

Organization and delivery of treatment services for dual diagnosis

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Abstract

There is no strong evidence base to support one particular form of service delivery for dual diagnosis. Effective interventions are available for substance use and substance dependence, but these interventions are under-utilized in the general psychiatric setting. Integrated, parallel and stand-alone services have been developed in different settings. It is possible to integrate motivational and cognitive-behavioural therapy (CBT) treatment programmes for people with psychosis and substance use problems and their carers. Currently, drug use on psychiatric wards and cannabis and cocaine use by chronically psychotic patients is resulting in high levels of stress and serious deterioration in overall outcomes in mental health services in the UK.

Keywords addiction; Care Programme Approach; dual diagnosis; intervention

Introduction

The overall scale of substance misuse within the community and in mental health services makes it generally impractical to consider stand-alone services rather than integrated approaches across community-based teams. The organization and delivery of services to people with major psychiatric problems and associated substance use problems is a major challenge for mental health services for the coming decade. It is now well recognized that dual diagnosis is associated with:

- increased inpatient psychiatric admissions
- prolonged duration of stay
- violence

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- suicidal behaviour
- poorer treatment outcomes.

A recent English study reported that 44% of community mental health team (CMHT) patients reported past-year problem drug use or harmful alcohol use; 75% of drug service and 85% of alcohol service patients had a past-year psychiatric morbidity.¹ The COSMIC study reported that most patients appeared ineligible for cross-referral between services. Large proportions of the problems were unidentified by service providers and received no specialist interventions.¹

A study of the homeless population identified very high rates of substance use and psychiatric comorbidity.² The prison population has extremely high rates of drug and alcohol dependence and associated psychiatric comorbidity.³ These two populations require specific interventions to address the massive scale of need and require separate consideration.

Overall, there is a very significant overlap in populations between mental health services and addictions services, but there are also key differences in the main target populations for these different services that influence prioritization and workloads of the different services.

Addiction as part of mental health services organizations

The UK has some advantages over other countries because a significant number of addiction services are placed within mental health services. However, there are major barriers, access problems and a lack of integration of addiction services with other mental health services, primary care services and other social agencies, such as social services and the probation service, as well as other criminal justice agencies. In addition, the drug and alcohol field has a strong component of services placed within the voluntary sector (non-governmental organizations). This important component of service delivery may have limited staff with experience in mental health issues and may require good partnership with local mental health services to ensure adequate quality of care.

The problem of service integration and problem demarcation is not unique to dual diagnosis; there are many interface problems between child and adult services, between adult and old age services and between adult and forensic services. The recent development of first-episode psychosis services highlights a similar interface problem. Some argue that first-episode psychosis services detract from the development of comprehensive, high-standard community mental health services.⁴

The Care Programme Approach

Within mental health services in the UK, the Care Programme Approach has been developed as part of an overall approach to better integrated care for people with severe substance misuse problems. More recently, the addictions field has seen the implementation of models of care for drug dependence. These have been promoted by the National Treatment Agency and also through local drug action teams (DATs), which have the role of supporting the multi-agency response to drug problems at a local level.

Models of care: towards integrated services

Partnership arrangements are vital between agencies spanning specialist drug treatment services, general medical, general

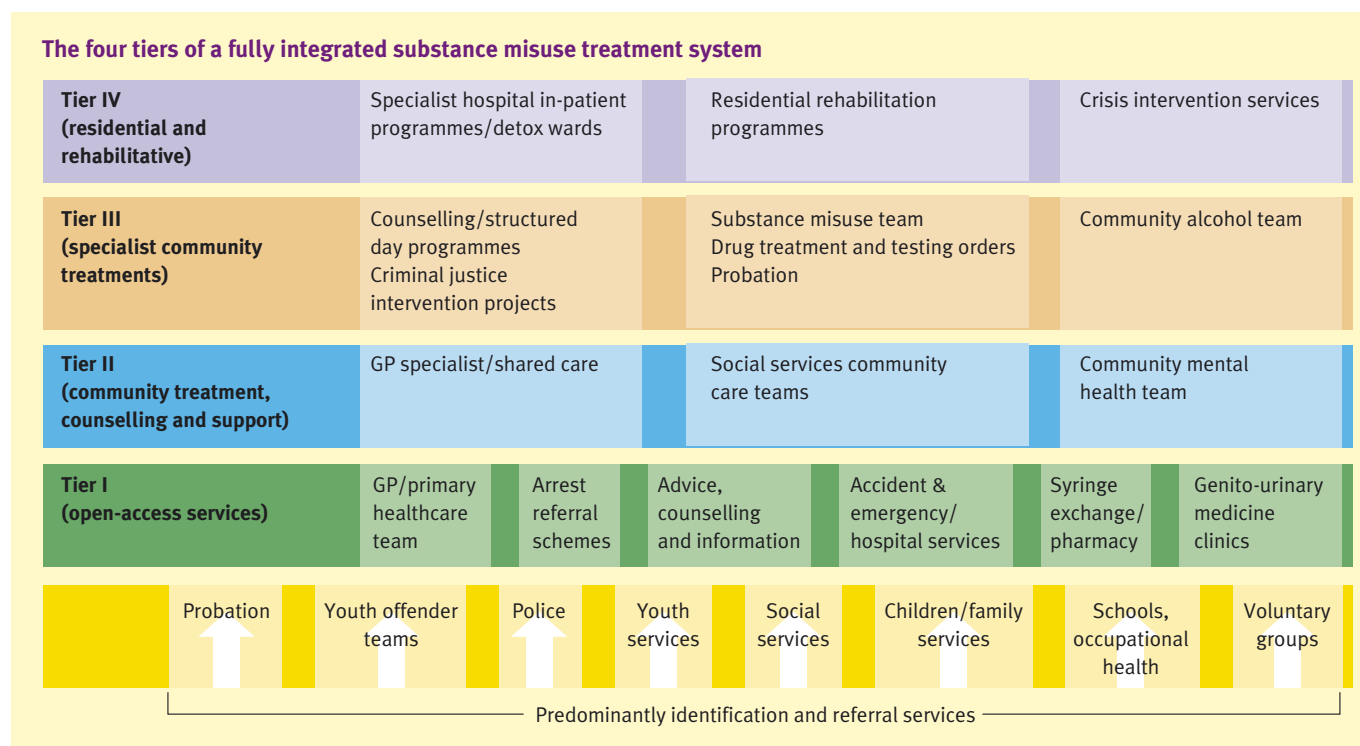


Figure 1

practice and across health authorities, social services, non-statutory agencies, and criminal justice services. Based on the four tiers outlined as part of the National Treatment Agency's models of care, Figure 1 summarizes the shape of a fully integrated substance misuse treatment system. In this tiered system, all agencies have a role to play in staging a coordinated response. Individuals in need of treatment for drug misuse may present to any one of the predominantly identification and referral services shown at the bottom of the tiers. The substance misuse team (SMT) occupies a critical role as the 'hub' of the treatment system. The SMT should serve important functions across client assessment, direct treatment provision, onward referral, community liaison, and promotion of users' groups, professional and volunteer training and service development areas.⁵

The Department of Health has published a policy implementation guidance on the development of dual diagnosis services and has recommended the mainstreaming of services with a strategic approach that aims to improve the identification and management skills in generic community mental health teams (CMHTs).⁶

Approaches to intervention

In the USA, the Yale group with Drake and Mueser has developed a model of integrated treatment for dual diagnosis⁷ that has been partially reproduced but significantly modified in the UK by Graham and colleagues.⁸ The core of this approach is that all staff need to demonstrate competency in the management of both substance misuse problems and severe mental illness. Probably the core of a modified UK approach will see most staff in all settings adding new skills and new competencies to their existing repertoire of clinical and organizational skills.

In the UK, Haddock *et al.* reported a randomized controlled trial of CBT and motivational interviewing and family intervention for a group with schizophrenia and substance misuse over 18 months. They found significant improvement in patient functioning compared with routine care. They report that the overall costs of both treatments were comparable.⁹ However, a controlled evaluation of an assertive outreach approach for dual diagnosis did not find any benefit for intensive case management.¹⁰

Overall, there is a need to evaluate and promote the evidence-based practice approach to tobacco, drug and alcohol problems in the generic mental health field. There is reasonable evidence of effectiveness for interventions for tobacco cessation, alcohol reduction, opioid agonist treatment, cannabis cessation and cocaine cessation. These interventions, mainly based on social learning models, are CBT, social-skills training and motivational interviewing approaches, with some additional pharmacotherapy. There is a need for more evaluation of these approaches within generic mental health settings to determine if similar efficacy is reported (Table 1).

Areas needing greater awareness of evidence for therapeutic efficacy

- Nicotine cessation
- Alcohol reduction
- Cannabis reduction
- Opioid agonist therapies
- Brief interventions

Table 1

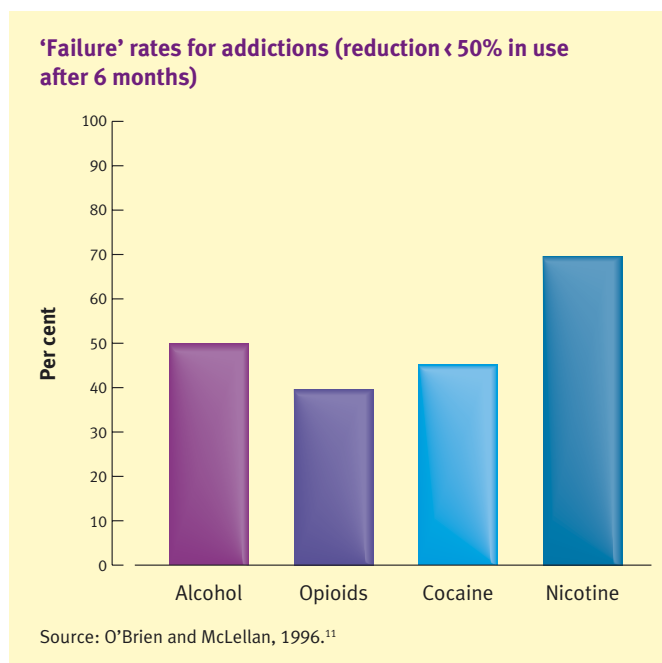


Figure 2

O'Brien and McLellan report that doctors have unrealistic expectations of interventions for addictions, with an overall nihilistic view of the impact of treatment.¹¹ However, if treatment for tobacco, alcohol, opioid and cocaine dependence (Figure 2) is compared with compliance and relapse in asthma, diabetes and

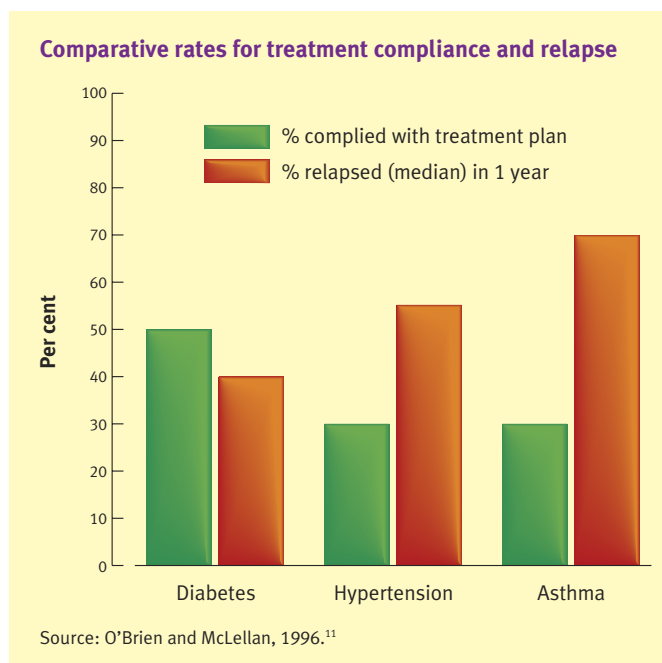


Figure 3

hypertension (Figure 3), then the overall compliance rates for these chronic behavioural disorders are broadly comparable.

Conclusion

Dual diagnosis services are developing rapidly in the UK in response to a substantial growth in the use of illicit drugs over the past decade and a major problem of drug use in psychiatric services, including in-patient services. These mounting problems call for a concerted response, the expansion of appropriate psychosocial skills and a better integration of services across a wide range of community-based agencies. The momentum of change has increased, but the challenge to deliver competent, capable and effective services for those most in need remains daunting. Success will be achieved only if there is positive collaboration across health, social and criminal justice services and generic community agencies. ◆

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