Slide 1

Dual Diagnosis:

Models of Care and Local Pathways

St. Anne's Community Services
Dual Diagnosis Project

Slide 2

AGENDA

Part one:

- Models of Care.
- Clinical Guidelines & Evidence Base
- Local Care Pathways Guide.

Part two:

- A case study of collaborative care for drug users with Schizophrenia.

Slide 3

Part one:

Models of Care

- **Serial or 'sequential' care:** treating one condition before moving on to treat the other, usually one service involved at a time.
- **Parallel care:** a number of services involved and working with minimal or no interagency communication.
- **Collaborative or 'shared' care:** a number of services involved under an agreed care plan which is led by a designated care co-ordinator.
- **Integrated care:** a single service offers treatment for mental health and substance use issues.

Slide 4

National Guidelines

DH Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide (2002)

Recommends integrated treatment within mental health services for severe mental disorders and addictions, otherwise referred to as 'mainstreaming'.

Staged approach to treatment, emphasis on harm reduction and assertive outreach.

Slide 5

National Guidelines

NICE clinical guideline 51 – drug misuse: psychosocial interventions (2007)

Recommends evidence-based psychological treatments for the treatment of comorbid depression and anxiety disorders "for people who misuse cannabis or stimulants, and for those who have achieved abstinence or are stabilised on opioid maintenance treatment".

Slide 6

National Guidelines

Drug misuse and dependence: UK guidelines on clinical management (2007)

"Assessment and evidence-based care provided by liaison or a multidisciplinary team is appropriate."

"Specialist addiction psychiatric services and mainstream mental health services that work jointly and flexibly with these individuals".

Slide 7

Current Evidence Base

The Cochrane Collaboration: Psychosocial interventions for people with both severe mental illness and substance misuse (2008)

- Pooled data from 25 RCTs (n= 2,478)
- Interventions: one-off PSIs, or as integrated or non-integrated programme
- Outcomes of interest: reduction in substance use, retention in treatment, improved mental state
- Heterogeneous studies with respect to: setting (hospital vs community, outcome measures, drug use patterns, diagnoses, treatment fidelity

Slide 8

(Cochrane review continued…)

Review made comparisons between:

1. Integrated care vs TAU
2. Non-integrated care (case management) vs TAU
3. CBT + MI vs TAU
4. CBT vs TAU
5. CBT + rehab vs TAU
6. CBT + intensive case management vs TAU
7. Intensive case management vs TAU
8. MI vs TAU

OVERALL RESULTS: No significant difference in loss to treatment, substance use or functioning between intervention and control groups. Comparison 4 favoured CBT with respect to loss to treatment. Comparison 8 favoured MI with respect to loss to follow-up at aftercare stage.

Slide 9

Local Policy & Care pathways guide

City-Wide Care Co-ordination Protocol:
http://www.dual-diagnosis.org.uk/doc/DDprotocol.pdf

Care Pathways Guide:
http://www.dual-diagnosis.org.uk/doc/DDpathways.pdf

Slide 10

Part two: case example of collaborative care

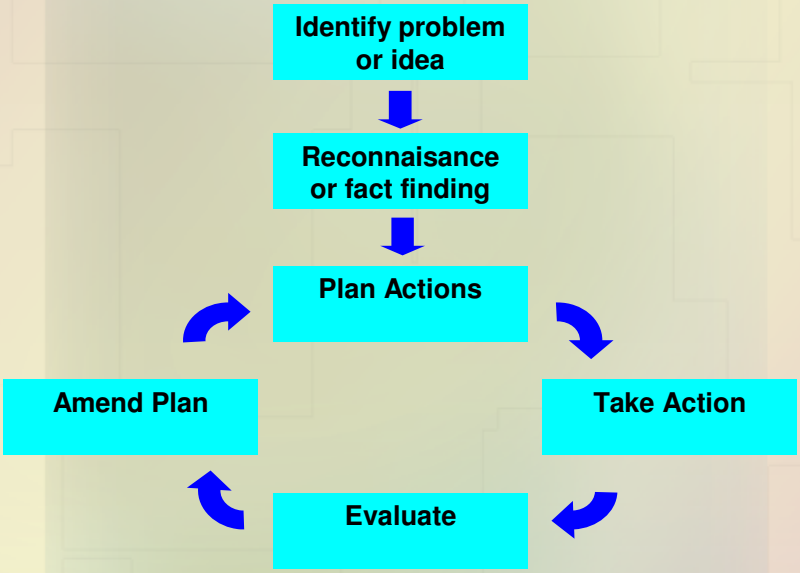
Evaluation of a pilot project:

Outreach-based harm reduction interventions for drug users with a diagnosis of Schizophrenia

Slide 11

Framework:

Action-Research Cycle (Lewin, 1948)



Slide 12

1. Problem Formulation:

Central Problem

Perception that numerous AOT patients with Schizophrenia use alcohol & drugs, to the detriment of health & treatment concordance.

Research Questions

- What is the actual prevalence of substance misuse (SM) in AOT caseload?
- What are the consequences of SM on health & treatment?
- What can be done to minimise any adverse consequences of SM?
- How effective is assertive outreach in addressing SM?

Slide 13

2. Fact Finding:

Methods

- Cross-sectional audit to determine prevalence of Dual Diagnosis
- Key variables identified, data collection sheet designed
- Data collection via interviews with all AOT case managers during 2 weeks

Main Findings

- 51% = patients with a 'significant addiction'
- Most common = cannabis (25%), alcohol (22%), amphetamines (20%)
- Only 10% with 'significant addiction' currently in treatment

Slide 14

3. Action Planning:

Known Facts

- Large prevalence of Dual Diagnosis in AOT caseload
- Current systems unsuitable: minimal cases in addictions treatment
- DH Policy & guidelines recommend harm reduction to engage with high risk groups

Plan

- Develop Joint-working protocol: AOT and Harm Reduction Service
- Organise joint-outreach work
- Evaluate joint-outreach work

Slide 15

4. Action Stage:

(Nov 2008 – March 2009)

- Joint-Working Protocol between AOT and HRS agreed.
- Lead practitioners nominated and trained.
- Evaluation of joint-outreach protocol designed.

(April – June 2009)

- 12 week pilot project: targeting dependent drug users with Schizophrenia.
- Quantitative and qualitative data collected throughout.

Slide 16

5. Evaluation:

Key Questions

- How effective is assertive outreach in addressing SM?
- What are the consequences of SM on health & treatment?

Methods

- Base-line and end outcome measures for: drugs used, patterns, severity.
- Qualitative interviews conducted: reasons for use, impact of use, self-rate mental and physical health, feedback on joint-outreach visits.
- Case notes submitted for analysis.
- Focus group involving all staff involved in pilot: feedback summarised.
- Data analysis: descriptive statistics and thematic analysis for qual. data.

Slide 17

Evaluation (continued...)

Main Findings

Quantitative Data:

- 36% of contacts resulted in drug related assessment
- 18% of contacts successfully engaged in harm reduction & health promotion
- Success ratio: 1 in 6 cases engaged in structured harm reduction

Qualitative Data:

- Reasons for using: to cope with distress, to enhance mood, to enhance social life, to relieve boredom
- Evidence found of direct impact of SM on physical health, mental health and poor concordance with medication / treatment
- Most patients had little insight into impact of SM & poor motivation to change
- Staff found joint-outreach useful way to gain knowledge, skills & confidence

Slide 18

6. Amend Plan:

(July 2008)

- Joint-working Protocol revised.
- Joint-working visits re-organised to minimise unsuccessful appointments.
- Protected time in practitioners' diaries to ensure follow-up sessions are prioritised.
- Services agreed to continue to support partnership and joint-outreach model.