Dual diagnosis: a challenge for the reformed NHS and for Public Health England

A discussion paper from Centre for Mental Health, DrugScope and UK Drug Policy Commission

The extent and significance of dual diagnosis

A large proportion of people in England with mental health problems have co-occurring problems with drug or alcohol misuse. Likewise poor mental health is commonplace in people who are dependent on or have problems with drugs and alcohol. And, for many people, mental ill health and substance misuse combine with a range of other needs including poor physical health, insecure housing and offending.

The 2002 Co-morbidity of Substance Misuse and Mental Illness Collaborative study or COSMIC[1] concluded that:

- 75 per cent of users of drug services and 85 per cent of users of alcohol services were experiencing mental health problems;
- 30 per cent of the drug treatment population and over 50 per cent of those in treatment for alcohol problems had 'multiple morbidity';
- 38 per cent of drug users with a psychiatric disorder were receiving no treatment for their mental health problem;
- 44 per cent of mental health service users either reported drug use or were assessed to have used alcohol at hazardous or harmful levels in the past year.

A 2002 study in Bromley by Geraldine Strathdee[2] and colleagues, found that:

- Dual diagnosis was present in 20 per cent of community mental health clients; 43 per cent of psychiatric in-patients; 56 per cent of people in secure services;
- The group identified as dually diagnosed had worse physical health, higher levels of personality disorder, greater levels of disability, greater risk profiles and lower quality of life than those who were not identified as having a dual diagnosis.

In addition, the Prison Reform Trust's 2010 Bromley Briefing reports that 75 per cent of all prisoners have a dual diagnosis.[3]

Where are we now?

In 2002 the Department of Health published a Dual Diagnosis Good Practice Guide.[4] It stipulated that mental health services were responsible for ensuring anyone with a severe mental health problem and a substance misuse problem were their responsibility and that integrated care was the norm for this group. A number of guidance documents have since been published including A guide for the Management of Dual Diagnosis in Prisons (2009). [5]

There has undoubtedly been real progress on this issue. However, support for people with a dual diagnosis, including those with a range of multiple needs, is still frequently inadequate.

While the need for integrated support for people with concurrent mental health and drug or alcohol problems is widely understood, the reality is often very different:

- 'Drug Misuse and Dependence – UK Guidelines on Clinical Management' (2007) concluded that 'there is still a need for more collaborative planning, delivery and accountability of services for people with co-morbidity, including those with mild-to-moderate mental ill-health, early traumatic experiences and personality traits and disorders'. It expressed concern about lack of specified core competencies, inadequate assessment and co-ordination of services, and only limited progress on the development of integrated care. [6]
- A CSIP 'Themed Review' on Dual Diagnosis (2008) found that four in 10 Local Implementation Teams had no agreed dual diagnosis strategy, less than two thirds had conducted a needs assessment and fewer than half had assessed training needs, with evidence of signficant regional variations (it also commented that local definitions tended to focus on people with severe mental health problems and stressed the need for those with 'less severe mental illness to be considered'). [7]
- Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system concluded that 'despite the recognised high prevalence of dual diagnosis among offenders with mental health problems, services are not well organised to meet this need. In fact, services are currently organised in such a way as to positively disadvantage those needing to access services for both mental health and substance misuse/alcohol problems'. [8]

An effective response to dual diagnosis is essential for the effective delivery of key policy objectives, including drug recovery, welfare reform and the 'rehabilitation revolution'. For example, the 2010 Drug Strategy recognises that one of the the key outcomes to the delivery of a successful recovery-orientated system is 'improvement in mental and physical health and wellbeing'.

While there is guidance and there are recognised pathways for accessing appropriate provision for those with severe mental health problems alongside substance misuse issues (what might be called 'classic' dual diagnosis) it is still a challenge to make these a reality on the ground.

For the larger number of individuals with less severe mental health conditions alongside substance misuse problems, however, provision is less developed and they may be particularly at risk from any fragmentation of service provision arising from the different commissioning arrangements for mental health and substance misuse services under the current reforms. It is important that the differing needs of both these groups are considered as the reform process develops.

There is now an increased focus on people with co-morbidity whose mental health problems are not at the most severe end of the spectrum which needs to be sustained whatever new commissioning arrangements emerge. For example, the Improving Access to Psychological Therapies programme (IAPT) has produced a 'Positive practice guide for working with people who use drugs and alcohol' (2012), in partnership with DrugScope and the National Treatment Agency.

At the same time, the current set of health reforms poses both threats and opportunities for people with dual diagnosis or multiple needs. This discussion paper examines these threats and opportunities and how they might be managed.

Health reforms

The Health and Social Care Bill sets out major changes to health, social services and public health as well as treatment services for people with drug and alcohol problems. These include:

The creation of a new public health system: A national body, Public Health England, will be responsible for implementing national public health policy while Directors of Public Health will be moved from the NHS to upper tier local authorities. Both will be established in April 2012 in shadow form and take full responsibility for public health in April 2013.

The abolition of the National Treatment Agency as a separate body:
The remaining functions of the NTA will in future be the responsibility of Public Health England.

The emergence of GP-led commissioning in the NHS:
Primary care trusts (PCTs) will be replaced by clinical commissioning groups (CCGs) formed of groups of general practices along with representatives of other clinical groups covering a geographical area and responsible for commissioning the majority of specialist health services for their patients with representation from other clinical groups.

The creation of an NHS National Commissioning Board:
The board will take responsibility for holding CCGs to account for achieving improved outcomes for patients. It will also commission health services in prisons and some 'tertiary' services including high and possibly medium secure mental health care.

The development of Health and Wellbeing Boards:
Upper tier local authorities will be required to set up these new boards to coordinate local strategies for health and wellbeing and to join up NHS, public health and social care services for people of all ages.

Outcome measures and Payment by Results:

In mental health and substance misuse services alike, existing contractual arrangements between commissioners and providers are being replaced by new systems that base payments on the delivery of packages of care (in the case of mental health services) and on the outcomes services achieve for users (in the case of the drug and alcohol recovery pilots).

Strategies

In addition to these reforms, the Government has published strategies for mental health and for drug recovery and is in the process of developing an alcohol strategy. Achieving the objectives of these strategies will be contingent on how much influence they have over the wider reform processes.

The 2011 mental health strategy, No Health Without Mental Health, sets out six headline objectives including: more people will enjoy better mental health, and: more people with mental health problems will recover. The strategy is a cross-government document that aims to draw together a range of activities across departments to achieve the agreed objectives.

Similarly, the 2010 drug strategy, Reducing Demand, Restricting Supply, Building Recovery recognises the clear association between mental illness and drug dependence. It stresses the importance of mental health and substance misuse services working together in relation to prevention and early intervention as well as in treatment and recovery. As such, it illustrates the complexity of the relationship between mental health and substance misuse problems which ranges from the aetiology of disorders to recovery outcomes.

Implications

In combination, these reforms will have major implications for mental health and substance use services. Key issues include:

Directors of Public Health:
The creation of a new public health service, led by high profile local Directors of Public Health, has the potential to transform local drug and alcohol services as well as linking promotion and prevention much more closely with treatment and care for substance use and mental health. There is, conversely, a risk that drug and alcohol services are not prioritised by Directors of Public Health given their broad responsibilities.

Joint commissioning:
If we are finally to offer people with a dual diagnosis integrated services, joint commissioning of mental health and drug or alcohol services needs to become the norm. TThe existing gap between services may continue or worsen unless arrangements are made to ensure that CCGs and local public health structures work together to commission services and ensure that all

contracts with providers stipulate effective joint working and clear pathways to meet the needs of people with co-existing mental health and substance misuse problems.

Joined-up support will be particularly important within the justice system. Prison health care will be commissioned nationally through the Commissioning Board, as will some secure mental health services. It is vital that they develop effective partnerships with drug and alcohol services, especially within prisons and at transition points when people move into and out of custody.

Payment systems:
The Department of Health has developed a set of 'clusters' of NHS mental health service types in order to produce a tariff for introducing payment by results (PBR) for mental health based on best practice treatment provision. Similar developments are taking place in substance use services, with eight pilots testing a PBR approach to drug and alcohol recovery services, which is focused on outcomes rather than activities. Concerns have been expressed that the mental health cluster for dual diagnosis is too restrictive. Similarly, our understanding is that people with 'dual diagnosis' are explicitly excluded from the drug and alcohol recovery PBR pilots. If the two payment systems being developed do not combine fully or leave out significant groups of people, they will create barriers to better services rather than encouraging improved care for all.

Ways forward

Local leadership is vital to ensure people requiring support from more than one service get coordinated and consistent responses and appropriate priority from a range of agencies. Directors of Public Health are likely to be pivotal in this regard, especially given the pressure on many agencies' budgets which could affect people whose needs cross boundaries particularly hard.

Health and Wellbeing Boards should offer a forum for joining up local services and could coordinate the commissioning of service**s** for people with multiple service needs (including for example supported housing, health and social care).

Robust **outcome measures** are vital to support the commissioning and provision of integrated support for the full range of people with a dual diagnosis. We need to develop meaningful and measurable outcome indicators that cross public sector silos and align different organisations to the same ends, achieving outcomes that matter to service users in a timely manner.

Payment by Results systems for alcohol, drug and mental health services need to be aligned carefully to ensure all groups of service users are included and that early intervention is promoted. Incentives will also be needed to encourage providers to work with people who have complex and multiple needs. A focus on recovery, quality of life and self-reported improvements in wellbeing may help to achieve this.

Pooled and community budgets also offer the potential to improve support for a wide range of people with dual diagnosis. Pooled budgeting has been an effective way of joining up health and social care services in some areas. Much of the focus on community budgets to date, meanwhile, has been on families with the most complex and entrenched needs. Both approaches could be developed further to offer improved support to a wider range of people, probably at lower overall cost and before emerging problems develop into a crisis.

Building on the momentum in prisons and the criminal justice system will improve health outcomes among offenders and reduce re-offending. The recommendations of Lord Bradley's review on diversion (2009) and Lord Patel's report on prison drug treatment (2010) provide guidance on the way forward. The role of 'offender health' within the emerging commissioning landscape creates opportunities for 'joined up' approaches, and for the identification of dual diagnosis as a strategic priority for this population. The Government has indicated an interest in looking at innovative

community sentences for offenders with co-morbid substance misuse and mental health problems.

A shared vision of recovery could provide a narrative and a driver for integrated systems and approaches to service delivery. The 2010 Drug Strategy set out the Government's vision for a recovery-oriented drug and alcohol treatment system that is able to engage holistically to address the multiple needs of individual service users, including their mental health issues. Recovery is also growing in currency as an underlying principle for mental health services. In this context, recovery is focused on enabling people to take control of their lives, with or without the symptoms of mental illness, supported by professionals on their own terms. Developing a shared understanding of what recovery means for people with a dual diagnosis or complex needs may go some way to bringing services together more effectively in practice. In the USA, SAMSHA has developed just such a definition and a similar process could be valuable in the UK.

Workforce development has an important role to play in ensuring that both workforces are receiving the necessary training and support to work effectively and confidently with clients with co-occurring substance misuse and mental health problems. For example, the recent establishment of the independent Substance Misuse Skills Consortium provides an opportunity to improve awareness and training on mental health issues for workers in drug and alcohol services.

References

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9. See: http://www.samhsa.gov/newsroom/advisories/1112223420.aspx.

Contact us

The **UK Drug Policy Commission (UKDPC)** is an independent body providing objective analysis of evidence related to UK drug policy. It aims to improve political, media and public understanding of drug policy issues and the options for achieving an effective, evidence-led response to the problems caused by illegal drugs. For more information see: www.ukdpc.org.uk

DrugScope is the national membership organisation for the drug field. Our aim is to inform policy development, reduce drug-related harms to individuals, families and communities - and promote health, well-being, recovery, inclusion and integration. For more information see: http://www.drugscope.org.uk

Centre for Mental Health aims to help to create a society in which people with mental health problems enjoy equal chances in life to those without. We focus on criminal justice and employment, with supporting work on broader mental health and public policy. For more information see: Http://centreformentalhealth.org.uk