Ensuring integrated treatment for people with mental health and substance use problems

The coexistence of mental health and substance use problems, known as dual diagnosis, is common. Integrated care models are vital to provide joined up care services and those known to drug and alcohol services are more likely to have a dual diagnosis than not.

Menezes et al’s (1996) seminal paper put the prevalence of substance use among psychiatric patients in the UK at up to 33%, while Weaver et al (2003) reported prevalence of up to 75% in a sample of community psychiatric patients. The DH et al (2007) reported that 75% and 85% of those in drug and alcohol treatment respectively had experienced a psychiatric disorder in the past year. What is clear from the research is that substance use among those with mental illness is higher than that in the general population.

Why people with mental illness use substances

Practitioners commonly believe that people with a dual diagnosis use substances as a form of self-medication, either to change the way they feel or to counteract the side effects of prescribed psychiatric medication. However, when this client group was asked why they used substances, most identified social reasons such as to improve social relationships, relax or have a good time (Gregg et al, 2009), which accords with the reasons given by the general population.

It is not surprising that a group of people who are stigmatised and potentially isolated would value a means of improving their perceived ability to socialise. This factor is important for healthcare staff to understand when trying to engage this group, as an appreciation of the benefits of substance use from the clients’ point of view may help professionals to focus on interventions which change lifestyle or social networks rather than purely on symptomology.

Supersensitivity

The supersensitivity model, first proposed by Mueser et al (1998), suggested that the supersensitivity model, first proposed by Mueser et al (1998), suggested that the supersensitivity model, first proposed by Mueser et al (1998), suggested that the supersensitivity model, first proposed by Mueser et al (1998), suggested that the supersensitivity model, first proposed by Mueser et al (1998), suggested that the supersensitivity model, first proposed by Mueser et al (1998), suggested that...
substance use increases the vulnerability of people with mental health difficulties to psychological disturbance more severely than it does people without. This means a small amount of substance use can have greater negative consequences for them than the general population.

This model is based on Zubin and Spring’s (1977) well established stress vulnerability model, and its approach presents several challenges for services.

Many assessment instruments focus on frequency or amount of substance use. The threshold set for identifying a problem is too high in that it would not pick up people who occasionally use a small amount of a substance. Equally, these clients would not meet the criteria for services which focus on frequent substance use.

**ASSESSMENT**

To date there is no psychometrically sound instrument for assessing dual diagnosis. Many psychiatric instruments ask little about substance use, and many addiction assessment tools do not ask about mental health.

The lack of proper assessment tools makes detection and treatment extremely difficult. At best, services amalgamate existing instruments in an attempt to gain information from clients, or assess the same person using both a mental health and substance use tool. While this is clearly better than not investigating at all, it is time consuming and cumbersome for both clients and assessors.

However, a number of screening tools have been developed that attempt to assess both aspects of dual diagnosis. The Dartmouth Assessment of Lifestyle Instrument (DALI) (Rosenberg et al, 1998) was developed to assess substance use in acutely ill patients admitted to psychiatric units in the US. The Substance Use Event Survey for Severe Mental Illness (SUESS) (Bennett et al, 2006), also developed in the US, explores clients’ reasons for seeking treatment, which could improve opportunities for practitioners to engage them in treatment plans.

Graham (2004) developed the Cognitive-Behavioural Integrated Treatment (C-BIT) model, which has a useful assessment phase covering six themes (see below for more on treatment). Each prompts the assessor to gather detailed information from the client. This is a useful contribution to the assessment of dual diagnosis as it focuses on the relationship between the mental health problem and substance use.

While these instruments have not been fully validated, I would argue they are useful aids for nurses.

**PHILOSOPHY OF TREATMENT**

The prevailing philosophy of treatment in mental health services has changed radically over the past 20 years, moving from institutional care to responsive community orientated treatment.

For example, assertive outreach teams meet clients wherever they can, such as in their home or in a social setting. This philosophy contrasts starkly with addiction services, which are mostly clinic based.

Historically, addiction services would see clients as responsible for seeking treatment and offer support once they have made contact, whereas mental health services take a different approach, and view clients as needing support. In the case of assertive outreach teams, service users are engaged in a flexible and responsive way.

The issue of dual diagnosis highlights this contrast in treatment approaches, as the two services view clients so differently. A move from a service centred to a client focused approach in addiction services is long overdue.

**INTEGRATED TREATMENT**

In the past, mental health services would simply refer clients who used substances to specialist addiction services, while addiction services reciprocated by referring clients with mental health problems to mental health services. Parallel or sequential treatment models are outdated, ineffective and actively dissuade people with dual diagnosis from accessing treatment (Hughes et al, 2008).

Although the evidence for integrated treatment models is limited, this approach offers several opportunities for clients, families and practitioners (Haddock et al, 2003).

If addiction and mental health services work independently, they are likely to duplicate efforts, with the same clients in contact with both services. The high prevalence of dual diagnosis means this represents a significant cost to healthcare providers, and a single point of contact will make more effective use of resources.

It is also more likely to optimise engagement, treatment and recovery, unlike the traditional brokering or “ping pong” effect, where clients are sent from one service to another. This alternation requires a degree of determination and motivation from clients that they may not have early in their recovery.

Despite the potential savings from such synergies, the two commissioning streams for services offer no incentive for integrated treatment. In fact, they actively discourage attempts to develop integrated services by setting targets that are specialty specific and do not account for the combined problems of people with dual diagnosis.

The development of two separate yet almost identical systems of care exacerbated this situation and represents a missed opportunity to develop a single system. These are the Care Programme Approach (DH, 1990), which covers mental health, and Models of Care (National Treatment Agency for Substance Misuse, 2002) for addiction.

**HIGH EXPRESSED EMOTION**

High expressed emotion (HEE) is acknowledged to occur within families of people with mental illness and among the clinicians who work with them, but less so among those associated with people who have dual diagnosis.

The three components of HEE are overt criticism, hostility and emotional overinvolvement. Family members or clinicians express their frustration with clients in a way that apportions blame to them, framing their lack of progress or relapse in a critical way.

Although there is a parallel between people who use substances and the way families and clinicians respond, HEE is not an established concept in addiction (Watts, 2006).

Given the frustrations and stresses of working with people with dual diagnosis, it is likely that HEE is a factor. Identifying this concept is an important part of any individual or family work with this client group, and should be a discussion point in clinical supervision for practitioners.

**COGNITIVE FUNCTIONING**

It has been known for some time that using psychoactive substances and mental illness independently has a negative effect on cognitive functioning. Evidence is now beginning to emerge on the combined effect of mental illness and substance use on cognitive function.

People with dual diagnosis have a greater degree of cognitive impairment than would be expected from combining the effect of each factor independently (Manning et al, 2009).

Impaired cognitive functioning has major implications for engaging clients and the way treatment is delivered. Clinicians need to consider the pace, timing and pitch of the
intervention, to take account of potential problems with memory, concentration and problem solving.

**DRUG INTERACTIONS**

All drugs interact with each other, whether they are prescribed or not. Most interactions go unnoticed as they cause no adverse effect; some produce an unwanted effect while others lead to a benefit. Although there is an interaction, it is often not known which drug causes the overall effect.

For people with dual diagnosis, drug interactions are a significant area of concern as they are more likely to experience them given their use of substances and prescribed medication. Some potential interactions are presented in Table 1.

Some of this information is collated through the yellow card scheme via the British National Formulary, where a suspected adverse drug reaction is reported on a yellow card and sent to the Medicines and Healthcare products Regulatory Agency.

Although this system has been extended in recent years so that patients, nurses and other healthcare professionals can use it, the number of reports has remained at approximately 14,000 a year. There is a need to publicise this system with the aim of improving reporting of drug interactions, to ensure practitioners and patients are better informed of the potential risks.

However, it is unlikely that significant numbers of interactions involving illicit substances would be reported.

**SMOKING**

Although 60-90% of people with severe mental illness smoke cigarettes, the issue of smoking has been largely ignored among people with mental health problems generally and, specifically, among those with dual diagnosis.

Smoking cessation programmes have targeted other high risk groups, such as those with physical problems including diabetes, cardiovascular and respiratory problems. However, there are specific interactions between psychotropic medication and cigarettes which must be considered in treatment (Ciraulo et al, 2006).

Smoking increases the metabolic clearance of many psychotropic drugs such as olanzapine and clozapine, and clients may need up to twice the dose of a prescribed drug to achieve a therapeutic effect (Haslemo et al, 2006). If they cut down or stop smoking, they will need less to achieve a therapeutic effect.

As nicotine enhances cognitive skills such as memory and attention, those who have problems in these areas may derive a direct benefit from smoking, so clinicians need to consider this when clients stop smoking.

**PHYSICAL HEALTH**

Both service users with mental illness and those who use substances experience inequalities in terms of the quality of care they receive. For those with dual diagnosis, less is known about the contact they have with medical services or the quality of care they receive, although there is some evidence that the care they receive for cardiovascular problems and diabetes mellitus is inferior compared with that provided to the general population (Mitchell et al, 2009).

Given the risk involved in having a mental illness and using substances at the same time, there is an urgent need to establish what physical health problems are specific to people with dual diagnosis and what, if any, lack of equity they experience in accessing treatment.

**ZONING**

Since a large amount of information needs to be considered for clients with dual diagnosis, it is necessary to think about how that is communicated and organised within teams working with service users who have dual diagnosis.

One such method with great potential is the system of zoning, which is a simple and effective way for teams to prioritise and manage care (Ryrie et al, 1997).

Using a large whiteboard in the team office, service users are placed in one of four zones: red, amber, green or black. The red zone represents those at greatest risk or in a crisis through to the green zone for those who are stable. The black zone is for service users who are not currently able to access services, for example because they are in prison or hospital.

The team reviews its caseload daily and clients are moved from one zone to another, depending on their presentation and the information the team has. This allows practitioners to give additional support to those in the red zone, with the aim of moving them to amber.

This system offers several benefits; as the information about the caseload is visual, this gives an immediate picture of the work required that day; there is a sense of team ownership and input into risk assessment; and a measure of progress or deterioration of individual clients.

Although this system is used in some community mental health teams, it is not used in addiction teams. Given the complex needs of those with dual diagnosis and their contact with both mental health and addiction services, such a system could be beneficial for both clients and practitioners.

**COGNITIVE-BEHAVIOURAL INTEGRATED TREATMENT**

Graham (2004) developed Cognitive-Behavioural Integrated Treatment

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**TABLE 1. POTENTIAL DRUG INTERACTIONS**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Interaction</th>
<th>Effects</th>
<th>Increased stimulant effect</th>
<th>Categorie</th>
</tr>
</thead>
<tbody>
<tr>
<td>Escitalopram</td>
<td>Amphetamine</td>
<td>Effects of alcohol enhanced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>Inhibits SSRI metabolism</td>
<td>Effects of alcohol enhanced</td>
<td>Increased stimulant effect</td>
<td></td>
</tr>
<tr>
<td>Olanzapine</td>
<td>Tachycardia and hypotension</td>
<td>Reduced antipsychotic efficacy</td>
<td>Increased sedative effect</td>
<td></td>
</tr>
<tr>
<td>Lithium</td>
<td>Not harmful, but unable to get high</td>
<td>Enhanced sedation</td>
<td>Lithium toxicity</td>
<td></td>
</tr>
</tbody>
</table>

Sources: BNF (2009); Baxter (2006)
CONCLUSION
All nurses working in acute and primary care have a role in detecting clients with mental health problems who use substances. Nurses should be alert to possible signs of substance use in those with diagnosed mental health problems, and should also be aware that clients who attend addiction services may have a mental illness.

Nurses should find out what services are available in their area, for example, whether there is a specific dual diagnosis service or champion, and should refer clients appropriately.

Practitioners working in mental health and addiction services are involved in engaging and treating clients with dual diagnosis, and should work to ensure they receive joined up services in an integrated model where possible. 

REFERENCES


Mental Health and Substance Use: dual diagnosis; 2: 1, 24-39.


