

Drug Misuse and Mental Health: learning lessons on dual diagnosis

**A report of the
All Party Parliamentary Drugs Misuse Group**

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ALL PARTY PARLIAMENTARY DRUGS MISUSE GROUP

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1. Introduction

1.1 The All Party Parliamentary Drugs Misuse Group embarked on this investigation after concern was expressed by members that our responses to people who suffer from mental illness and who are also substance misusers remain inadequate.

1.2 Several high profile cases of homicide have brought to public attention the role of alcohol and other substance misuse when people with mental health problems commit violent crimes. But this group wishes to emphasise that only a very small proportion of people with mental illness are a risk to others in society. It is very important not to stigmatise all those who are mentally ill and/or are misusing substances.

1.3 We carried out our study at a time when the United Kingdom Anti-Drugs Co-coordinator was setting out targets for reducing drug misuse and when, concurrently, a large scale review of the Mental Health Act was taking place and a new National Service Framework for Mental Health was being drawn up.

1.4 During the course of our enquiry, we heard from experts in NHS and voluntary sector treatment agencies, researchers who had looked at the links between dual diagnosis and crime, the police service and the probation service, the Government Health Minister with responsibility for mental health and from people who had been through treatment for both substance misuse and mental health problems. We also obtained written submissions from a large number of interested organisations. We are very grateful for the time people took to give us the evidence which forms the basis of the following report.

2. The nature and extent of the problem of dual diagnosis

2.1. Dual diagnosis is defined for the purposes of this report as the occurrence of a substance misuse problem and mental illness in the same patient at the same time. Substance misuse is defined as the misuse of alcohol and/or other substances including illegal drugs, solvents and over-the-counter medicines.

2.2 There are conflicting views on how many people in the UK may be suffering from dual diagnosis and are in need of treatment. The health minister told us more than half of those using mental health services have a dual diagnosis and that this is most common in young men aged 18-24. But one expert told us there are probably around five thousand such cases in the country. Another reported that a needs assessment carried out in one London borough suggested a much larger group of potential patients.

2.3 The most robust data on the degree of overlap of substance misuse and mental health is from America. It shows that a person with substance misuse problems is 3-6 times more likely to have an additional mental health problem and vice versa¹. One of the problems of using the term dual diagnosis is that it assumes two diagnoses, whereas individuals may have a number of problems concurrently.

2.4 US studies also show 50% of people with mental illness also use drugs and alcohol. UK studies find a lower rate: a study in Camberwell of subjects with psychotic illness showed 36% with substance misuse problems². A recent study of subjects with first-episode psychosis showed 37% with any substance misuse problem³.

¹ Regier et al. *Co-morbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (EA.) Study.* JAMA, 264, 2511-8

² Menezes et al 1996 *Drug and Alcohol Problems among Individuals with Severe Mental Illness in South London.* B.J. Psych, 168, 612-9

³ Cantwell R et al 1999 *Prevalence of Substance Misuse in first episode psychosis BJPpsych.* 174 150-3

2.5 An epidemiological study in Croydon of people with psychotic illness found dual diagnosis rates to be at the same level (33% in Croydon) as those rates found in inner city areas. Dual diagnosis patients had double the length of inpatient stay compared to patients with psychosis alone⁴.

2.6 In a study undertaken for St George's Hospital Medical School in London, a sample of 80 admissions to a residential opiate detoxification programme were examined for co-morbidity of personality disorder and opiate dependence. The prevalence rate of personality disorder was 86%⁵.

2.7 A report into co-morbidity in mental health and substance misuse patients in Hammersmith and Fulham found a high prevalence in both populations and identified a shortfall in the provision of treatment to co-morbid patients⁶.

2.8 Dual diagnosis patients often have very complex needs and are often amongst the most socially excluded. Many negative outcomes are related to mental illness and substance misuse: more relapse (of both disorders), demoralisation, disengagement from services, non-compliance with treatment, repeated hospitalisations, suicide, violent behaviour, repeated imprisonment, homelessness, medical illness including HIV/AIDS and early mortality.

2.9 UK experts say a third of substance users have a mental health problem but may not contact mental health services. While those with serious mental illness are on psychiatric wards or in touch with services, many more people with mental disturbance are in touch with drug or alcohol services but not with a mental health specialist.

2.10 It is not always obvious which is the primary diagnosis. Substance misuse and mental illness can compound each other. Signs and symptoms of mental illness may be mimicked by those of intoxication and withdrawal and vice versa. Associations between symptoms or clinical syndromes can lead to misdiagnosis.

2.11 Psychiatrists told us that for those with mental illness, substance use can cause stress, which can worsen the symptoms. The chemical effects of substances, combined with depression and stress are damaging over time, even though in the short term the patient may feel it does them good.

2.12 A psychiatrist working at Broadmoor told us there is no evidence that substance misuse itself causes schizophrenia but drug and alcohol use is a marked stressor and so may bring on the first expression of the disorder without actually being the cause.

2.13 Research has shown that drug and/or alcohol use can lead to the misdiagnosis of schizophrenia⁷. Recent reports suggest that black people may also be more likely to receive an inappropriate diagnosis of schizophrenia in these circumstances⁸.

2.14 One psychiatrist told us cannabis use in patients who suffer from serious mental illnesses such as schizophrenia causes rapid, serious and prolonged deterioration in mental state in a large proportion of patients.

⁴ Wright, S., Gournay, K., Glorney, E., and Thornicroft, G. *Dual Diagnosis in the Suburbs: prevalence, need and in-patient service use/ Dual Diagnosis in the Suburbs: violence and offending (unpublished)*

⁵ Oyefeso et al, 1998

⁶ *Report of a Research Study into the Prevalence and Management of Clients with Mental Illness and Substance Misuse Co-morbidity in the London Borough of Hammersmith and Fulham*, Tim Weaver and Deborah Rutter. July 1999

⁷ Cohen, I.S (1995) 'Over diagnosis of schizophrenia; the role of alcohol and drug misuse' *The Lancet* 346, 1541-2

⁸ 'Alcohol and mental health diagnosis' *Diverse Minds* (2 October 1998)

2.15 Public perception is that homicides are often committed by people with mental illness. Statistics show that actually only 14% of people convicted of homicide in the UK had symptoms of mental illness at the time of the offence. Substance misuse is often a major feature in homicide cases involving perpetrators who are mentally ill⁹.

2.16 Most clients do not represent a risk to anyone but themselves. The National Confidential Enquiry into Suicide and Homicide by People with Mental Illness found 24% of suicides had been in contact with mental health services in the year before death (over 1000 cases per year). There were high rates of alcohol and drug misuse; 17% were misusing both alcohol and drugs¹⁰.

2.17 Most mentally ill people are not violent; serious mental disorder is uncommon but is strongly associated with violence. Co-morbid individuals are more likely to be violent than those with mental illness alone. In the MacArthur Violence Risk Assessment Study, 1,136 people with a mental illness were surveyed over a year: 18% of those with no other diagnosis had a tendency to violence; that figure rose to 31% for those who used drugs or alcohol¹¹.

2.18 The increased risk of self-harm, suicide or violence amongst mentally ill people who misuse substances is compounded by the fact that they are less likely to comply with taking their medication.

2.19 The substance abuse element in homicide cases involving mental illness is often a very significant part of subsequent enquiries BUT it is very often not picked up in the conclusions and recommendations of those enquiries¹².

3. Current treatment provision

3.1 People with dual diagnosis tend to fall through gaps in service provision. They experience the "ping pong" effect where neither drug services nor mental health services want to take responsibility for them. The exclusion criteria often operated by both sets of services acts as a bar to them getting the help they need.

3.2 There is a significant difference in philosophies between drug and mental health services. Drug services primarily treat those willing to be helped, whereas mental health services try to treat everyone with a mental disorder (although the new drug treatment services being developed in prison and through probation will begin to change the nature of some drug treatment to a more coercive model). The chief challenge is to bring two quite different philosophies together, particularly through more and better training.

3.3 At present services are narrow in the types of problems they will deal with. We heard that services from both fields need to widen their focus: drug services need to deal with mental health issues and mental health services need to identify and tackle substance misuse.

3.4 Lack of communication between services seems to be a major problem. Some witnesses told us meetings between different services is taking place at too low a level: they should be at Chief Executive level. Other witnesses believed it is more important that good communication takes place between professionals and services at grassroots level.

3.5 There are three main models of management for clients who do receive treatment for both diagnoses: consecutive treatment; parallel treatment, facilitated by communication between the two services; and integrated treatment where the care of the patient is jointly managed by both services.

⁹ *Safer Services, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Report, 1999*

¹⁰ *Safer Services, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Report, 1999*

¹¹ *Steadman HJ et al (1998) Arch. Gen. Psych. 55.393*

¹² *"The Unlearned Lesson - the Role of Alcohol and Drug Misuse in Homicides Perpetrated by People with Mental Health Problems" Applin and Ward (Wynne Howard books, 1998)*

3.6 We heard evidence from a number of services that are doing some excellent pioneering work in this difficult field:

- One Health Authority funds a service targeting people with dual diagnosis, run by a Consultant Psychiatrist specialising in addictive behaviour.
- The Sainsbury Centre for Mental Health is working with the Department of Health on a study of models of care, comparing the effectiveness of statutory services with voluntary ones.
- A Turning Point project working with people who have multiple needs, aims to provide intensive, accessible and individually tailored support in the community. It provides a service to people with severe mental illness and who also have substance misuse problems and/or a history of violent offending.
- Phoenix House, a national voluntary sector organisation involved in residential care for drug misusers and community services, has set up an action research project with a large hospital. Workers from specialist agencies are seconded to other, different specialist agencies. Training manuals have been developed which have enabled staff to assess clients at any level of intervention. Information on clients is held centrally in the host agency and provided where necessary to other services. The scheme is currently being evaluated but - two years in - much more has been achieved than was thought possible in the beginning.
- A Health Authority is now developing guidelines for working with substance misuse and mental health through a dual diagnosis co-coordinator. This means it now has established protocols and systems, which are designed to protect staff and patients. Health and social services have signed up to the guidelines at strategic level. At the moment people cannot access many day mental health services if they have a drug/alcohol problem. This will now change. On wards, the fear of arrest will be taken away for people who self identify with a drug problem.

3.7 It seems that examples of good practice are not being replicated and the examples quoted above are still few and far between. This is unacceptable and we need to develop better responses to dual diagnosis nationally.

3.8 Staff training was an issue that came up repeatedly. It is imperative that mental health professionals are skilled in dealing with drug misuse and that those working in drugs services have knowledge of mental health. Non-specialist workers also need training in both. People with complex and difficult problems need staff with a high level of skill.

3.9 Mental health and drug problems do not occur in isolation from other hardships such as homelessness and unemployment. There is not close enough liaison between drugs and mental health agencies and other services such as housing, criminal justice, leisure and employment.

3.10 Assertive outreach where teams go out into communities to try to identify people in need of treatment can be used to create a bond between clients and service staff. We heard calls for more such assertive outreach teams made up of people from many sectors. Such teams require secure support systems when working in the community with what can be an unpredictable client group.

3.11 Continuity of care is crucial. We are pleased to see the new national service framework for mental health includes 24-hour access to support. However, we are deeply troubled by reports that follow-up care and treatment for people leaving prison is woefully inadequate. Despite the new prison service CARATS programme, the outlook for sufficient help to be available is not at all good.

3.12 Many agencies we spoke to highlighted uncertainty over funding and complexity of funding arrangements as a major obstacle to improving responses to this problem. Mental illness and substance misuse services come from different funding streams. It is difficult, within this system, to find funding for those people in the gap. One witness from a small voluntary sector service told us: the work in this field is dangerous and demoralising, and motivating workers to take on the further training and work necessary to deal with complex cases is hard enough without the added burden of insufficient and insecure funding.

3.13 The Government is working towards a partnership system in health. There are lots of initiatives aimed at promoting partnerships (Drug Action Teams, Health Action Zones etc). Clear lines of responsibility on drugs and mental health and funding to support them are necessary.

4. The views of people who have used drug and mental health services

Service users told us:

4.1 People who are mentally ill and in hospital can be arrested if they are found to be taking drugs on the wards. Sniffer dogs are used. They should be given help to get off the drugs and not just “banged up by people looking the other way and not trying to help.”

4.2 Drug services should be advertised, as people who need them often do not know that they exist. They should be advertised on mental health wards, in prisons and anywhere else people with mental health problems may go. There should be more walk-in centres.

4.3 There is a problem with training on drug misuse on mental health wards. The nurses on the wards do not know what to do with the problem so patients have no one to turn to.

4.4 Many social workers are not properly qualified in drug misuse. Users can be devious so there is a need for someone highly trained to cope. People often want help with their drug problem but do not know how to ask for it: better-trained people can identify that.

4.5 Treatment coerced through the criminal justice system can work. A probation treatment order is not an easy option. One person told us the threat of five years in prison meant she went to the hardest treatment centre and completed the treatment order. Now she must complete the aftercare order.

4.6 Many may be given medication for a condition they haven't got because of symptoms or behaviour, which are actually a side effect of drug taking. Our witness said he knew of someone who was diagnosed with schizophrenia who actually had “speed psychosis” and a housewife who was diagnosed as having a mental health problem when she was actually abusing slimming tablets.

4.7 Not all GPs and health professionals have expertise in substance misuse. People quoted above were all finally helped when they met professionals experienced in treating drug dependence and their real condition was recognised.

4.8 Drug rehabilitation centres often do not accept clients who are on medication for mental health problems.

4.9 Aftercare is crucial. Rehabilitation centres are a place of safety but the lack of support when leaving the centre means that a crisis can bring about a relapse. Nothing had prepared one client for being alone in his flat and having to ‘white knuckle it’ on his own. The only people he knew were users, therefore he went back to using. Users who have been through rehab need a network of supportive people to contact.

4.10 The right people need to be in the right places with the right training. Addicts will run rings round professionals - they are experts in manipulation. People who have been through similar problems are good at helping if they have enough clean time behind them and are in good mental and emotional health.

5. The criminal justice perspective

5.1 We heard from the Sussex police force which has set up a full time project to look at the issues around substance misuse and mental health, including internal policies, staff guidelines, inter agency working and training development. Superintendent Melvyn Elliott told us that someone with symptoms of a mental disorder may end up in police cells, which are geared towards holding offenders who are well. Staff are not trained in mental illness but have to supervise the person - who may be violent or engaging in self-harm - for many hours until a psychiatric bed is found.

5.2 Agencies tend to put problems in boxes and may refuse to deal with a client whom they perceive as being someone else's problem. For example, an ambulance crew may refuse to transport someone with a mental illness because they see it as the responsibility of the police.

5.3 There have been cases in Sussex where a mentally ill offender has been held in police cells for nearly 72 hours while staff try to find a bed. There are often debates about who will pay for the placement - causing further delays.

5.4 Legislation is needed along the lines of the Crime and Disorder Act to ease processing of people through the cells. Police stations should not be considered a place of safety. People with complex problems such as this need a hospital or semi-secure unit with trained staff and expertise.

5.5 A relaxation of the Data Protection Act to facilitate information sharing is needed.

5.6 We heard from the South East London Probation Service. Chief probation officer, Paul Hayes told us an integrated approach dealing with problems in parallel has the most optimistic outcome. Dual diagnosis is said not to affect enough people to justify a network of services but many dual diagnosis clients are involved with the criminal justice system. Even if investment is not justified on health grounds, it is surely justified on the grounds of strengthening community safety.

5.7 When services for people with mental health problems close, the people that cannot survive in the community will end up in prison. More places of safety and crisis intervention services are needed.

6. The Government view

We heard from John Hutton MP, the Minister of State at the Department of Health with responsibility for mental health.

6.1 Dual diagnosis is an important issue for those providing services in the NHS: the government is trying to put in place foundations for a coherent strategy to tackle this problem including a ten year approach and new money.

6.2 There are difficulties concerning the lack of recognition of the problem and consequently people can be bounced around the system.

6.3 The government has published a national service framework for mental health that is designed to tackle inconsistent standards of care. It expects health and local authorities to have local arrangements in place by April 2001 to tackle mental health issues. The government will monitor the framework and set up a national implementation team and will invest £7 million over 3 years to support implementation.

6.4 Mental health services cannot be marginalised as mental health is too big an issue; they need to be first class.

6.5 On the issue of training, if the national service framework is to work, then front line staff will need to be supported. How this can be done is currently being looked at.

6.6 Dual diagnosis candidates may not admit to drug use for fear of conviction, but the Government's view is that the NHS has a responsibility to uphold the law. If drugs are found anywhere by professionals then this becomes a criminal justice matter and if drugs are found in a hospital then appropriate action should be taken.

Conclusions

Through the investigation we have carried out, it is apparent that the area of dual diagnosis is a difficult and complex one, particularly as it is an issue which straddles boundaries and professional organisations. But we have also found that it is an area which has been neglected for too long, even though patients and/or offenders with drug/alcohol misuse and mental health problems are often some of the most vulnerable and socially excluded.

We recognise that there are no easy solutions to the problems of trying to help this group and we welcome the work that has already started on addressing some of their needs. But not enough has yet been done and we believe there is as yet no substantial drive (nor targeted resources) to tackle the issue head on.

We believe stronger leadership is needed to bring together the separate agencies working with drug users and with people with mental illness. The Government must provide this leadership, as the problems associated with dual diagnosis are so important that it should no longer be seen as a tangential issue.

Recommendations

1. There should be a concerted effort on the part of Government and others to highlight the fact that most people with mental illness do not commit acts of violence. Attention should be paid to the fact that there is a higher risk of violence in people who are mentally ill and also misusing substances, including a increased risk of self-harm and suicide.
2. Service provision must be improved to stop people with dual diagnosis from falling through the gaps which occur when nobody wants to take responsibility for them. The exclusion criteria used by both sets of services must be completely rethought.
3. Work must begin to overcome the wide variation in philosophies between drugs and mental health services. Services must become more flexible and cross boundaries where necessary. Pressure must be put on mental health services to identify and tackle substance misuse and on drugs services to deal with mental health issues. Examples of pioneering work must be evaluated and good practice identified and replicated as part of a national strategy. Service users, carers and families should be involved in service planning and patient care.
4. There must be a national strategy to promote much closer working between drug and mental health services with better cross-referral mechanisms in place. Strategies for closer working should be developed at senior level and be encouraged to cascade down. Co-operation at grassroots level must also be developed.
5. The potential for establishing more services dedicated to dual diagnosis should be investigated, perhaps where there are identified 'hot spots'. There is a particular need to develop appropriate services for the most chaotic clients who may represent the most risk to themselves and others.
6. There should be a national drive and significant new resources for more dedicated in-service training in dual diagnosis. Training should also be directed at non-specialist workers. All GPs and health professionals should have expertise in substance misuse.
7. Those responsible for the training of doctors, nurses, social workers, probation officers, police and prison staff, and voluntary bodies must ensure that the issue of mental health, substance misuse and dual diagnosis is built into training both before and after qualification.
8. Uncertainties and complexities in funding for dual diagnosis must be tackled. People should not be kept waiting for treatment while authorities argue over who is paying. One way of stabilising funding for small groups may be to fund them centrally, possibly on a contract basis, and for reasonable periods of time.
9. People on mental health wards should be positively encouraged to admit drug use so that they can receive appropriate treatment where necessary.

10. Aftercare services should be available for every client who has been treated for mental health and substance misuse, whether in the community or in prison. People risk relapsing if they are not supported in the community. Some people may take much time to improve and not be ready to go into employment programmes. It is imperative that sufficient training and non-work activities be provided to help them on a long-term basis.

11. Ways of easing the processing of people through police cells need to be found. Police stations should not be considered a place of safety. People with complex problems need a place with trained staff and expertise.

12. The prison service must ensure that it is addressing the needs of people with dual diagnosis adequately.

13. A joined-up approach involving other agencies must be applied. There should be locally agreed policies to ensure much closer liaison between drug and mental health services and others - particularly housing - to ensure a rounded response to need.

14. There should be more resources for research into the prevalence of the problem of dual diagnosis nationally and for the evaluation of effective ways of caring for people.

The following people gave oral evidence to the All-Party Group:

Dr Andrew Johns, Senior Lecturer and Honorary Consultant Forensic Psychiatrist, Institute of Psychiatry and Broadmoor Hospital, Berkshire

Dr Matt Muijen, Director, Sainsbury Centre for Mental Health

Dr Alison Lowe, Consultant Psychiatrist, Addictive Behaviour, Haringey Health Care Trust

Mike Roarty, Director, Supportlink Project (Turning Point), Hemel Hemstead

Ben Whur, Director of Operations, Phoenix House

Dr Tom Craig, St Thomas's Hospital, London

Melba Wilson, Policy Director, MIND

Mike Ward, Assistant Commissioning Manager, Substance Misuse/Mental Health Services, Surrey Social Services and co-author of the report *"The Unlearned Lesson – the role of substance misuse in homicides by mentally ill people"*

Claire Applin, Mental Health Worker, Surrey Social Services and co-author of *"The Unlearned Lesson – the role of substance misuse in homicides by mentally ill people"*

Superintendent Melvyn Elliott, Sussex Police Force

Paul Hayes, Chief Probation Officer, South East London Probation Service

Paul Russell, Junction Project, Brent, London

Natasha, Paul, Liz, Robert: users and ex-users of mental health and drugs services

John Hutton MP, Minister of State at the Department of Health with responsibility for mental health