Coexisting severe mental illness and substance misuse: community health and social care services

NICE guideline
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Public Health England guidance on Co-existing alcohol and drug misuse with mental health issues: guidance to support local commissioning and delivery of care

[to be published December 2016]
Co-occurring substance misuse and mental health issues

Introduction

Welcome to the Co-occurring Substance Misuse and Mental Health Issues Profiling Tool. It has been developed to support an intelligence-driven approach to understanding and meeting need. It collates and analyses a wide range of publically available data around tobacco smoking, alcohol use and drug use, including data on prevalence, risk factors, treatment demand and treatment response. The tool also features indicators around mental health prevalence and services. From December 2016, it will also feature related indicators on mortality.

The tool provides commissioners, service providers, clinicians, service users and their families with the means to benchmark their area against other areas.

Although much of the data is already available, either in the public domain or through
Scope

- ‘Dual diagnosis’ or ‘co-morbidity’ covers a broad spectrum of mental health conditions and substance misuse problems that an individual might experience concurrently. The nature of the relationship between these two conditions is complex. Possible mechanisms include:

  - A primary psychiatric illness precipitating or leading to substance misuse
  - Substance misuse worsening or altering the course of psychiatric illness
  - Intoxication and/or substance dependence leading to psychiatric symptoms or illness (e.g. Acute or residual psychosis after substance misuse – F1*.7)

- Substance use does not inevitably lead to deterioration in mental health problems and may be used to cope with anxiety, hallucinations and sedation from medication with mixed effects. Assessment of individual responses, both positive and negative, is necessary for effective engagement and management.
• Problematic substance misuse is defined as that which would warrant the person being referred to the drug and alcohol service in the absence of a mental illness. However the presence of mental illness may lead to problems developing at a lower level of intake of substances and a lower severity of mental illness lead to greater problems with use of substances.

• ‘Personality disorders’ especially borderline and antisocial frequently provide a further degree of complexity. Where these have developed from complex trauma, psychological intervention can be successful but practitioners may need to work with substance misuse services to enable individuals to access it.
BACKGROUND

- Substance misuse and mental health services have evolved and been commissioned separately – within one service alone or shuttled between services.
- Repeated changes in the commissioning and design of both mental health and substance use services have led to confusion around access routes and interfered with collaboration. New services e.g. IAPT with new interfaces have developed.
- 30 – 40% of people with severe mental illness also have problems with substances.
- Up to 70% of people in drug services and 86% of alcohol services users experience mental health problems which precede the development of substance abuse problems in most individuals.
- The National Confidential Inquiry Into Suicide And Homicide By People With Mental Illness found that suicides among patients with a history of alcohol or drug misuse (or both) accounted for 54% of the total sample, an average of 671 deaths per year.
- 20% of mental health crisis related admissions to acute hospital via A&E in 2012/13 were due to alcohol use.
BACKGROUND

- Co-existing alcohol and drug misuse and mental health issues are the norm rather than the exception among most offenders. Liaison and Diversion Programme identified over 55% of service users in with mental health needs also had problem with either substance abuse.

- Amongst those with alcohol misuse issues, over three-quarters also suffered a mental health problem. In people with other substance misuse, the percentage who also demonstrated mental health needs was even higher at 79%.

- Both alcohol and drug misuse and mental health problems can lead to considerable physical morbidity and premature mortality (15-20 years in people with mental health problems and 9-17 years in those with alcohol and drug misuse disorders).
Guidance for delivery of care

- Secondary treatment services should work collaboratively and co-operate to meet the needs of people with dual diagnosis through existing mental health and drug and alcohol services. Any interventions designed to meet these needs should be reflected in *individualised care plans* that are jointly developed with service users, their families or carers and any care agencies.

- There are frequently differences in *clinical recording systems*. However, services need to ensure that they communicate effectively so that the differences do not create a barrier to communication.

- An initial *assessment* of mental health and substance misuse needs should be completed, and individuals should be supported to access other services as appropriate. The following principles should inform service delivery and development of working protocols between providers in mental health and substance misuse services:
Principle 1 – Providers in alcohol and drug, mental health and other services should have an open door policy for individuals with co-existing alcohol and drug misuse and mental health issues, and should make every contact count.

- Service users can access screening, advice and comprehensive assessment which address alcohol and drug and mental health issues, and other presenting needs in both alcohol and drug and mental health services.

**AUDIT/DUDIT & CORE**

- Use of diagnoses as exclusion criteria compounds issues of stigma and this is likely to result in unmet need and increased risk of harm.

- Services should work to identify risks and mitigations to support engagement of all presenting individuals (including intoxicated individuals).

- Additionally, every opportunity should be taken to reduce health harms and early death among individuals with these co-existing issues by offering advice and support to:
  - stop smoking
  - eat healthily
  - maintain a healthy weight
  - drink alcohol within the recommended daily limits
  - undertake the recommended amount of physical activity

- Components of the Assessment Process
Risk assessment

- The risk assessment process should explore the presence of different risk factors across a range of indicators and cover the dual issues of mental health and drug alcohol use (DH, 2007).

- Factors associated with the increased likelihood of particular risks include:
  - Poor compliance with medication regimes
  - Increased rates of inpatient admissions
  - Homelessness
  - Social exclusion
  - Offending behaviour
  - HIV or other BBV or physical health concerns
  - Disengagement from services
  - Suicidal ideation and actions
Crisis response:

- People presenting in crisis frequently have dual diagnosis and management can present complex problems. Presentations can be to the Emergency Department, Police, Ambulance or Acute and Community Mental Health Teams and Substance misuse services. Safety issues often arise in terms of risk to self or others especially when the individual is intoxicated.

- Management of the acute situation will focus on reducing agitation and risk to self or others. Assessment of mental state, including under the Mental Health Act, may be attempted but may have to await reduction in the intoxication. During this period, safety of the individual and others will be the priority. Assessment can then commence and appropriate actions taken which may include referral to substance misuse or mental health services.

- Prevention of further such presentations should then be undertaken through prompt re-assessment and offering appropriate services. Work on motivation to access services should be considered as it may be possible between periods of substance misuse.

- Early intervention should be facilitated by contact with relevant services through referral or duty worker/manager systems including early intervention for psychosis services.

- Frequent attenders at ED or presenting to emergency services should be considered by area **High Intensity User Groups** including mental health and substance misuse lead practitioners: **MyCrisisPlan**
How to know if this principle is translating to delivery:

· Service users:

  □ are never turned away from services based on levels of alcohol and drug use or degree of mental ill health, and are supported to access the care they need in the service(s) most appropriate to their needs

  □ have their alcohol and drug needs recognised, prioritised and responded to by mental health practitioners, and their mental health needs recognised, prioritised and responded to by alcohol and drug practitioners

  □ regardless of their entry point to the care pathway, report that the care they receive is timely, compassionate and responsive to their needs

  □ are encouraged and supported to make healthier choices to achieve positive long-term behaviour change
Making Every Contact Count
Skills Workshop Session

Developed for the East Midlands Health Trainer Hub, hosted by NHS Derbyshire County
Alcohol

Why is it important?

Drinking too much alcohol increases the risk of developing:

• Serious liver disease
• Stomach and pancreas disorders
• Anxiety and depression
• Accidents
• Cancers (mouth, liver, colon and breast)
• Muscle and heart disease.
Alcohol

Suggestions you could make:

• Don’t binge drink

• Consider drinking a non-alcoholic drink to quench your thirst before having alcohol

• Pace yourself – set a limit and stick to it

• Try to eat when you drink as you’ll drink less

• Reduce the number of days when you drink more than 1-2 units

• Go out to the pub or club later in the evening

• Resist pressures to drink more.
How to know if this principle is translating to delivery:

- Clinicians and frontline staff:
  - Use effective screening, assessment, and (where appropriate) diagnosis information to inform development of comprehensive care planning, never to exclude people from services.
  - Ensure where people are assessed as having co-existing issues that the provider addresses both initially and refers on when needed, rather than only addressing one area of need.
  - Work flexibly across organisational boundaries to enable service users to access the care that they need for alcohol, drug and mental health issues.
Principle 2 - Providers of substance misuse and mental health services have a joint responsibility to meet the needs of individuals with co-existing substance misuse and mental health issues

- The assessment and treatment of people who need care for co-existing alcohol and drug misuse and mental health issues are the responsibility of both mental health and alcohol & drug services, and all partners need to work together effectively across and outside organisational boundaries to meet their needs.

- Mental health and alcohol and drug services should work together in line with relevant NICE and other national guidance, to deliver evidenced based interventions as part of jointly agreed care pathways. These should be jointly planned, designed to minimise any gaps in provision and opportunities for disengagement and relapse. Services should also work in partnership with other services as necessary, particularly housing, employment and criminal justice services. If services are unable to engage certain individuals this should be seen as a system failure not a client failure. The partnership should work with the individual and services involved to establish better or more appropriate ways of engaging these individuals.
Individuals with co-existing alcohol, drug and mental health issues are often at significant risk of suicide and self-harm, particularly during periods of intoxication or untreated withdrawal. Services (particularly crisis care services) need to be able to respond appropriately and safely to mental health needs such as suicide risk which arise during periods of intoxication where the individual is not dependent on alcohol or drugs.

Services also need to be able to respond effectively to individuals who present a risk to others e.g. violent/sex offenders or MAPPA clients who may not engage well with treatment services, but may present in crisis. This is likely to require short-term safety measures with provision of longer-term support with mental health and/or substance use issues.
Treatment Pathway

- Following identification of Dual Diagnosis or Co-morbidity, AMH will allocate a Care Co-ordinator or lead professional who will develop a care plan. The allocated Care Co-ordinator maintains lead responsibility for the care and is responsible for arranging a joint assessment with Substance Misuse Services when appropriate. A joint assessment with Substance Misuse is when the care needs identified may be best met by a joint intervention and joint care planning from both Mental Health and Substance Misuse Services.

- Depending on service user’s needs, it may not be necessary to refer to a substance misuse co-worker, however, it is the responsibly of the care co-ordinator to ensure that the service user’s substance misuse needs are assessed and met and mental health may not have all the resources required to meet the substance misuse needs. In addition, the service user may not consent to a referral to Substance Misuse Services. In such circumstances, it is the care co-ordinators responsibility to assess the risks and plan the management of these risks in relation to the Substance Misuse needs.

- Pharmacological treatments, e.g. naltrexone, methadone and acamprosate, will usually be prescribed through substance misuse services but Shared Care Guidelines can enable their use by other doctors with support.

- AMH and Substance Misuse will proceed with the treatment intervention, monitor progress against the Care Plan objectives which will be reviewed regularly.
Treatment Approaches

- **Engagement** – this should be non-confrontational, empathic and respectful of the client’s subjective experience of substance misuse. It may also have to focus on meeting a client’s immediate practical need rather than focusing on the cessation of substance misuse.

- **Motivation for change** – the purpose is to strengthen a person’s motivation and commitment to change whilst avoiding confrontation and resistance. Techniques include detailing objective assessment of the current situation, pros and cons of continual use, barriers to change etc.

- **Active treatment** – it needs to be acknowledged that it may take some time before the person is ready to engage in active treatment interventions for their substance misuse, it may be more appropriate to focus on harm reduction.

- **Relapse prevention** – given the chronic relapsing nature of substance misuse it is important that interventions focus on identifying high-risk situations and rehearsing coping strategies. As people may be in different stages in relation to their mental health and substance misuse, it is important that interventions are flexible and that the workforce is skilled in working in this way.
Behavioral Interventions for Individuals Dually Diagnosed with a Severe Mental Illness and a Substance Use Disorder

‘We evaluate recent studies of behavioral interventions for substance abuse among SMI individuals. These include cognitive–behavioral, motivational interviewing, and contingency management interventions, as well as combinations thereof. Consistent with prior systematic reviews, ours indicates that no behavioral intervention has clearly demonstrated efficacy beyond that of usual care.

Clara M. Bradizza & Paul R. Stasiewicz & Kurt H. Dermen

CBT & dual diagnosis

- Integrated motivational interviewing and cognitive behavioural therapy for people with psychosis and comorbid substance misuse: randomised controlled trial

- Does not improve outcome in terms of hospitalisation, symptom outcomes, or functioning.

Barrowclough et al: BMJ 2010; 341
## CBT in dual diagnosis

A randomised study in patients with comorbid alcohol or substance abuse

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GAF, Global Assessment of Functioning scale

* p<0.05 integrated vs routine care

† Integrated care = routine care + CBT + motivational interviewing + family intervention

Barrowclough et al 2001; Haddock et al 2003
CBT & dual diagnosis

- Cognitive behavior therapy for schizophrenia in patients with mild to moderate substance misuse problems.

- Brief CBT trial (6 individual +3 family sessions) with positive outcomes at 3 mths and 1 year - no difference compared to non-substance users

Special Consideration Groups

- **Young People**
  - 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 (Dual Diagnosis Good Practice Guide).

- **Homeless People**
  - Studies have highlighted high levels of concurrent substance misuse and mental health problems amongst the homeless and rough sleepers. Homelessness almost trebles a young person’s chance of developing a mental health problem (Dual Diagnosis Good Practice Guide 2002). Collaborative working with Homeless Healthcare Teams can lead to benefits for this group.
Special Consideration Groups

- People from Ethnic Minorities
  - Ethnicity is associated with poor access to services generally and, with different meanings and values attributed to drugs and alcohol, need to be understood. Service provision must therefore be congruent with and sensitive to the needs of each ethnic group.

- Safeguarding Vulnerable Children and Adults
  - The Children Act sets out the responsibilities of local authorities and other services for protecting children and promoting their welfare. The Act places a duty on agencies engaging with people who misuse substances who have dependent children and on mental health services to assess the needs of children, their health and well-being as they may be at risk.
  - Within the risk assessment full account should be taken of the particular challenges posed by parents with dual diagnosis problems, and the need for supervision, staff training, assessment, care management, and inter-agency liaison.
  - Where there are safeguarding concerns for the service user, the Mental Health Service will remain the lead agency for the safeguarding process.
Best Practice in Dual Diagnosis
Who is Responsible for Co-ordinating Care?

Client assessed in mental health, drugs or alcohol services

Standardized measures completed to supplement clinical assessment
- Concerns re alcohol – use AUDIT
- Concerns re drug use – use DUDIT
- Concerns re mental health problems – less severe – use PHQ-9 & GAD-7
  - more severe – use CORE-OM

HIGH mental health need  
HIGH substance misuse need  
- Lead: AMH  
- Joint working with: Assessment, Review & Monitoring Service (ARMS) (25yrs+)
- No Limits / DASH (11-24yrs)

HIGH mental health need  
LOW substance misuse need  
- Lead: AMH  
- Support from: Assessment, Review & Monitoring Service (ARMS) (25yrs+)
- No Limits / DASH (11-24yrs)

LOW mental health need  
HIGH substance misuse need  
- Lead: Assessment, Review & Monitoring Service (ARMS) (25yrs+)
- No Limits / DASH (11-24yrs)
- Support from: Steps to Wellbeing

LOW mental health need  
LOW substance misuse need  
- Joint Working: Assessment, Review & Monitoring Service (ARMS) (25yrs+)
- No Limits / DASH (11-24yrs)
- Steps to Wellbeing
Service design

- Dual diagnosis ‘champions’ selected in CMHT’s, AMHT, Inpatients
- Local DD Pathway groups: AMH managers, clinicians and ‘champions’, SA providers incl clinicians, LA, homeless, hostels, commissioners, etc
- Hampshire ‘oversight’ committee
Training Requirements

- Training will be available to all staff in both Adult Mental Health and Substance Misuse Services, who routinely come into contact with people with dual diagnosis and will seek to involve reciprocal training from partner agencies.

- Training needs around complexity of care planning and risk management are met within current risk management and CPA training.
  - Level 1 Dual Diagnosis training addresses skills, attitudes and knowledge to screen, detect and be aware of the needs of service users with dual diagnosis (interactive training package)
  - Level 2 Dual diagnosis training addresses skills and competencies to deliver effective care in relation to comprehensive assessment engagement and treatment approaches.
  - Level 3 Training for dual diagnosis ‘Champions’ – individually assessed and may include secondment opportunities to substance misuse services.
Conclusions

• Dual diagnosis is common and can be complex and risky to manage

• Relationships between organisations and teams are key: responsibilities need to be defined and joint working considered

• Preventative work e.g. MECC, is simple to do

• Treatment involves effective care coordination but evidence for specific interventions is limited: consider involving families