Policy context for dual diagnosis service delivery

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Abstract
This paper aims to provide an overview of the policy guidance and will begin with an introduction and overview of policy development during this period; then focus on the more specific guidance in four broad areas: dual diagnosis specific guidance, risk, training, and service specific – guidance. Assessment and treatment are cross-cutting themes and key messages in relation to these areas will also be highlighted. Having outlined the policy guidance, consideration will be given to how effective it has been in changing service delivery and suggestions made as to what might be required to ensure more consistent implementation.

Key words
Dual diagnosis, guidance, policy development, training

Change in service delivery can only occur if there is motivation and commitment at the organisational level as well as the delivery level. There is now a significant raft of national policy and guidance to drive the dual diagnosis agenda in local organisations, and it is clear that dual diagnosis issues should not be side-lined by any organisation; it is everyone’s business.

Over the past decade there has been an evolving awareness of the challenges that come with co-morbid mental health and substance use problems and this has resulted in the development of policy guidance to drive the development of services to meet their complex needs.

Tackling Drugs to Build a Better Britain (Home Office, 1998), flagged up dual diagnosis as an issue, identifying psychiatric and psychological problems as the most significant health risks for seriously dependent drug misusers. However the first significant mental health policy guidance to draw attention to dual diagnosis was the National Service Framework for Mental Health (NSF) (DH, 1999a). It highlighted dual diagnosis as a major challenge and stated that the needs of this group should be met within existing mental health and drug and alcohol services. In a review of the progress of the implementation of the National Service Framework for Mental Health (DH, 2005), dual diagnosis was viewed as ‘the most challenging clinical problem we face’ and requires ‘urgent attention’ with a broad co-ordinated response including better collaboration between agencies, training in assessment and clinical management, preventative work, and prevention of drug misuse on inpatient units.

Dual diagnosis – specific guidance
It was not until 2002 that a policy dedicated specifically to dual diagnosis was published: The Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide (DDPG). This was a part of a series of implementation guides to help with the implementation of the broader National Service Framework for Mental Health. This had been pre-empted by the publication of the HASCAS Standards for Dual Diagnosis (HASCAS, 2001), which although not a policy document, is very useful, and many of the key messages are similar to DH, 2002.
The focus was on the needs of people with serious mental illnesses (SMI) (such as schizophrenia and bi-polar affective disorder) and substance misuse problems, but it provided a framework for planning services to meet the needs of the wide range of people who might be considered to have a dual diagnosis. It set out the direction of travel for dual diagnosis care and treatment. Building on the premise stated in the NSF for Mental Health care that needs of people with a dual diagnosis should be met within existing mental health and drug and alcohol services, it advocated an ‘integrated approach’ to service provision whereby both mental health and substance misuse problems are addressed at the same time, in one setting, by one team.

Specialist (separate) dual diagnosis teams were not going to be established on a national basis (because of the high prevalence) and instead advocated ‘mainstreaming’ the care of those with serious mental illness to the mental health services. Mainstreaming means that the generic services are responsible for delivering care to people with dual diagnosis, and they should have the adequate range of skills and resources in order to do this. Training and support should be available to these clinicians in order to do so. Both mental health and substance misuse teams have a role in supporting the other to attain these goals. The need for mental health and substance misuse services to work more closely together has become a recurring theme in policy guidance (for example, DH, 2004).

The guidance recommended that all local implementation teams should have a strategy in place regarding dual diagnosis, including training). The guidance also recommended that where there was a high prevalence of dual diagnosis (for example, in urban settings) there should be lead clinicians in specialist roles to provide training, supervision and advice.

Although the DDGPG has broad application, specific attention has been given in policy guidance to assertive outreach teams (AOT) and acute psychiatric inpatient wards. The DDGPG remains the key policy guidance shaping service provision in England.

Guidance related to risk

One of the drivers for the development of dual diagnosis policy was the increasing recognition that people who had both MH and SM problems posed much greater risks to themselves and others than people who had a MH problem alone. The series of National Confidential Inquiries into Suicide and Homicides and by People with Mental Illness (Safer Services DH, 1999b; Appleby et al, 2001; University of Manchester, 2006), highlighted the significant association between drug and/or alcohol use and suicide and homicide. The most recent National Confidential Inquiry Report, Avoidable Deaths (University of Manchester 2006) report that significant proportions of suicides (27%) and homicides (36%) are committed by those with mental illness and co-morbid substance use. It recommends that provision for dual diagnosis should be central to modern MH care.

The DH (2002) dual diagnosis guidance reiterated the importance of risk assessment and risk management for people with a dual diagnosis. It stated that all service users should be subject to a full risk assessment and have risk management plans (DH, 2002). The Suicide Prevention Toolkit (NIMHE, 2003) includes standards around the needs of people with a dual diagnosis. Staff who provide care to people at risk of suicide are given approved training in the clinical management of cases of co-morbidity/dual diagnosis.

Risk to children has become an increasing concern over recent years. Both mental health and substance misuse can impact on a person’s ability to care for children and this has been reflected in policy guidance (Hidden Harm (ACMD, 2003) report focuses on protecting the needs of children of drug-users).

Although not policy guidance a key driver for MH trusts is the NHS Litigation authority risk management standards. Trusts are assessed on their ability to demonstrate that they have processes in place to manage the risks associated with dual diagnosis services users. This includes: having arrangement for addressing service users needs, details of internal and external joint working arrangements, the process to be followed where there is a difference of opinion between professionals and the organisation’s expectations regarding staff training as identified in a training needs analysis. Information is also required about which roles or committees have specific responsibility for implementing and monitoring.

Guidance related to training

To equip staff to work effectively with this group national guidance has consistently identified the need for staff training. Given the lack of training on substance misuse generally and dual diagnosis in particular in the undergraduate and pre-registration training of all professionals, staff are generally poorly equipped to deliver integrated care. (O’Gara, 2005; Hughes et al, 2008)

A range of policy guidance (some already mentioned in this article) have highlighted the need for staff to be trained to work more effectively with people with a dual diagnosis. This includes:

- Health Advisory Service (2001) Dual Diagnosis Standards
- NIMHE (2003) Preventing Suicide Toolkit
- DH (2004) NSF – Five Years On
- DH (2006a) Dual Diagnosis Inpatient Guidance
- University of Manchester (2006) Avoidable Deaths - National Confidential Inquiry Report
- DH (2006b) Chief Nursing Officer’s (CNO) Review of Mental Health Nursing.
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Closing the Gap, the dual diagnosis capability framework (Hughes, 2006), was commissioned by the National CSIP Dual Diagnosis programme to describe the core competencies required to deliver effective care to people with a dual diagnosis. The aim of this is to provide a common capability set for training, job descriptions, and appraisal. It comprises three sections: values, knowledge and skills, and practice development. Within each section, three levels of capability are described: core, generalist and specialist.

Generally, policy guidance suggests that all staff require some basic training in dual diagnosis and those with significant contact with people in this group require more advanced training. The proportion of staff in each team that should receive training is generally not specified, however, DH (2002) states that all staff in assertive outreach must be trained and that ‘adequate numbers’ of staff in crisis resolution, early intervention, community mental health teams and inpatient services should receive training. DH (2006a) indicates that local training needs analysis should identify who needs training and the need for updates.

Guidance recognises that training in isolation will have limited benefits. Practice development and supervision are required to support staff in transferring their learning into practice. The need for access to specialist advice is also highlighted (eg DH 2002, DH 2006a, 2006b).

Service-specific policy

Assertive outreach teams

The NHS Plan (DH, 2000) highlighted that there are small numbers of people who are difficult to engage, who are high users of services and have complex needs including dual diagnosis. The NHS plan recommended the establishment of Assertive Outreach (AOT) services to engage and work with this group. In 2001 the Mental Health Practice Implementation Guide (DH, 2001) described in more detail the expectations of AOTs. In recognition of the challenges posed by this group, the guidance indicates that staff should receive training to equip them to work more effectively with people with a dual diagnosis – a recommendation which was reiterated in the DD Good Practice Guide (DH 2002) - and that specialist help, support and supervision should be available. The importance of AOT in working with this specific group of people with a dual diagnosis is again highlighted in the NSF 5 Years On (DH 2004).

Inpatient psychiatric services

Substance use is highly prevalent in psychiatric inpatient facilities, and causes a great deal of conflict and anxiety. Staff feel torn between the role of the clinician and that of the law enforcer. The Dual Diagnosis Inpatient Guidance (2006) was produced to offer guidance around the specific problems caused by substance misuse in psychiatric inpatient and day hospitals. It covers care and treatment (detection, assessment, interventions, discharge planning) as well as managing ethical and legal issues of illicit substance use on NHS premises.

Substance misuse services

There has been little attention to dual diagnosis in substance misuse policy. The National Treatment Agency (NTA) has, however, endorsed the Dual Diagnosis Good Practice Guide in Models of Care (MoC) (DH 2006c), Models of Care for Alcohol (MoCaM) (DH 2006d) and the ‘Orange Guidelines’ (DH et al 2007)

The NTA has made it clear that drug treatment should be available, appropriate and accessible to everyone who requires it, regardless of their background, location and drug misuse problem, and that everyone with alcohol related problems should have equal access to relevant alcohol interventions with no group suffering under-representation or poorer treatment outcomes due to services not being relevant or appropriate. Although progress has been made, the Orange Guidelines (DH et al 2007) recently identified a need for more collaborative planning and service delivery for people with a dual diagnosis. They suggest that an emphasis on assertive outreach, engagement, and retention in treatment is required along with joint, flexible approaches between substance misuse and mental health services.

The new drug strategy Drugs: Protecting Families and Communities (Home Office 2008), barely mentions mental health. People with mental health problems are identified as one of a number of groups which the strategy identifies as an under-represented group for which improved access is required.

What has been the impact of policy guidance?

There are two main national surveys that have gathered some data on implementation of dual diagnosis. The Annual Themed Review (as part of the Autumn Assessment) of 2006/7 was focused on dual diagnosis. Although there has been a steady increase in the number of areas having a dual diagnosis strategy, coverage is still patchy. The report makes a series of recommendations (which are covered in the paper by Gorry and Dodd in this edition). The Healthcare Commission undertook a survey of inpatient mental health services in 2007 and asked a series of questions related to dual diagnosis including whether substance use was included as part of assessment; and whether staff had access to training for dual diagnosis. Both surveys highlight that while there are some pockets of excellence, many NHS organisations still lack a proper organisational strategy, training strategy, and assessment and treatment procedures for dual diagnosis.
So why has implementation been so slow? Those with responsibility for dual diagnosis at local and regional level highlight significant challenges in implementing and sustaining change. Three contributory factors can be identified. First, (unlike other mental health policy guidance) Dual Diagnosis Good Practice Guide (DH 2002) set out broad principles which required local areas to apply locally, without being specific. Second, no new funds were made available to implement the dual diagnosis guidance and services were expected to implement change within existing resources. Finally, although trusts/organisations were expected to respond to the guidance, the requirements were not included in key performance targets, and there were no adverse consequences for not implementing guidance. The recent HC commission inpatient assessment framework, which included dual diagnosis indicators, represents a significant move forward. Not only are dual diagnosis standards being ‘mainstreamed’ but trusts failing to achieve in the overall process (the bottom 10% in each region) receive visits from improvement teams to ensure that standards are raised. The inclusion of dual diagnosis standards in such assessment processes should stimulate new momentum.

Another issue, which is perhaps harder to quantify is the attitudes of the services to dual diagnosis. People with dual diagnosis are perceived as ‘hard to engage’, ‘chaotic’ and ‘difficult’ by the nature of their complex needs. Workers still feel that it is not part of their role to work with substance use as well as mental health, and perceive that this should fall under another service remit. However, given the prevalence, mental health workers need to accept that in order to deliver mental health care in the 21st century, substance use will be an everyday part of this work. Organisations need to recognise that their staff feel overburdened and burnt out and require extensive support and supervision, as well as good quality training, in order to fulfill their roles.

Conclusions

We have come a long way in the past 10 years in the recognition of dual diagnosis and the development of treatment responses to this. However, there is still a long way to go. Specific targets will help focus and target developments within organisations from the top down, but there is also some work to be done on shifting attitudes from the bottom up. Training is a good way of addressing attitudes, but should be accompanied with a sustainable programme of support and supervision. This will include the role of the specialist dual diagnosis worker and consultant nurse. These individuals can act as role models and motivators in clinical practice, which can help embed new ways of working into the culture of the team. The ultimate aim is that dual diagnosis should not be seen as a ‘separate’ or specialist area; that all services have responsibility.

Services need to be better at working more closely together and have a better understanding of each others roles and responsibilities under a collaborative local strategy. The CSIP Dual Diagnosis National Programme, and the regional networks has done much to promote the development of better services for dual diagnosis, and it is hoped that this programme will be able to survive the next few years to continue its excellent work.

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