DMRI

Drug Misuse Research Initiative
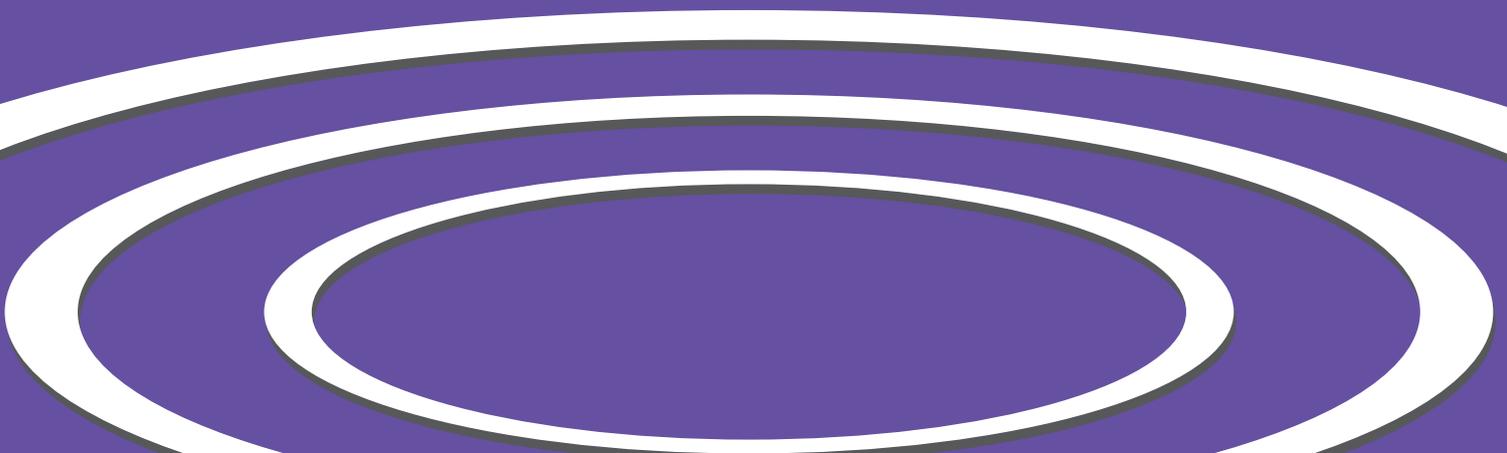
Department of Health

Executive Summary

Dual Diagnosis in A Primary Care Group (PCG), (100,000 Population Locality): A Step-By-Step Epidemiological Needs Assessment and Design of a Training and Service Response Model.

Report prepared by:
Dr Geraldine Strathdee, Victoria Manning, Dr David Best, Dr Francis Keaney, Dr Kam Bhui, John Witton, Sharon Wall, Lauren McGillivray, Dr John Marsden, Dr Fiona Johnson, Dr Chantal Piek and Dr Charlotte Wilson-Jones

Dual Diagnosis in A Primary Care Group (PCG), (100,000 Population Locality): A Step-By-Step Epidemiological Needs Assessment and Design of a Training and Service Response Model.

Executive Summary

Report prepared by:
Dr Geraldine Strathdee[1], Victoria Manning[2], Dr David Best[2], Dr Francis Keaney[2], Dr Kam Bhui[3], John Witton[2], Sharon Wall[2], Lauren McGillivray[2], Dr John Marsden[2], Dr Fiona Johnson[4], Dr Chantal Piek[1] and Dr Charlotte Wilson-Jones[5]

[1] Oxleas NHS Trust
[2] Institute of Psychiatry
[3] Queen Marys' School of Medicine and Dentistry
[4] University College London
[5] Kings College London

Please address correspondence to:
geraldine.strathdee@oxleas.nhs.uk

Disclaimer

Acknowledgements

Study aims

The study was a multi-method needs assessment of dual diagnosis in a primary care sector in the London Borough of Bromley, which sought to address a range of research and applied issues. The study's objective was to develop a screening and assessment tool to identify dual diagnosis for use in routine clinical practice by using an educational outreach training model, and to use this to assess the prevalence of dual diagnosis and related health, social and lifestyle needs across a range of treatment services. Specifically, the project aims were:

- *To determine the extent and nature of co-morbidity in the PCG 1 treatment services which serve a population of 100,000 in the London Borough of Bromley.*
- *To design an innovative training programme for local health and substance misuse staff based on the evidence base of the needs of dual diagnosis populations*
- *To design and implement a method of screening and assessment for dual diagnosis for use by staff working within routine mental health and substance misuse settings*
- *To identify the dual diagnosis characteristics, patterns of substance use and psychiatric profiles, and other related social, health and lifestyle characteristics across the five populations served by a) the CMHT; b) the in-patient service, c) the specialist substance misuse services; d) the local forensic services; and e) the PHCT*
- *To develop a step-by-step dual diagnosis training and service response model that can be used in PCTs nationally*

Method

The study consisted of a number of stages embedded within a range of research approaches. This comprised the development of a screening and assessment tool for dual diagnosis, the development and implementation of an educational outreach training model and a cross sectional needs assessment and prevalence survey. A repeated measures component was used to assess changes in a staff attitudes, knowledge and awareness of dual diagnosis over the course of the study, in addition to a range of qualitative methods including focus groups, key informant interviews and a mapping exercise of local services.

A two-tier assessment process was developed to assess prevalence, using measures suitable for use on clients attending each of the treatment agencies. A

brief screen was constructed to identify at-risk dual diagnosis cases (positive screens) which takes around 7-10 minutes to complete. This screen can be completed by clinicians, regardless of professional background, and can be incorporated within standard assessment processes. Clients screening positive for at least one mental health, and one substance use symptom then completed a comprehensive 45-60 minute assessment. This assessment identified dual diagnosis cases, i.e. those with concurrent substance use and mental health disorder as well as related social, health and lifestyle needs.

Results

Prevalence of positive dual diagnosis screens

Of the 589 clients screened, 45% reported (potentially problematic) substance use and mental health symptoms, thereby screening positive for dual diagnosis, The highest rates were reported in the substance misuse agencies (93% in the alcohol service and 91% in the drug service), with 62% in the forensic service, 55% in the in-patient mental health service, followed by 37% in the Community Mental Health Team (CMHT), and the lowest rates reported among the primary care sample (24%).

In terms of illicit drug use, clients from mental health and alcohol services were using mainly cannabis and cocaine powder. In contrast, substance misuse clients were using primarily opioids, crack cocaine and cannabis. The most common mental health symptoms reported by substance misuse clients were depression, generalised anxiety disorder and panic attacks. In terms of socio-demographic characteristics, those screening positive for dual diagnosis were more likely to be young, male and unemployed, although no significant differences in ethnicity were observed.

Prevalence of dual diagnosis and nature of multi-axial needs

Of the 265 people who screened positive, 191 (72%) were successfully followed up for a dual diagnosis assessment. Just under three-quarters (73.2%) of the 191 clients assessed met research criteria for at least one mental health disorder and at least one substance use disorder. This meant that 27% of the total sample of 589 met the research criteria for dual diagnosis, 22% of them were also severely mentally ill, although this figure is distorted by the dropout group. This suggests that the two-tier screening mechanism was an effective method of identifying dual diagnosis status across service settings. In terms of estimated population prevalence, rates of dual diagnosis were highest in the substance misuse settings (83%), followed by

forensic services (56%), then the psychiatric in-patient service (43%), followed by the psychiatric out-patient service - CHMT (20%), with the lowest rates of dual diagnosis observed in primary care settings (8%).

There were distinct differences in the profiling of mental health disorders across the service settings. Of the mental health clients who completed an assessment, just under half (48%) met the research criteria for alcohol use disorder and 48% for a drug use disorder, (mainly cannabis and cocaine powder). Amongst substance misuse clients who completed an assessment, neurotic disorders were particularly prevalent including generalised anxiety disorder (55%), agoraphobia (43%) and current depression (41%). The more complex psychiatric disorders (including psychosis and suicidality), were most prevalent amongst mental health clients (particularly those in forensic or in-patient settings).

Dual diagnosis clients demonstrated significantly more complex and multi-axial needs in relation to elevated likelihood of personality disorder, physical health problems, risk / violence, lower quality of life and overall level of disability. Similarly, these needs were increased further amongst those who fulfilled the research criteria for poly-substance use disorder in comparison to those with only one substance use disorder or no substance use disorder. A series of regression analyses demonstrated that the best predictor for being dual diagnosis (excluding measures or symptoms relating to mental health or substance use) was the extent of overall disability - assessed using the Threshold Assessment Grid (TAG). Other predictive factors were criminal involvement, risk behaviour and quality of life for both the mental health and substance misuse patients.

Finally, the dual diagnosis screening tool proved to be a reliable and valid rapid identification tool for persons with dual diagnosis, particularly for more severe psychiatric disorders such as psychosis, mania, and suicide risk, as well as alcohol and drug use disorder. Overall, the screen had adequate sensitivity, identifying 72% of dual diagnosis cases, was consistent over time (2 weeks) and the self-report drug component was valid against objective measures of drug use.

Staff component (staff assessment and attitudinal monitoring)

This component of the study used a repeated measures design to assess changes in staff attitudes, experiences and awareness of dual diagnoses over the course of the study. At the inception of the study, the prevalence of dual diagnosis was largely underestimated by 32 staff members across services. Staff showed a

more positive attitude to dual diagnosis clients as the study progressed and considered themselves to have become more competent in screening and assessing dual diagnosis. The majority of the staff reported that the study had made a positive contribution to their working practice, but expressed the need for training in effective interventions and more specifically management of dual diagnosis cases.

Development of the service response model

Focus groups involving the full range of agencies and disciplines identified that that there is a clear need for further training in dual diagnosis across services which are managing large numbers of clients with complex and multi-axial needs which are not at present being adequately addressed. The research has demonstrated that the educational outreach model of training has a high degree of support for training large numbers of practitioners to screen and assess dual diagnosis in the practice setting and involving entire teams.

In terms of the service model, the focus group findings suggest that there is a willingness to manage mild to moderate dual diagnosis cases within 'mainstream' mental health and substance misuse agencies. However, for the most complex SMI cases, specialist teams, such as Assertive Outreach or Dual Diagnosis Teams were advocated. The prevalence of the mental health and substance misuse problems is such that they must be seen as 'core' needs for any client presenting to the services, rather than unusual needs, and therefore assessment must be routine. The development of inter-agency assessment and intervention care pathway and protocols were seen as pivotal to efficient use of resources and as a communication tool between agencies. Major clinical governance issues facing all medication prescribers in both primary and secondary care were identified. If dual diagnosis is to be successfully assessed and treated in primary care settings, the issues of stigma, the potential legal and social impact of being 'diagnosed' as having a substance misuse or mental health problem, and the changes that this leads to in doctor-client relationships need to be openly acknowledged and solutions aired.

Implications and conclusions

The research findings generated a number of clinical practice and clinical governance implications, and related issues for service design, training, research and policy. The high prevalence rates of dual diagnosis across addiction, mental health and related services necessitate the prioritisation of training practitioners

in both voluntary and statutary services in the identification and assessment of dual diagnosis.

The implications for service modelling and staff training beyond a single PCG locality in South London need to be tested but consistency with the limited UK literature would suggest that the needs identified are generalisable, and can be adapted according to the training model developed. Furthermore, the research method employed has considerable relevance to the application of evidence based educational outreach within routine applied clinical settings, and providing applied training with immediate relevance for local service development.

This study has pioneered an innovative approach to translating evidence-based practice into routine clinical settings in the field of dial diagnosis screening and assessment. The next logical step is to evaluate further the training and service response models which have emerged, both from the research findings and the consensus reached in the focus groups by the local agencies participating in this study. ∎