/archive/20180517060539/http://www.gov.scot/Publications/2003/11/18567/29493>

¹⁰⁸ Cox, S. et al (2004) *A fuller life Report of the Expert Group on Alcohol Related Brain Damage* https://x.iriss.org.uk/sites/default/files/resources/ARBD_afullerlife.pdf

¹⁰⁹ Scottish Government (2007) *Closing the Gaps* <https://www.gov.scot/publications/mental-health-scotland-closing-gaps-making-difference-commitment-13/pages/7/>

Action 28: Offer opportunities to pilot improved arrangements for dual diagnosis for people with problem substance use and mental health diagnosis.¹¹⁰

The Scottish Government has also published guidance on *The delivery of psychological interventions in substance misuse services in Scotland*¹¹¹ for commissioners, and service providers. Likewise, correspondence with the Public Health Scotland shows it is consulting on standards for Medication Assisted Treatment¹¹² for the “*intention of more equitable mental health and substance use support*”¹¹³ for those with opioid disorders. These standards aim to see more in the way of partnership working; in terms of person-centred care - pharmacological treatment, psychological support for trauma or anxiety, and welfare or housing advice where needed.

In terms of people presenting in crisis, Scotland has also developed a Distress Brief Intervention programme to improve inter-agency working, and to provide compassionate connected support when people present to services in distress (for example at A&E, the Police, the Scottish Ambulance Service and primary care). Pilot projects have been in operation for four years across four sites and are due to be evaluated in 2021.¹¹⁴

6.4 Wales

Wales has a specific framework for mental health and substance abuse.¹¹⁵ It contains a number of core principles around holistic, timely care, integrated systems, effective communication and treatment protocols, with competent staff and an emphasis on the need for ease of access to services for people with a DD. It also stresses the need for partnership arrangements across a broad range of services including housing, homelessness, and criminal justice agencies.

Wales also has a mental health strategy entitled ‘*Together for Mental Health*’ and a substance misuse strategy ‘*Working Together to Reduce Harm*’.¹¹⁶ Each strategy is supported by its own Delivery Plan.¹¹⁷

¹¹⁰ Scottish Government (2017) Mental Health Strategy 2017-2027. <https://www.gov.scot/publications/mental-health-strategy-2017-2027/>

¹¹¹ Scottish Government (2018) <file:///C:/Users/Chris/Downloads/00536118.pdf>

¹¹² Scottish Drugs Death Taskforce (2020) MAT Standards for Scotland https://drugdeathstaskforce.scot/media/1164/sddt-mat-standards-for-consultation_nov2020.pdf

¹¹³ Personal correspondence author and Public Health Scotland’s Drugs Team on 22.01.21

¹¹⁴ Distress Brief Intervention <https://www.dbi.scot/>

¹¹⁵ Welsh Government: Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem (2015) <https://gov.wales/sites/default/files/publications/2019-02/service-framework-for-the-treatment-of-people-with-a-co-occurring-mental-health-and-substance-misuse-problem.pdf>

¹¹⁶ See <https://gov.wales/sites/default/files/publications/2020-06/together-for-mental-health-delivery-plan-plain-english-version.pdf> and <http://www.hcvaction.org.uk/sites/default/files/resources/Welsh%20sub.pdf>

¹¹⁷ See https://gov.wales/sites/default/files/publications/2020-10/review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19_0.pdf and <https://gov.wales/sites/default/files/publications/2019-10/substance-misuse-delivery-plan-2019-22.pdf>

At present there are no dedicated dual diagnosis services. Correspondence with the Welsh Government acknowledges, like in other jurisdictions, that services tend to work separately, and that DD has often been viewed and treated in isolation. In its response to a request for information regarding current service delivery, the Welsh Government states that it has committed to:

“investing significant time into promoting a more co-ordinated, collaborative approach and through a multiagency Strategic Group which is exploring the barriers to effectively joining both mental health and substance misuse services, notwithstanding that housing is a critical factor that also has to be considered.”

In terms of how services operate, the response goes on to indicate the benefits of co-located services:

“...There appear to be differing models across Wales that often are led by key individuals who have made the necessary links to other services and influence practice, rather than a corporate method of responding to need. Clearly where services are co-located, this assists greatly in producing better outcomes for individuals and we have in the past decade invested significantly in multi-agency hubs to meet this exact need. Often, it will depend on where the individual was initially referred to and thereafter the other services’ willingness to engage. It is often reported by service users that if they are in a substance misuse service, mental health services will not engage with them and vice-versa. This is most significant challenge that we have...”¹¹⁸

7. Conclusion

This paper has provided an overview of the challenges of DD from a service perspective. DD is a major and growing problem. Management of these conditions is complex, and people with a DD can present with differing needs depending on the level of severity of their problems. Historically, services for mental health and substance misuse have evolved and been commissioned separately. This has led to disjointed service provision. Despite evidence to suggest integrated practices are the way forward, coupled with numerous policy initiatives sharing similar sentiments for improved and more equitable access to care, evidence shows that healthcare systems have struggled to adapt to more collaborative ways of working. Around the UK and Ireland service gaps remain, as does unmet need. Given the prevalence of DD, and the implications COVID-19 pandemic, considerable leadership and resource will be required to implement services that are better equipped to meet the needs of this particularly vulnerable group.

¹¹⁸ Personal correspondence with the Welsh Government on 28.1.21