**Agenda Item No. 5**

# Dual Diagnosis of Substance Misuse and Mental Health Conditions

To: Health and Wellbeing Board

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## 1.0 PURPOSE

1.1 The purpose of this report is to provide the Health and Well Being Board with information regarding issues, concerns and recommendations relating to dual diagnosis of substance misuse and mental health conditions. For the purposes of this paper substance misuse refers to drugs and alcohol. This is a cross cutting issue and a similar issue is being taken to the Peterborough Health and Wellbeing Board.

## 2.0 BACKGROUND

2.1 There is a spectrum of overlapping or co-occurring substance misuse and mental health conditions, which range from mild to severe. The severity of each of these conditions may vary greatly, and at what point, or threshold, a dual diagnosis is defined will vary. Locally the term dual diagnosis is used for patients with both severe mental illness and drug and/or alcohol use. In clinical terms severe mental illness refers to a clinical diagnosis of schizophrenia, schizotypal and delusional disorders, bipolar affective disorder, severe depressive episode(s) with or without psychotic episodes and specific personality disorder. These individuals have very complex issues and are often very vulnerable with multiple needs.

Co-occurring disorder is a broader term that encompasses a wider range of people who have alcohol/drug misuse problems together with a mental health problem of any severity.

2.2 People with these co-existing mental illness and substance misuse have some of the worst health, wellbeing and social outcomes. Duality serves to amplify their health and social problems dramatically, leading to greater rates of homelessness, suicide, relapse, crime, and isolation with social function and quality of life rapidly declining.

2.3 The following data taken from a range of national studies describe the scale of dual substance misuse and mental health issues, indicate that it is a long standing issue and describe the context and how it impacts upon different parts of the system.

- Signs of drug dependence were evident in one adult in thirty, with a similar level found for probable alcohol dependence. Both types of substance dependence were twice as likely in men as women. (2016)
- Approximately 40% of people with psychosis misuse substances at some point in their lifetime, at least double the rate seen in the general population. (2016)

- 20% of mental health hospital admissions were due to alcohol use (the second highest cause after self-harm and undetermined injury. (2015)
- More than one in five (22%) of 189 drug treatment services in England say that access to mental health services deteriorated over the 12 months to September 2014.
- 54% of suicide and homicide by people with mental illness had a history of drug or alcohol misuse (or both): an average of 671 deaths per year. (2015)
- 12% of homeless people have both a mental health and substance misuse problem. 41% of homeless people surveyed by Homeless Link said that they used alcohol or drugs to cope with their mental health issues. (2014)
- Up to 70% of people in drug services and 86% of alcohol services users experienced mental health problems. (2003)
- 14% of alcohol dependent adults also receive treatment for a mental health issue. (2007)
- 4 in 5 prisoners who are drug dependent have 2 additional mental health problems. (2009)
- Between 22 and 44% of adult psychiatric inpatients in England also have a substance misuse problem. (2009)

2.4 Data from mental health and substance misuse services for Cambridgeshire paints the following picture:

- In 2014/15 the Camdbridgeshire Child and Adolescent Substance Use Service (CASUS) received 38 referrals from health and mental health services; this was 17-19% of referrals each quarter.
- Of those in adult drug treatment in 2014/15 in Cambridgeshire, 23% of newly presenting clients (126 individuals) were also in contact with mental health services for reasons other than substance misuse. This is slightly higher than the England average. (21%)
- Of those in adult alcohol treatment in 2014/15 in Cambridgeshire, 51 clients (6%) were also receiving care from mental health services for reasons other than substance misuse. This is below the England average (20%).
- In 2013/14 there were 732 hospital admissions where there was a secondary or primary diagnosis of drug related mental health and behavioural disorders and in 2014/15 2,125 hospital admissions due to alcohol related mental or behavioural disorders in Cambridgeshire. There has been an increase in concurrent mental health and substance misuse hospital admissions between 2013/14 and 2015/16. This is described and broken down to Appendix 1.

2.5 In 2015 an audit of suicides in Cambridgeshire and Peterborough was undertaken. There were 66 suicides and of these 52 of the cases were audited. Fifteen of the cases had a current or historical substance misuse problem. Of these cases nine also had a diagnosis of a mental health condition. None fell into the definition of the local definition of dual diagnosis, that is, severe mental health and substance misuse issues. Care should be taken however in interpreting this as other factors may be implicated in the suicide.

2.6 Dual substance misuse and mental health conditions impacts on physical health and is associated with a wide range of socio-economic issues that demand input from a range of services. The prevalence of health and social care needs are much higher for individuals with dual conditions than for comparable groups without duality, particularly in terms of

severity of mental health symptoms, medication non-adherence, homelessness, violence and contact with the criminal justice system as either a perpetrator or a victim.

2.7 These wide ranging impacts are difficult to quantify and, along with the lack of agreement with regard to definitions, has affected the development of any robust economic evidence for impact and treatment. There is limited economic analysis of the costs of treating severe mental health and substance misuse issues. The costing statement for the recent National Institute for Health and Care Excellence (NICE) guidelines on dual diagnosis states that hospital episodes may be twice as long for people with psychosis and co-existing substance misuse when compared with people with psychosis alone, the costs are likely to be higher for people with both conditions. The cost of inpatient mental health episodes per occupied bed day varies between £418 in a low security service and £763 in a maximum secure unit. NICE recommends that effective management of these patients can avoid hospital admissions.

With regard to service configurations, NICE concluded that currently there is no robust economic evidence for collaborative models for people with a dual diagnosis and the important public sector and wider societal costs are excluded in any studies to date.

2.8 The model of individually funded and commissioned mental health and substance misuse services has a risk of creating a fragmented approach which is reflected in the experience of the service user. It has the potential to exacerbate issues for those who suffer with both, given the enhancing nature of the problems. There are longstanding policies from, for example, NICE and the NHS's Five-year Forward View for Mental Health that call for early intervention and effective collaboration across substance misuse and mental health services along with other support organisations that address factors such as criminal justice, housing or employment.

NICE guidelines produced in 2011 and more recently in 2016 on severe co-existing mental health and substance misuse problems advocate a multi-agency approach to provide holistic care and ensure that joint strategic working is in place to provide continuity of care and services. Working between agencies should include joint assessments and agreeing joint care pathways and a protocol for sharing information between mental health, substance misuse services, health, social care, education, housing, voluntary and community services. The emphasis is on flexibility and adapting existing services, rather than creating a specialist 'dual diagnosis' service that requires a whole systems approach to commissioning.

2.9 In 2014 the Cambridgeshire and Peterborough Dual Diagnosis Strategy and Protocols were produced by a range of agencies that included the Cambridgeshire and Peterborough Clinical Commissioning Group, mental health and substance misuse providers, the constabulary and voluntary sector. The Strategy reflects the NICE guidelines and has a focus upon those with a dual diagnosis having ready access to co-ordinated inter-agency assessment, treatment and support to address the complex mix of problems they present with. It calls for a consistent model for service delivery with more effective working across individual agencies with clear access arrangements. Training and upskilling of staff was seen as essential to enable them to effectively identify, assess needs and plan collaboratively a joint care plan. To support the Strategy, Protocols were developed that for the shared processes and pathways that would be used in the management of dual diagnosis.

## 3.0 SUPPORTING PARAGRAPHS

3.1 In 2016 the Cambridgeshire Drugs and Alcohol Joint Strategic Needs Assessment (JSNA) described on-going issues with the management of dual diagnosis that were undermining the implementation of the Dual Diagnosis and Protocols. Subsequent discussions with key stakeholders, which included commissioners and providers, have confirmed and developed the issues associated with managing dual substance misuse and mental health problems.

3.2 As indicated above, defining dual diagnosis can be problematic and this is impacting upon identification, diagnosis and treatment. The effective use of the pathways found in the Strategy and Protocols could be enhanced if definitions were universally agreed between all services and embedded into commissioned service pathways.

3.3 Training for staff working in substance misuse and mental health services is recommended by NICE and is an integral part of the Strategy and Protocols. The aim is to increase their awareness and enable them to assess, refer and manage patients collaboratively with other relevant services. Although some staff have received training this is by no means universal. A report by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) describes a further layer of complexity to this issue. This involves the difference in philosophies and therapies traditionally used by mental health and substance misuse services. Standard psychiatric practice once was to recommend treatment for substance misuse prior to mental health treatment as it was thought that this was necessary for engagement with therapy. Furthermore, it required drug users with mental health problems to cease drug use completely for recovery. Conversely, people who worked in the drug treatment field did not have knowledge or training around recognition of mental health problems.

3.4 A strongly held view is that the lack of any data sharing agreements between substance misuse and mental health services exacerbates staff reservations relating to joint care planning. The lack of data sharing agreements has the potential to create risks for the patient. This has been referred to in the initial responses to a survey currently being undertaken by the Cambridgeshire Drug and Alcohol Commissioning Team amongst staff working in substance misuse services, where it is associated with serious incidents. However, it should be noted that the results of this staff survey have not been validated through any type of audit.

3.5 There is a need for caution when interpreting data relating to dual substance misuse and mental health issues. The data provided above excludes those not seeking treatment for their mental illness or substance misuse problems. NICE estimates this to be around 50% of those affected which is linked to stigma. In addition, patients are not routinely asked in some services about both conditions as part of a routine initial assessment. This has been attributed to staff concerns about it undermining the therapeutic relationship. These factors combined with limited training and concerns with data confidentiality have the potential to underestimate need.

It is possible to apply national prevalence figures to local populations and use small studies to identify how many patients with the conditions should be represented in local services. This analysis suggests that the numbers identified with these conditions are lower than that suggested by the modelling. However, these kind of national study estimates, applied to

local demography for mental health related issues, often generate wide ranges of estimated numbers for prevalence/cases/clients.

3.6 The local Strategy and Protocols have three core pathways and supporting protocols that reflect the severity of mental health and substance misuse issues. This includes those with lower levels of severity who do not fall into the severity associated with the term dual diagnosis. (See Appendix 2).

1. Severe mental health and severe substance misuse leads to the dual diagnosis pathway which provides a joint assessment and a collaborative care package approach.
2. Severe mental health and low substance misuse leads to a mental health pathway.
3. Severe substance misuse and low mental health issues leads to substance misuse pathway.

The concerns associated with these pathways focus most strongly upon the criteria for accessing services:

a. The threshold for accessing the dual diagnosis pathway, which is considered to be the most effective pathway, is set too high and excludes patients who have complex mental health and substance misuse issues that might not require the care provided by the dual diagnosis pathway but are unable to access other appropriate provision;

b. Patients with mild to moderate mental health issues access the Increasing Access to Psychological Therapies (IAPT). However, if they have severe substance misuse issues this service will not provide care. A similar situation is found amongst those assessing the personality disorder services.

The shared view amongst stakeholders is that the needs of those who are unable to access the Dual Diagnosis Pathway are not being met and they are excluded from collaborative care planning processes.

3.7 In summary, these factors contribute to a fragmented and uncertain picture of both the scale and management of dual diagnosis and co-occurring disorders. As indicated earlier the current NICE Guidelines do not recommend a bespoke dual diagnosis or co-occurring condition service, but comprehensive collaborative planned services. These include not just mental health and substance misuse services but also those that help address wider socio-economic issues that are barriers to recovery. A number of recommended actions have emerged for addressing the issues highlighted in this paper and improving services in Cambridgeshire and Peterborough. The aim is to ensure that services are providing the most effective accessible collaborative treatment pathways and wider interventions for the full spectrum of dual mental health and substance misuse issues.

3.8 **Identify an inclusive collaborative delivery model.** Local stakeholders to revisit the Strategy and Protocols to ensure that pathways capture the full spectrum of mental health and substance misuse needs. They need to be supported by clear definitions of diagnoses, protocols for ensuring that all patients with either what is classified as a dual diagnosis or on the wider spectrum of co-occurring disorders, have access to a collaborative care plan that addresses both conditions, as well as their socio-economic issues.

3.9 **Evidence for service delivery**: There is a lack of evaluated evidence based service delivery models. However, there are some examples from around the country where more innovative approaches to collaborative service delivery have been explored which could inform many aspects of the pathways.

3.10 **Robust alignment of commissioning strategies to underpin the local Strategy and Protocols.** A business case needs to be developed to inform the alignment of commissioning strategies and their translation into robust commissioning practice that will deliver positive outcomes. This will include the identification of the any innovation that is cost effective and has the potential for cost savings.

3.11 **Data Sharing Agreements**: An audit is required to validate the anecdotal reports of risks to patients that are linked with a lack of data sharing agreements. The feasibility of establishing data sharing agreements could be explored.

## 4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 This paper links to Priority 4 of the Cambridgeshire Health and Well Being Strategy "Create a safe environment and help to build strong communities, wellbeing and mental health" This priority includes a focus upon implementing early interventions and accessible, appropriate services to support mental health, particularly for people in deprived areas and in vulnerable or marginalised groups, minimise the negative impacts of drug and alcohol misuse, working with local partners to prevent and tackle homelessness. http://www.google.co.uk/url?url=http://www.cambridgeshire.gov.uk/download/downloads/id/359/cambridgeshire_health_wellbeing_strategy_2012-2017&rct=j&frm=1&q=&esrc=s&sa=U&ved=0ahUKEwjRkJrChMfSAhXnBsAKHU6fAbAQFggUMAA&usg=AFQjCNHHXBDKFye01DkFeKhCX9kbB9xqXg

## 5.0 IMPLICATIONS

5.1 In terms of resources the alignment of commissioning has the potential to increase effectiveness and efficiency through patients being treated more effectively, preventing progression to more intensive possibly more costly inpatient services.

5.2 There is a risk of patients with complex conditions not receiving the appropriate evidence based services that will address both their mental health and substance misuse needs. There are also risks related to the need for information sharing agreements that would facilitate the improvement of patient care.

5.3 Those who misuse substances and have mental health issues are a highly vulnerable group and the recommendations in the paper target this group.

5.4 It is recommended by NICE that patients and their families are included in service development initiatives.

## 6.0 RECOMMENDATION/ DECISION REQUIRED

6.1 The Health and Wellbeing Board is recommended to:

- Comment on the issues raised in this paper;

- Endorse the recommendations for taking forward the alignment of commissioning strategies to strengthen and develop services for those who have mental health problems and misuse substances.

## 7.0 SOURCE DOCUMENTS

| Source Documents | Location |
|---|---|
| Cambridgeshire Drug and Alcohol Joint Strategic Needs Assessment (2016) | *http://cambridgeshireinsight.org.uk/JSNA/Drugs-and-Alcohol-2015* |
| Crome I. et al The relationship between dual diagnoses: substance misuse and dealing with mental health issues. Social Care Institute for Social Excellence 2009 | Social Care Institute for Social Excellence 2009 *http://www.scie.org.uk/publications/briefings/briefing30/* |
| Co-existing alcohol and drug misuse with mental health issues: guidance to support local commissioning and delivery of care. Draft | Public Health England: |
| NHS Five Year Forward Plan for Mental Health | Department of Health |
| Coexisting severe mental illness and substance misuse: community health and social care services | NICE Clinical Guideline 58 2016 https://www.nice.org.uk/guidance/ng58 |
| Cambridgeshire and Peterborough Dual Diagnosis Strategy | 2014 |
| Cambridgeshire and Peterborough Dual Diagnosis Protocol | 2014 |
| Weaver et al (2003) Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. | The British Journal of Psychiatry Sep 2003, 183 (4) 304-313 |
| The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness | Annual Report 2015: England, Northern Ireland, Scotland and Wales July 2015. University of Manchester. |
| Care Quality Commission (2015) Right here, right now | http://www.cqc.org.uk/sites/default/files/20150611_righthere_mhcri |

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| | siscare_summary_3.pdf |
| The Bradley Commission (2009) the Bradley Report | *http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf* |
| Seeing double: meeting the challenge of dual diagnosis | *NHS Confederation (2009)* |
| The unhealthy state of homelessness: health audit results 2014 | *Homeless Link* |
| Adult Psychiatric Morbidity Survey 2014 | *http://content.digital.nhs.uk/catalogue/PUB21748* |
| Understanding dual diagnosis | *Cambridgeshire and Peterborough Foundation Trust http://www.cpft.nhs.uk/downloads/martin/dualdiagnosis.pdf* |
| Bell D: Leeds Dual Diagnosis Project Bell D 2014 | *Leeds Clinical Commissioning Group http://www.dual-diagnosis.org.uk/wp-content/uploads/2011/09/Future-DD-Needs-Report-2014-final.pdf* |
| Hawkings C., Gorry Y., Todd T., King M. Listening to Service Users: Developing Service User Focused Outcomes in dual diagnosis. A Practical Tool | *National Mental Health Development Unit http://www.dualdiagnosis.co.uk/uploads/documents/originals/listening-to-service-users.pdf* |
| State of the Sector 2014 – 15 | *Drugscope* |
| Platt S, McLean J, McCollam A, Blamey A, Mackenzie M, McDaid D, et al. Evaluation of the first phase of Choose Life: the national strategy and action plan to prevent suicide in Scotland. | *Scottish Executive Social Research; 2006 / PHE (2017) Support after a* |

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| | *suicide: a guide to providing local services* |
| Watson, S; Hawkings, C. Dual diagnosis: Good practice handbook 2007 | *Turning Point.* |
| Rassool, H. Dual Diagnosis in Nursing. 2006 | Blackwell Publishing |
| NICE Guideline NG 58 Coexisting severe mental illness and substance misuse: community health and social care services (2016) | https://www.nice.org.uk/guidance/ng58/history |
| Lankelly Hard Edges: Mapping Severe and Multiple Disadvantage in England (2015) | Chase Foundation and Heriot-Watt University |
| Megnin-Viggars o. , Brown M., Marcus E., Stockton S., Pilling S.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 - A systematic review (2016) | National Collaborating Centre for Mental Health https://www.nice.org.uk/guidance/ng58/evidence/evidence-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-2727941293 |
| Slade E., Stockton S. Pilling S. Which service models for health, social care and voluntary and community sector organisations are cost-effective and efficient at meeting the needs of people with a severe mental illness who also misuse substances? (2016) | National Collaborating Centre for Mental Health (NCCMH) https://www.nice.org.uk/guidance/ng58/evidence/evidence-review-4-which-service-models-for-health-social-care-and-voluntary-and-community-sector-organisations-are-costeffective-and-efficient-at-meeting-the-needs-of-people-with-a-severe-mental-illn-98205886548 |

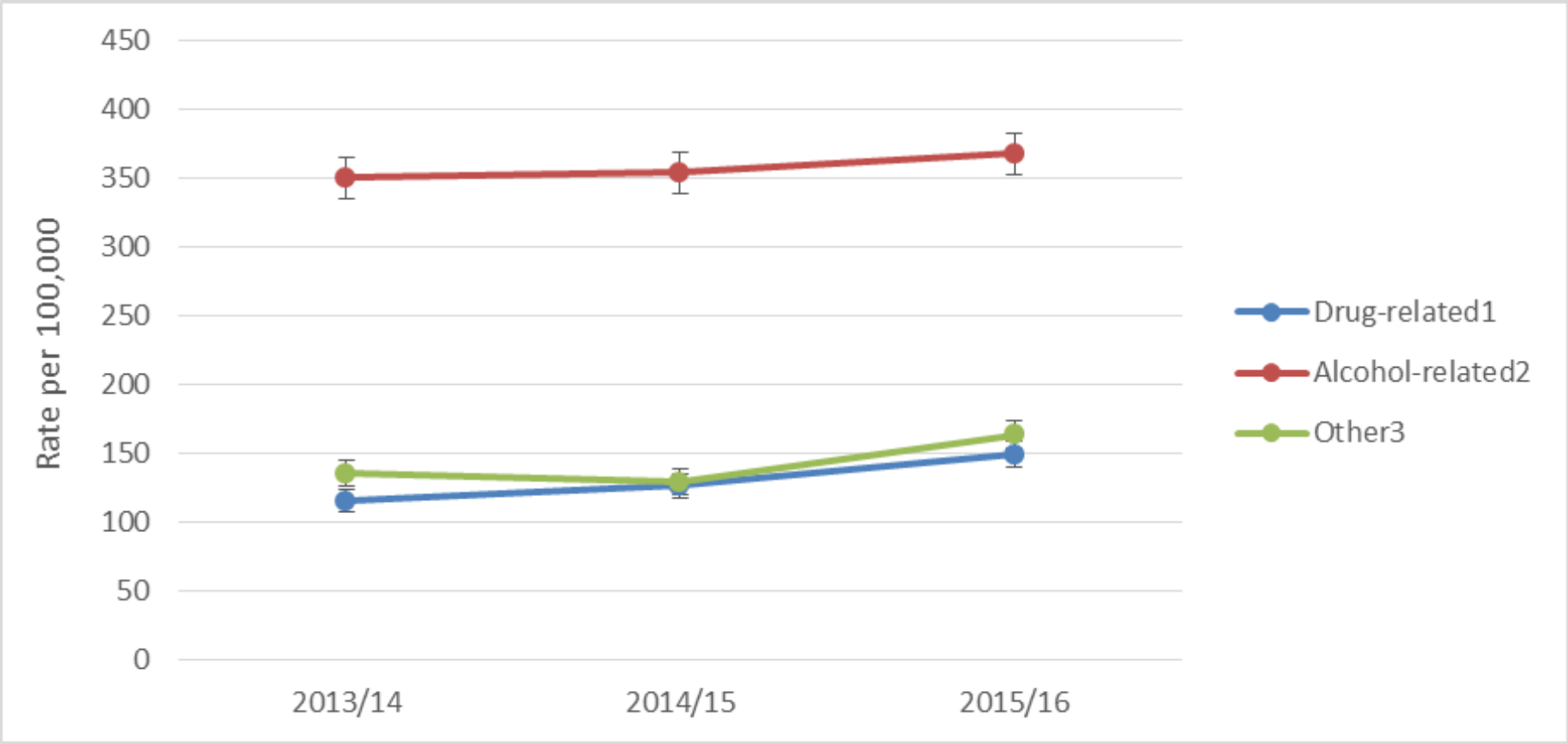
**APPENDIX 1**

## Hospital Admissions for Dual Diagnosis

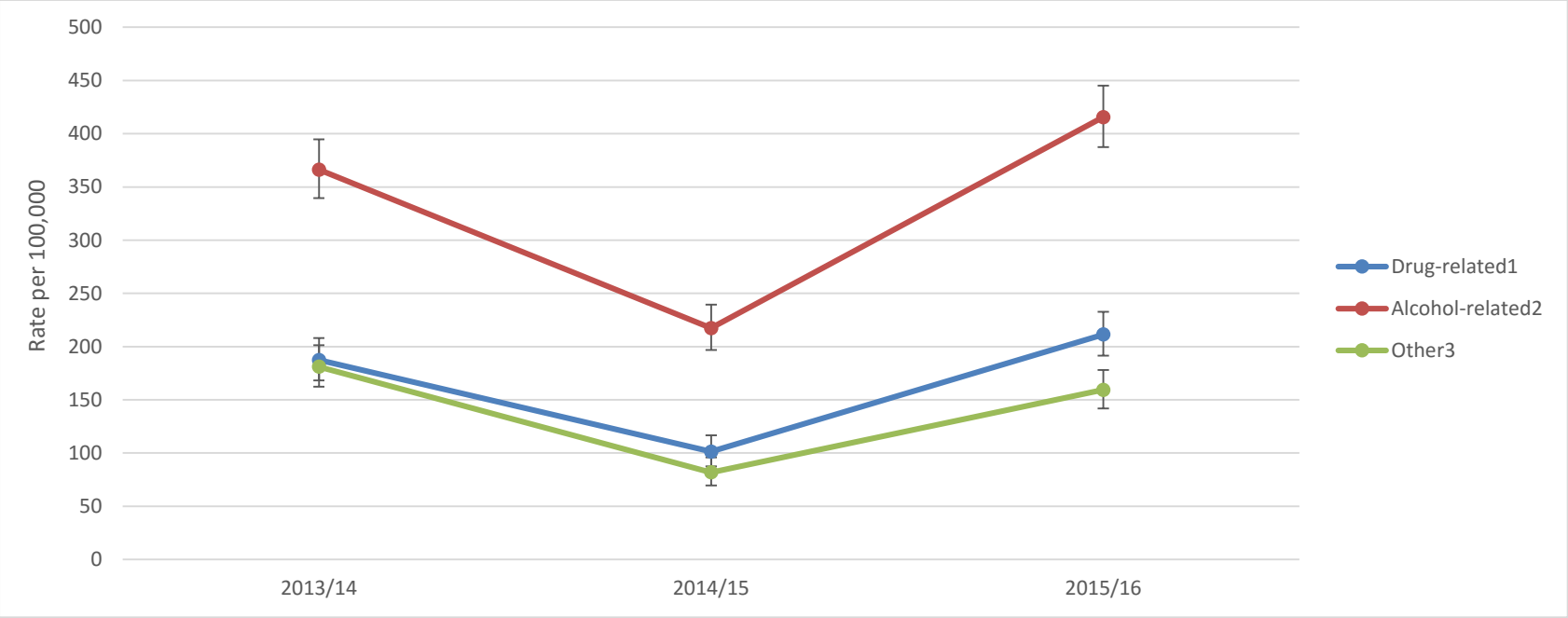
In Cambridgeshire, there was a 28% increase in concurrent mental health and drug admissions between 2013/14 and 2015/16 and a 10% increase in concurrent mental health and alcohol related admissions. In Peterborough, there was a 16% increase in concurrent mental health and drug admissions between 2013/14 and 2015/16 and a 17% increase in concurrent mental health and alcohol related admissions

This increase is shown in the graph below where 'other' relates to admissions with both a recorded mental health or behavioural condition and substance misuse problem but where the admission was for a different reason.

**Hospital Admissions with recorded concurrent substance misuse and mental and behavioural disorders Cambridgeshire 2013/14 – 2015/16**

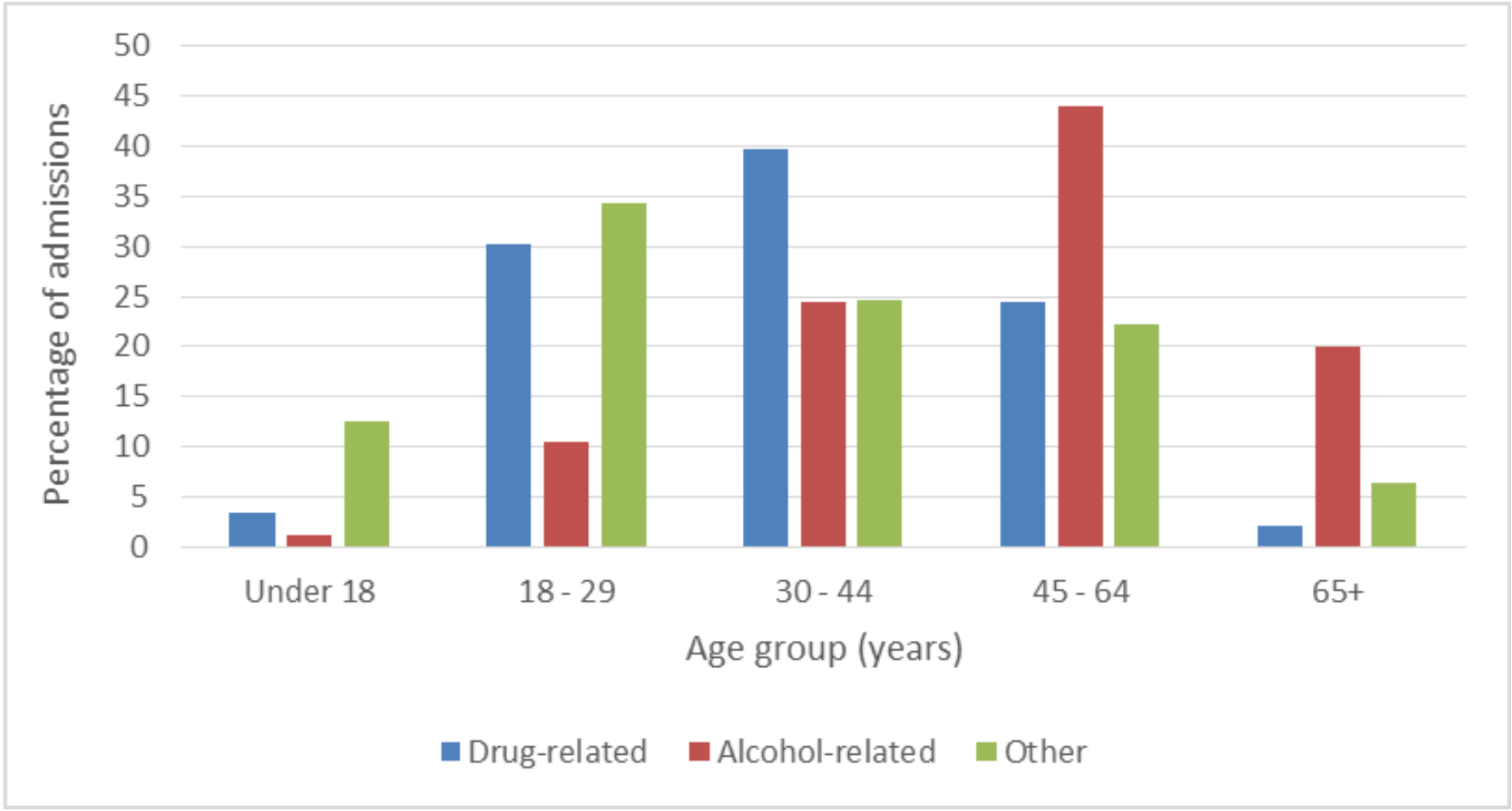


**Hospital Admissions with recorded concurrent substance misuse and mental and behavioural disorders Peterborough 2013/14 – 2015/16**

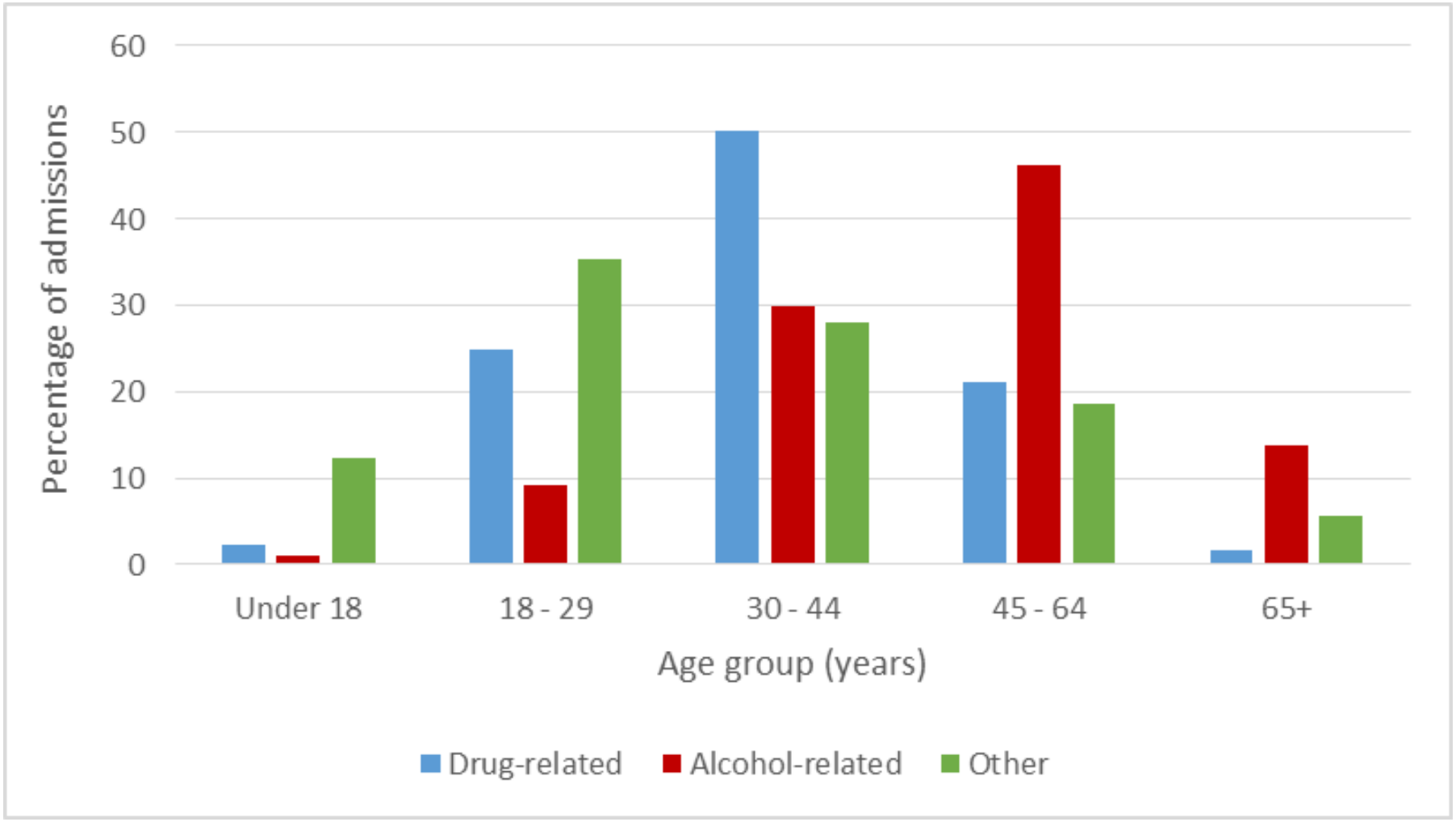



A breakdown of these admissions by demographics shows drug related admissions are highest in the 30-44 age bracket whilst alcohol related is highest in the 45-64 group in both Cambridgeshire and Peterborough.

**Hospital Admissions Age Distribution Cambridgeshire**

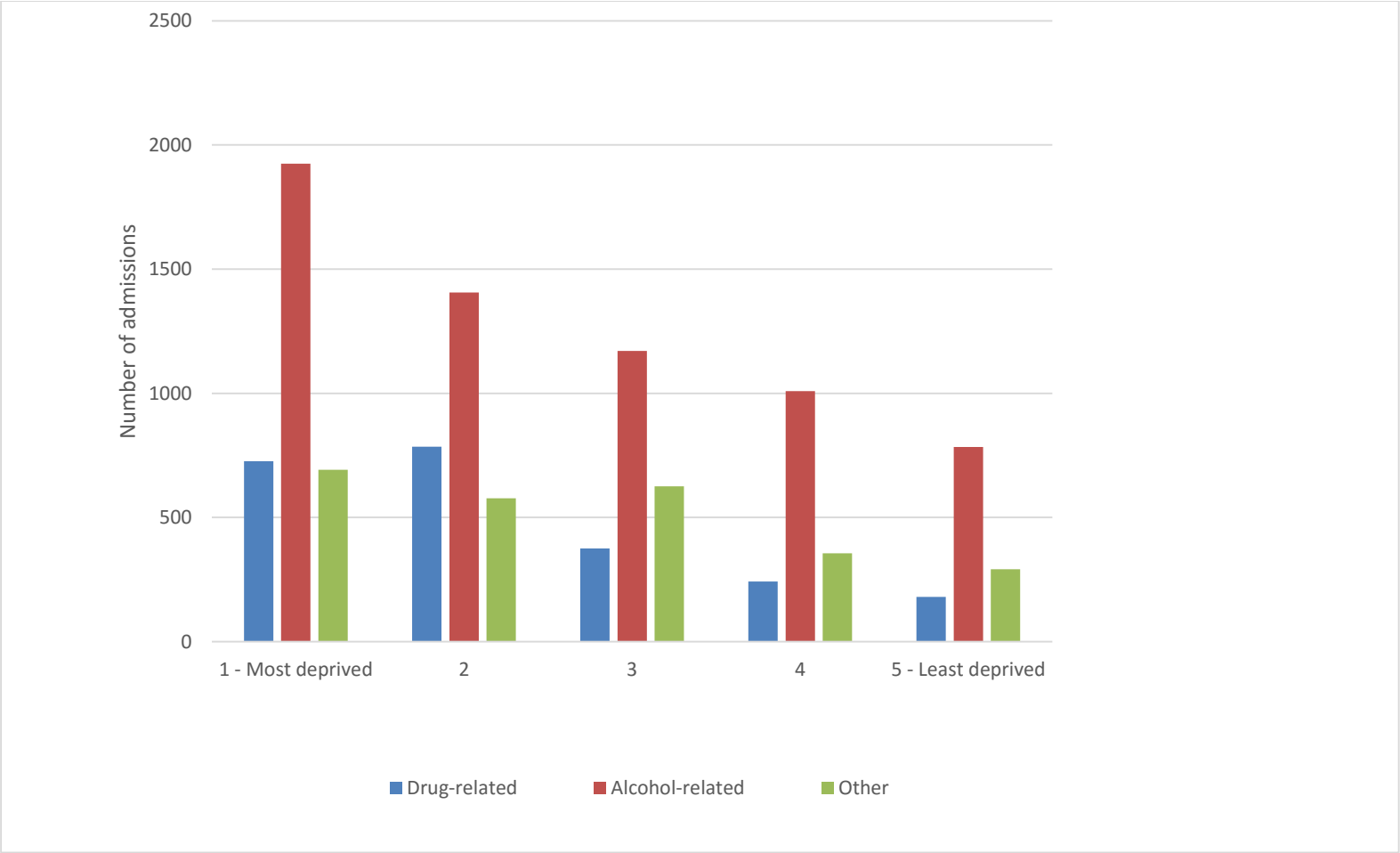


**Hospital Admissions Age Distribution Peterborough**

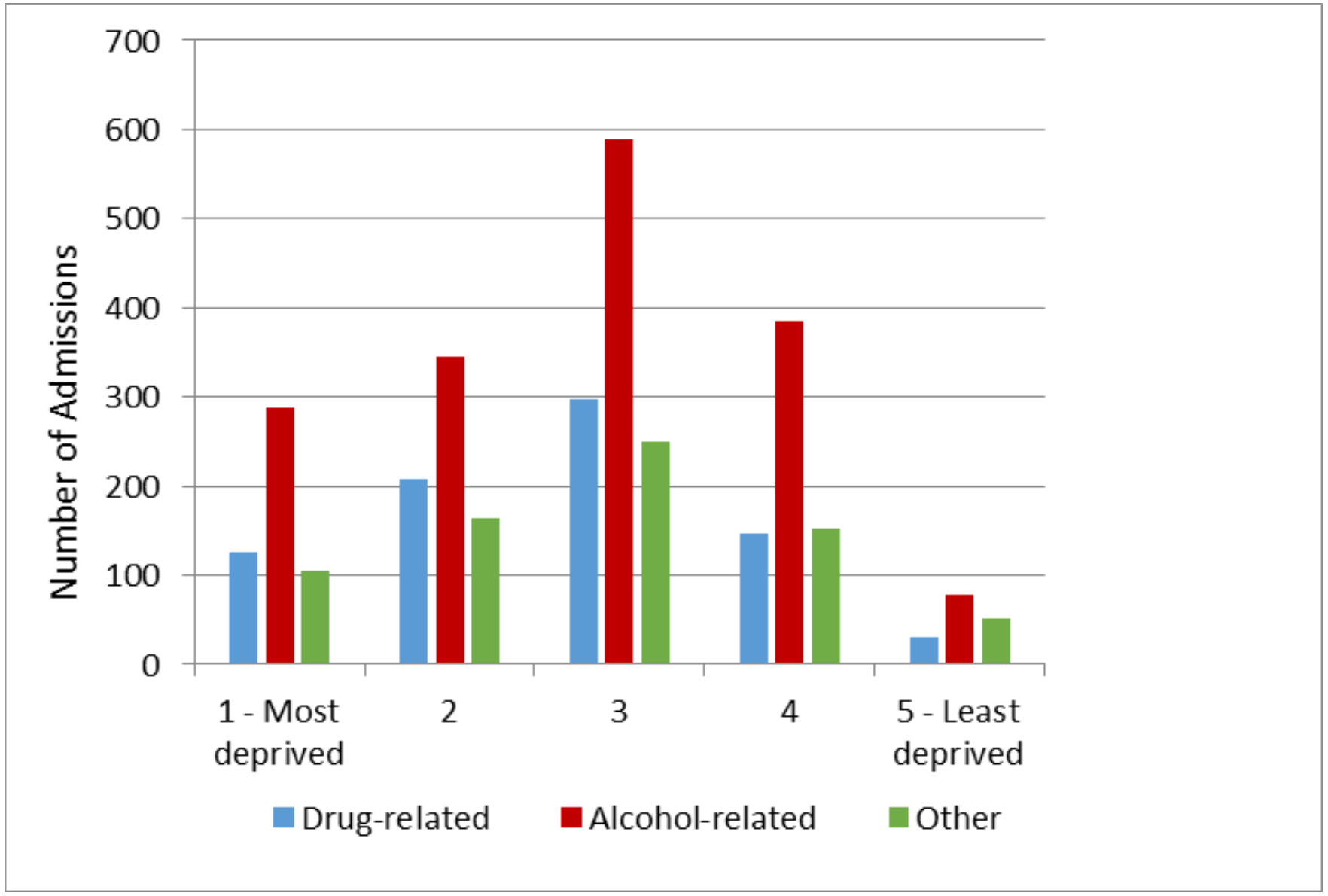


In terms of deprivation, there is a decreasing incidence of concurrent substance misuse and mental health related admissions as deprivation decreases.  This can be seen on the graph below.

**Hospital Admissions by Deprivation Cambridgeshire**



**Hospital Admissions by Deprivation Peterborough**



## APPENDIX 2

## Cambridgeshire and Peterborough Dual Diagnosis Strategy Treatment Pathways