

## **THE NEW INDUSTRY**

*Grand's Great Slip*



## **DUAL DIAGNOSIS?**

- ⌘ Diagnosis implies identifiable clinical picture
- ⌘ 'Dual' concept may oversimplify need
- ⌘ Associated with complex social problems
- ⌘ Heavy drinking, opioid injecting male with antisocial personality disorder who develops major depression in the context of chronic pain secondary to diabetic neuropathy

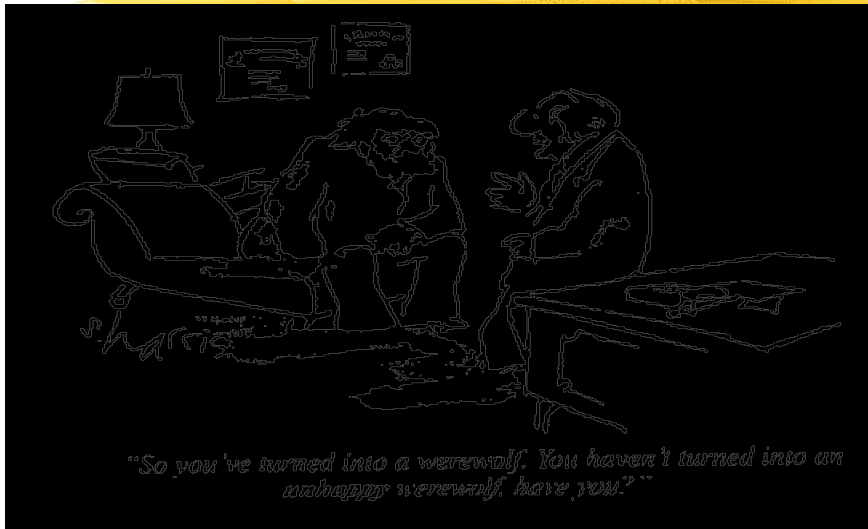
## ***DIAGNOSIS?***

- ⌘ Need to gather statistical information
- ⌘ Problems with concept of 'mental disorder'
- ⌘ No consistent operational definition
- ⌘ Many different indicators but none equivalent to the concept
- ⌘ DSM IV - 'clinically significant behavioural or psychological pattern.....associated with significantly increased risk of pain, death, disability or loss of freedom'

## ***DIAGNOSIS ? (2)***

- ⌘ No assumption of discrete boundaries
- ⌘ Tailored by 'clinical judgement'
- ⌘ Categories rather than dimensions
- ⌘ Problems when applied to communities  
e.g. high prevalence rates in ECA
- ⌘ Diagnosis does not equal need
- ⌘ Failure to measure 'Functionality'

# FUNCTIONALITY



# COMORBIDITY

- ⌘ 26 yr. old man - single - 2 children, no access
  - ☒ Psychotic episodes for >10 years
  - ☒ Homeless
  - ☒ Chaotic drug use
- ⌘ 37 yr. old woman - 3 children - no regular partner
  - ☒ On Methadone Px. - tops up
  - ☒ Various other downers
  - ☒ Heavy Alcohol intake
  - ☒ Depression, poor anger control, cutting
- ⌘ 76 yr. old man - lives with wife of 48 years
  - ☒ Admitted through A & E
  - ☒ Confused - evidence of repeated falls
  - ☒ Alcohol problem + cocktail of Prescription drugs
  - ☒ Demented / Depressed ?

## ***SCALE OF PROBLEM - 1***

- ⌘ Continuums - severe/mild drug abuse
  - severe/mild alcohol misuse
  - severe/mild mental illness
- ⌘ Continuums - types of drug/alcohol use
  - types of mental illness

## ***SCALE OF PROBLEM - 2***

- ⌘ Primary mental health probs → substance misuse
- ⌘ Substance misuse may worsen mental health
- ⌘ Substance misuse may lead to mental illness
- ⌘ Withdrawal may produce mental health problems
- ⌘ Concurrent development of substance misuse and mental health problems
- ⌘ Heterogeneous group with dynamic problems

## **SCALE OF PROBLEM - 3**

- ⌘ SDMD - 2001/2 - 40% of 10798 individuals reported that mental health was a problem area.
- ⌘ Weaver - 75% 1st time attendees had mental health problem.
- ⌘ ECA - 64% drug clinic attendees had associated mental health disorder.
- ⌘ ECA - 55% alcohol clinic attendees had associated mental health problem.

## **SCALE OF PROBLEM - 4**

- ⌘ G.P.s - 35% drug + 51% alcohol consultations related to mood or anxiety related disorders (comp. with 17% non substance prob. population)
- ⌘ NTORS - 20% drug clinic attendees had previously sought help for mental health problem - esp. if poly-drug use.
- ⌘ NTORS - 📈 levels of psychoticism if alcohol +drugs
- ⌘ NTORS - 📈 levels suicidal ideation in 3 months prior to clinic attendance.

## **SCALE OF PROBLEM - 5**

- ⌘ ECA - Anxiety disorders commonest (19% alcohol + 28% drugs)
- ⌘ Welsh (2002) - meta-analysis found 57% had personality disorder! (less in alcohol than drugs)
- ⌘ Gilchrist (2002) - Female drug users at crisis centre and methadone clinic -
  - 71% history of emotional abuse
  - 65% history of physical abuse
  - 50% history of sexual abuse

## **SCALE OF PROBLEM - 7**

- ⌘ PSYCHIATRIC MORBIDITY IN ADULTS (2000)
  - Obsessive compulsive disorders strongly linked with alcohol dependence.
  - More likely to misuse anything if a neurotic disorder present - 1% population
    - 2% with neurotic disorder
    - 5% if phobic
    - 6% if > 2 neurotic disorders

## **SCALE OF PROBLEM - 8**

- ⌘ PSYCHIATRIC MORBIDITY IN ADULTS (2000)
  - Women > men - neurotic disorder
  - Men with N.Dis > women - hazardous drinking + Drink + Drug dependant
  - will under estimate for those who are homeless or in institutions or custody
- ⌘ ECA - 30% of mental disorders had Sub Mis. problem
  - 37% of Alcohol probs had M/H problem
  - 53% of drug problems had M/H problem

## **SCALE OF PROBLEM - 9**

- ⌘ NES (England) 2003 - Increase of 64% in presentations of comorbidity too General Practice 1993-98
- ⌘ Glasgow Homeless 2000 - 35% comorbidity (higher with lower age)
- ⌘ Psychiatric Discharges -
  - 5% drug related Dx. (SCZ commonest)
  - 14% Alcohol related Dx. (Depression ")

## ***SCALE OF PROBLEM - 6***

### ⌘ SAFER SERVICES (2001) -

- 56% suicides had history of alcohol misuse
- 37% suicides history of drug misuse
- 20% primary diagnosis of alcohol misuse
- 10% primary diagnosis of drug misuse

## ***SAFER SERVICES - SUICIDE***

- ⌘ Commonest diagnoses -Depression, Personality disorder, Substance misuse
- ⌘ 1/2 had co-morbid diagnosis
- ⌘ High rates of alcohol and drug misuse
- ⌘ 1/2 had history of self harm and substance misuse
- ⌘ 10% did not have care plan altered because of personality or substance problems

## ***SAFER SERVICES - RECOMMENDATIONS***

- ⌘ Promote services for people with mental illness who also misuse alcohol and drugs
- ⌘ Resource determination should reflect level of risk (rates of co-morbidity)
- ⌘ Staff training in General Psychiatry to include management of substance misuse
- ⌘ Services for those with severe mental illness and substance misuse should be part of mainstream mental health services

## ***SCALE OF PROBLEM - summary***

- ⌘ Problem growing rapidly
- ⌘ 3 in 4 drug using clients reported as having mental health problems
- ⌘ 1 in 2 people with alcohol problems reported as having mental health problems
- ⌘ 2 in 5 people with mental health problems likely to have substance use problems

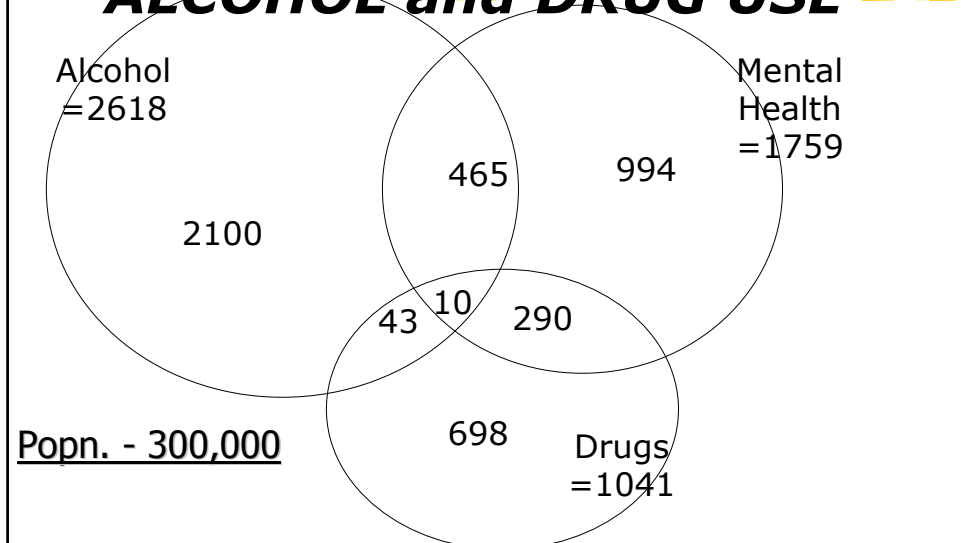
# **AETIOLOGY**

- ⌘ GENETIC
- ⌘ PERSONALITY
- ⌘ EARLY ENVIRONMENT
- ⌘ PHYSICAL or MENTAL DISABILITY
- ⌘ PSYCHOLOGICAL STRESSORS
- ⌘ SOCIAL STRESSORS

## **SOCIAL INCLUSION ↔ EXCLUSION** **MENTAL HEALTH ↔ ILLNESS** **SUBSTANCE USE ↔ PROBLEMS**

- |                                 |  |
|---------------------------------|--|
| ⌘ School non-attendance         | ⌘ Heavy, early use of legal drugs                            |
| ⌘ Early criminality             | ⌘ Personal experience of mental health problem               |
| ⌘ Experience of LA care         | ⌘ Parents actively criminal with history of substance misuse |
| ⌘ Unemployment as cultural norm | ⌘ Disruption of family unit                                  |
| ⌘ Experience of homelessness    |  |

# **RELnSHIP NEUROTIC DISORDERS, HAZARDOUS ALCOHOL and DRUG USE**



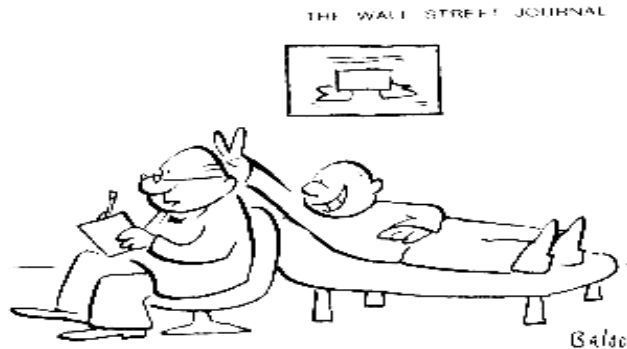
## **PERSONALITY DISORDER - 1**

⌘ Indeed?!

⌘ Antisocial P. D. 3 Of :-

- ☑ Unlawful Behaviour
- ☑ Deceitfulness
- ☑ Impulsivity
- ☑ Aggressiveness
- ☑ Recklessness
- ☑ Irresponsibility at work or financially
- ☑ Lack of remorse

## ***PERSONALITY DISORDER - 2***



"And when do you feel this hostility toward authority figures?"

## ***PERSONALITY DISORDER - 3***

- ⌘ Mainly Anti-social Personality Disorder (5% males, 1% females)
- ⌘ With Dx. Substance misuse - 18% comorbid
- ⌘ IVDUs - 44% ASPD
- ⌘ No worse results in maintenance treatment
- ⌘ If conduct disorder included rises to 70% (implications for treatment targeting)

## ***IMPLICATIONS***

- ⌘ Assessment by generic workers poor
- ⌘ Training responses slow
- ⌘ In-Patient units - 20% pre-screening  
- 35% post-screening  
(depends on catchment demographics)
- ⌘ 'A problem requiring help'

## ***EXISTING SERVICE PROVISION - 1***

- ⌘ Planning, delivery, and accountability of integrated service poor
- ⌘ Different planning processes for mental health and substance use services
- ⌘ Service provision for personality disorders and for childhood trauma patchy with no consensus

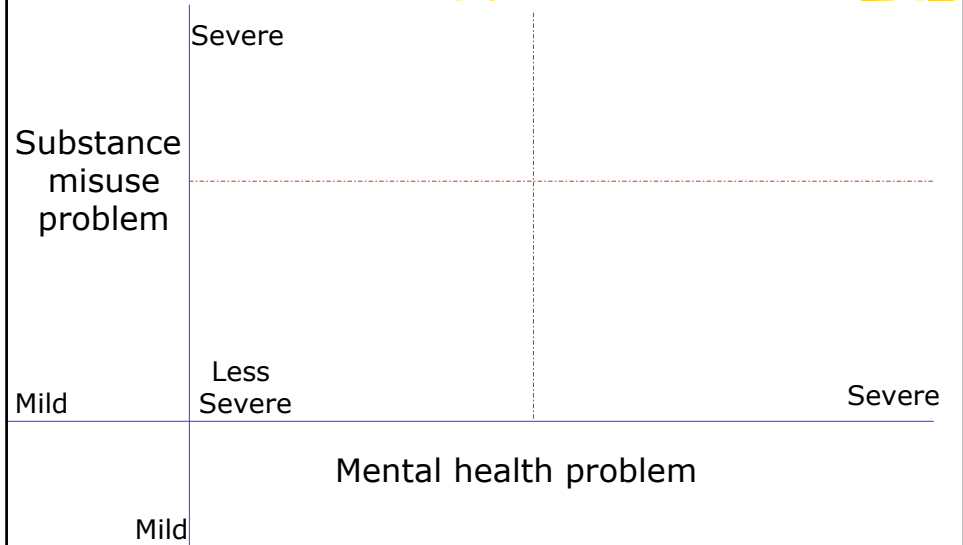
## ***EXISTING SERVICE PROVISION - 2***

- ⌘ Lack of operational communication between specialisms
- ⌘ Lack of willingness to work with this client group with inappropriate onward referral or no service
- ⌘ Poor planning of aftercare as integral part of service
- ⌘ Poor voluntary partnerships

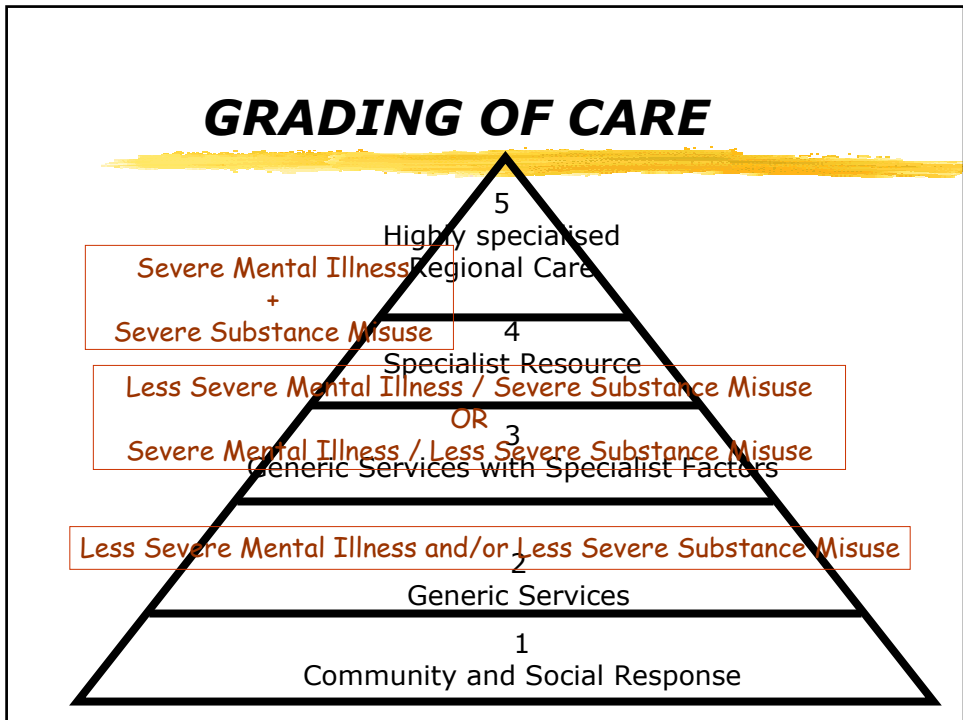
## ***ASPIRATIONS***

- ⌘ Shared understanding of types and sequencing of appropriate care
- ⌘ Flexible application
- ⌘ Diverse enough skill mixing to allow rapid response to need
- ⌘ Confident specialist workers
- ⌘ Confident generic workers
- ⌘ Understanding by commissioners of service

# QUADRANT MODEL



# GRADING OF CARE



## ***INTERVENTIONS***

- ⌘ Proper assessment is key -  
Comprehensive practical holistic analysis
- ⌘ Engagement - Empathy / realistic
- ⌘ Basic needs met - Comprehensive practical holistic analysis
- ⌘ Persuasion + Problem solving
- ⌘ Active, early, broad based, flexible intervention- Strong evidence base for efficacy

## ***OUTCOMES***

- ⌘ Less harmful substance use
- ⌘ Healthier in mind and body
- ⌘ Engagement with services
- ⌘ Stable living situation
- ⌘ Some psychological healing

## ***PLANNING and PROVISION***

- ⌘ Extremely challenging care group
- ⌘ Should have defined programme budget allocated
- ⌘ Concentration should be on generic provision with easy access to specialist services - Efficient movement through system essential
- ⌘ Early, broad-based, person centred interventions with full advocacy provision and positive expectations

## ***PLANNING and PROVISION***

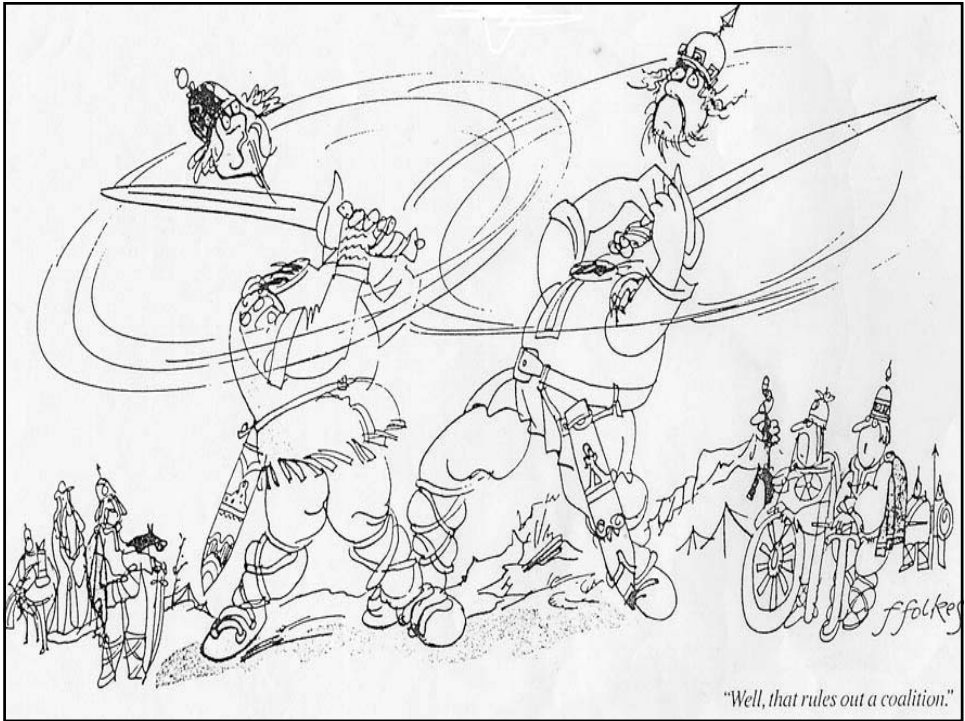
- ⌘ Person-centred best practice
- ⌘ Training in integrated assessment methods
- ⌘ Training in broad range of interventions
- ⌘ Supervision essential both clinical and managerial
- ⌘ Good quality information transfer essential
- ⌘ Voluntary sector has a key role - 'Partnership for care'

## ***KEY RECOMMENDATIONS***

- ⌘ NHS QIS should consider standard development
- ⌘ DAATs and M/H commissioners should work jointly to ensure integrated service
- ⌘ Development of tiered services in context of Integrated Care + Joint Futures
- ⌘ Flexible joint work with eg Criminal Justice, housing A&E, employment
- ⌘ Encouragement of voluntary sector

## ***KEY RECOMMENDATIONS***

- ⌘ Raise expectations of positive treatment outcomes amongst staff and clients
- ⌘ Ensure advocacy services
- ⌘ Re-examination of attitudes amongst generic mental health services
- ⌘ Assurance of continuing support and encouragement
- ⌘ 'Most people don't die they get better'



"Well, that rules out a coalition."