RESEARCH BRIEFING

30

January 2009

The relationship between dual diagnosis: substance misuse and dealing with mental health issues

By Ilana Crome and Pat Chambers, with Martin Frisher, Roger Bloor and Diane Roberts

Key messages

- The prevalence of co-existing mental health and substance use problems (termed 'dual diagnosis') may affect between 30 and 70 per cent of those presenting to health and social care settings.
- There is growing awareness of the serious social, psychological and physical complications of the combined use of substances and mental health problems.
- Given the multiplicity of social, familial and economic problems associated with dual diagnosis, social workers have a distinctive role to play in multi-agency work.
- Interprofessional training and working, encompassing statutory and non-statutory sectors is essential.
- Knowledge of screening and assessment for dual diagnosis should be core training elements for health and social care practitioners. The effectiveness of treatment and other interventions is improving.
- Service provision should actively engage users and carers from initial assessment to continuity of long-term care. The importance of understanding and working with service user's experience and perspective cannot be underestimated.
- Raising awareness among non-professionals, including carers, can make a major contribution to improved service access and treatment.

Introduction

This briefing examines the issues presented by service users with dual diagnosis for UK practitioners in health and social care. Confusingly, the term 'dual diagnosis' is used to describe several combinations of physical, psychological or developmental conditions; but for the purpose of this briefing, it refers to the co-existence of substance misuse and mental health problems. This briefing considers all age groups and uses the term 'substance' to refer to illegal or illicit drugs; alcohol; nicotine and prescription drugs. The terms 'substance' and 'drug' are used interchangeably. 'Mental health problems' refers to severe or enduring conditions, while 'substance misuse' refers to chronic or complex substance use problems. The briefing does not consider specific pharmacological or other treatment interventions in detail, but focuses on issues arising at the health and social care interface. It draws on research and literature from other countries, including the US where the majority of research on dual diagnosis has been conducted; to provide an overview for health and social care practitioners in the UK. Where there are gaps in the research, for example, in regard to service user involvement, recovery approaches

social care
institute for excellence
scie

and personalisation of services, the briefing draws upon evidence from relevant fields such as mental health and substance misuse. Throughout this briefing the terms, patient, client, and service user are used interchangeably to reflect the different usages prevalent within different sectors of health and social care.

What is the issue?

There are many different terms used to describe the combination of, and association between, substance misuse and mental illness with the most commonly used being 'dual diagnosis' and 'comorbidity'. These terms reflect the coexistence of substance use, misuse, harmful use or addiction, and psychological or psychiatric problems. Two or more substance disorder or psychiatric conditions may be present at the same time, or may occur at different times. There may also be physical illnesses that further complicate the picture, and the social manifestations may add another level of complexity.

A working definition of 'substance misuse' is the use of substances that are socially, medically or legally unacceptable, or that have the potential for harm. It should be noted that just one dose of a drug can sometimes be fatal and, therefore, any substance use must be considered important. In order to objectively identify occurrence of substance misuse, two similar (though not identical) systems have emerged. These are the World Health Organisation International Classification of Diseases (ICD-10)[1] and the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV).[2] The criteria established under either system (see appendix A) may be used for the diagnosis of harmful use and dependence syndrome (addiction).

The term 'drug' may be used to refer to licit substances (tobacco and alcohol) and illicit substances, such as opiates and opioids (e.g. heroin and 'street' methadone); stimulants (cocaine, crack, amphetamines and ecstasy); volatile substances; and cannabis. It also includes prescription drugs (e.g. benzodiazepines) taken in a manner that was not indicated or intended by a medical practitioner, and the misuse of over-the-counter preparations such as codeine-based products (e.g. cough medicines, decongestants). Furthermore, a combination of prescribed and over-the-counter medications may also be problematic, even where the individual medications are used correctly. This is known as 'polypharmacy', while the deliberate use of combinations of substances may result in 'polydrug' 'misuse', 'harmful use' or 'dependence' (addiction). Both polypharmacy and polydrug misuse may co-exist with physical or psychological conditions and result in dual diagnosis.

Why is it important?

Mental health and substance misuse problems are major public health and social issues. They are commonly encountered in the general population, but are perhaps more apparent in health and social care settings. In 1999 the Department of Health commissioned a review of psychiatric disorder and substance misuse[4] which led to a series of interlocking projects, which included the Drug Misuse Research Initiative,[5,6,7,8] and a comprehensive literature review,[9] and a training and information manual. This was followed by policy guidance in the National Service Framework for Mental Health[10] and subsequent guidance on implementation.[11,12] Similar developments in Scotland included 'Mind the Gaps' and a good practice guide.[13,14] More recently, this work has been included in a Europe-wide project.[15] There have also been a range of other guidance documents which make reference to co-morbidity.[16,17,18,19,20,21,22,23,24,25]

There are many reasons for the apparent increase in comorbidity, including the de-institutionalisation of patients with mental disorder and increasing substance use in the community. Consequently, there is greater heterogeneity in the presentations of people with dual diagnosis.[9]

Individuals may present during an episode of intoxication or withdrawal; may be dependent on one or more substances; and may suffer from more than one psychiatric symptom or syndrome as a result. It may, therefore, be challenging to distinguish 'what comes first' for all of these reasons, and a pre-occupation with 'what comes first' often results in potential service users being excluded from help.[26] Service organisation tends to revolve around specific disorders (e.g. mental health, physical health, substance use), which does not take account of the complicated realities of the individuals concerned, even though this feature may, in part, contribute to poor outcomes.[7,27,28,29] Services are likely to have different histories, and differing philosophies and ways of working with people who use those services. Most significantly, they may have little experience of each other's field.[26] For example, recovery approaches[30] that currently predominant in mental health services have not been embraced in substance use services.[31] The nature of the comorbidity may bar some service users from a particular service. For example, the criteria for accessing a mental health service may exclude those who misuse substances and vice versa.[12,26] Without access to specialist services, people with a dual diagnosis, who may already find it difficult to engage with services, will not only continue to have serious health and social care needs, but are even more likely to be resistant to approaching services in the future.[12] Professionals involved in health and social care services are likely to face ethical and legal dilemmas.[32] For instance, while seeking to encourage service users to engage with services (and minimize disengagement) difficult issues relating to risk (either to the individual, those within their social network, or the public) may have to be addressed, and where the service user is a primary carer, child protection procedures must be given due attention.[33] This may involve complex intra-agency working between adults' and children's services, and the importance of challenging traditional separations between services in situations where there are parents with mental health problems has been noted elsewhere.[136,138,137] On rare occasions, and following the new Mental Health Act 2007 (**www.doh.gov.uk/mentalhealth**) it may be necessary to consider detention as an option. In regard to the new Act, it is still too early to comment upon the extent to which either detention or compulsory treatment orders may be appropriately used with service users with a dual diagnosis, or to comment upon their effectiveness. While there is considerable stigma attached to substance misuse and mental disorder there is some evidence that this is gradually shifting.[3] Nonetheless, dual diagnosis remains an extremely complex field, and while progress has been made, service users with a dual diagnosis can present considerable challenges to services that struggle to satisfactorily address their needs.[14]

What does the research show?

The majority of the research on dual diagnosis has been undertaken in the United States but there is increasing interest across Europe, including the UK. However, differences in the health and social care provisions in each country mean that not all of these findings are applicable to a UK context. It should also be noted that medical research predominates in dual diagnosis and very little research has been undertaken from a social work or social care perspective. Nevertheless, generalisation from research into mental health issues might suggest that social isolation, stigmatisation and social exclusion are likely to be common experiences, as well as generally poor provision for some groups of people from ethnic minorities.[136] Importantly, the voice of service users and their families or carers is lacking in the majority of the research literature; a notable exception is a Scottish study[29] discussed later in this review. Several non-statutory organisations and service user organisations, such as Mind, Turning Point and Rethink, have drawn on the experience of service users with a dual diagnosis and their carers to develop 'toolkits'[26] and good practice handbooks.[14]

Relationship between drug misuse and mental health problems

Research shows that substance use, intoxication, harmful use, withdrawal and dependence may lead to or exacerbate psychiatric or psychological symptoms or syndromes.[15] Conversely, psychological morbidity and psychiatric disorder may lead to substance use, harmful use and dependence (addiction). The most common associations for substance misuse are with depression, anxiety and schizophrenia, but eating, post traumatic stress, attention deficit, hyperactivity and memory disorders also occur.[17,34-36] Alcohol problems, for example, are often seen with bipolar disorders, schizophrenia, and personality disorders,[37] while concurrent use of other illicit substances is well recognized in opiate dependence. Cocaine users, too, who may supplement their use with alcohol, may also have affective disorders and personality disorders.

In general, four inter-relationships in dual diagnosis are recognised:

- A primary psychiatric illness may precipitate or lead to substance use, misuse, harmful use, and dependent use, which may also be associated with physical illness and affect social ability.
- Substance use, misuse, harmful use and dependent use may exacerbate a mental health problem and physical health problem, e.g. painful conditions, and any associated social functioning.
- Substance use e.g. intoxication, misuse, harmful use and dependent use may lead to psychological symptomatology not amounting to a diagnosis, and to social problems.
- Substance use, misuse, harmful use and dependent use may lead to psychiatric illnesses, physical illness, and social dysfunction.

Prevalence – how common are the conditions?

The UK has amongst the highest levels of substance misuse in Europe.[38,16,39] The situation is, however, dynamic and it has become well recognised that combinations of substances may be misused. This includes two of the most commonly encountered substances, alcohol and nicotine. Since the early 1990s, despite a fall in overall prevalence of smoking from 45 per cent of the adult population in 1974 to 22 per cent in 2006, it has been higher among 20 to 24 year olds than other age groups.[40]

Alcohol

Around 25 per cent of the population drink above the recommended safe limits, with per capita alcohol consumption doubling over the last fifty years and continuing to rise.[41,42,43] There are some seven million hazardous drinkers in the UK. Hospital admissions for conditions related to alcohol consumption have doubled in the last ten years and death rates have doubled over the last fifteen years.[44] Alcohol misuse costs the country £20 billion per annum.

Illicit drugs

It is estimated that about eleven million people (35 per cent) aged 16-59 have used illicit drugs in their lifetime, with some three and a quarter million (10 per cent) having used illicit drugs in the previous year; and two million (6 per cent) in the previous month.[39] Cannabis is the commonly used drug, with 8 per cent of 16-59 year olds reporting use in the previous year. The use of Class A drugs increased between 1998 and 2006/7, and just over a million people aged 16-59 have used Class A drugs in the previous year.[39] Trends in drug use since 1998 indicate that drug misuse has stabilised or decreased, though even a conservative estimate suggests that drug misuse costs the country £15 billion per annum.[39]

Comorbidity

Co-existing mental health and substance problems are very common in health and social care practice. In a study on primary care in the UK during 1993-1998 the prevalence of co-existing drug and psychiatric conditions increased by

62 per cent in England and Wales, with the rates of drug problems and psychoses, schizophrenia, and paranoia increasing by 147 per cent, 128 per cent and 144 per cent, respectively.[5,6] In 1998, therefore, a typical general practice might have encountered eleven cases of comorbidity. This has implications for primary care and the workload of general practitioners. An examination of screening rates for a diverse range of services showed substantial differences between community mental health teams (37 per cent), inpatient mental health (56 per cent), forensic (62 per cent), substance misuse (93 per cent) and primary care services (24 per cent).[45]

Another study, on mental health centres and substance misuse services in the UK, showed that three quarters of drug service users and 85 per cent of alcohol service users had mental health problems, mostly affective disorders and anxiety disorders. Approximately one third of the drug treatment population and half of the alcohol treatment population also had multiple morbidity, i.e. the co-occurrence of several psychiatric disorders or substance misuse disorders.[7] The costs of caring for service users with dual diagnosis is higher than for single conditions because of the need for greater service utilisation.[46,47] Nearly 40 per cent of drug users had not received help for their mental health problems and just over 40 per cent of mental health service users reported drug use and/or hazardous or harmful levels of alcohol use in the past year. These individuals were perceived as being more aggressive, chaotic and less compliant with care plans.[7,48,49]

Drug users attending treatment also tend to carry a heavy burden of additional health problems, which in turn adversely affect their mental health, and are accompanied by high rates of unemployment.[50,51] Serious physical illness is, of course, an additional comorbidity and one that is, perhaps, overlooked, under-rated, and under-treated.[52] Physical problems such as pain, infection, injury and cancer, may result from substance misuse and may lead to mental illness. If not adequately treated these conditions not only add to the suffering of individuals, but may also undermine any treatment that is provided for substance misuse. As a result, people with multiple conditions often do not receive or access the full range of care that they need.

Problems may also commence in childhood or adolescence and continue into old age.[16,53,41,42,54-57] Childhood abuse is, for example, known to contribute to the prevalence of comorbid personality disorder in addiction populations.[58,59,60] Women who use substances and have been exposed to sexual, physical and emotional abuse as children are more likely to experience emotional distress than a control group of women substance misusers who do not have that background.[61,62]

Explanation for differing rates of co-occurring disorders depends on many factors including:

- Differences or lack of standardisation between diagnostic classification systems and diagnostic instruments used for mental disorder and those for substance use disorders.
- The setting in which condition is studied, e.g. a clinical setting being more likely to yield high rates than general population studies.
- Services that may conceptualise and diagnose the same users differently.
- An individual's substance use that may fluctuate in type, quantity and/or frequency.
- Time of assessment which may influence the result, e.g. during withdrawal or intoxication.
- Mental health presentations which may vary depending on environmental triggers.
- Geographic differences between regions, types of presentation and rural or urban communities.
- The combination of events that constitute an individual's life history.

Social complications

Combinations of problems often lead to difficulties in the domains of health, education, and the criminal justice system. Medication non-compliance, substance abuse and severe mental illness are associated with violence, although violence perpetrated by the severely mentally ill accounts for a small proportion of violent acts in the community.[63-66] In essence, problems associated with dual diagnosis tend toward a poorer prognosis and greater disability. This includes a greater likelihood of medical, psychiatric and social problems that arise as a result of poor compliance with treatment, unplanned discharge, relapse and rehospitalisation.[67,68,69] Self-harm, often by overdose, and eventual suicide are also strongly associated, as is early mortality. It is recognised, for example, that service users with 'dual diagnosis', who constitute 27 per cent of suicides, are inadequately treated.[70,71,72]

Drug-related violent crime can be divided between:

- violence arising from the effects of the drug
- violence associated with the interaction of a psychiatric illness and drug use
- violence associated with acquisition of drugs
- violence associated with disputes between drug users, dealers or gangs.[17]

There is evidence to suggest that a combination of a psychosis and co-morbid use of drugs results in a higher rate and severity of violence than in a population with psychosis and no co-morbid substance use.[73] Reviews of aggressive behaviour in users of heroin have also indicated that high rates of aggressive behaviour in this group may be independent of their use of heroin and more related to personality factors that are also associated with the risk of heroin dependence.[74]

Social instability and marginalisation, as manifested by homelessness, economic deprivation, unemployment, crime and violence, characterise this group, who are also at increased risk of victimisation, and may have experienced childhood and adolescent trauma, educational and social skill deficits arising from family problems, and childhood abuse.[75,76,77] As a result of these complications, comorbid service users present not only to primary care, secondary care and general medical, surgical and mental health services, but to social care and welfare services, such as education, housing, social work (child protection and adult services), and the criminal justice system.[24,78,79,80] It has been noted that it is the emotional and socio-economic issues that present the major challenges to recovery both for the individual and their families.[81] The social complications may be so pressing that many people with comorbidity may not present to health services. A wide range of social care professionals therefore need to be alert to the possibility of dual diagnosis and be skilled in assessing whether mental, physical and substance problems are at the core of the social presentations. Despite multiple vulnerabilities, there is a consistent failure to recognise this complex and demanding sub-set of service users.

Screening and assessment

Irrespective of the service to which problems are first presented, screening and assessment is fundamental to achieving better diagnostic outcomes. Considerations include; the experience of the assessment, the environment of the assessment,[82] a high index of suspicion, a robust assessment process that includes a thorough history, and the use of appropriate screening and assessment tools.[83,84] As with the Single Assessment Process for older people and the Common Assessment Framework for young people, in a multi-disciplinary context it is necessary to have a well-recognised and well-established common approach.[85] Without rigorous detection, problems will be missed or attributed inappropriately, and may result in the subsequent treatment or care response being inadequate, incorrect, or even neglectful. There

are a range of instruments for screening and the assessment of different substances[86] – a discussion of their merits lies beyond the scope of this briefing. The more commonly used ones which can help professionals to develop appropriate protocols can be found in the reference list.

Screening and assessment must seek to understand the service user's story and perspective on their illness, and should not exclude their family or carers.[87] Although screening and assessment may incorporate standardised tools and involve some medical investigations (blood, urine, and hair analysis), an evaluation of occupational capacity, social or relationship functioning and quality of life are also important in determining the client's life experience. Assessment is likely to take place over the mid to long term and thus require regular monitoring as well as continual interaction and collaboration between colleagues working in allied services. The use of common protocols and processes is desirable because it avoids the unnecessary repetition of multiple assessments, which service users may find exhausting and may lead to resistance to further assessment. It also helps to establish common understanding of terminology, definitions, approaches, interventions and outcome expectations.[3,10,88-92]

Stereotypical assumptions may also have an adverse impact on effective assessment of dual diagnosis. Practitioners and carers may, for example, deny the use of substances in older people despite being aware of the implications of use on physical and mental conditions. For example, they may collude with them in bringing alcohol into the care home, or if they learn of this, ignore it, because they do not know what to do. This obviously hinders treatment or support that may be required.[93]

Interventions

If possible, the first objective of intervention following assessment is to engage the service user in reduction or abstinence. If this can be achieved, this often markedly reduces the psychiatric illness or psychological symptomatology although sometimes this is not feasible. Where a person is suicidal, for example, treatment may have to be initiated immediately, often within an inpatient setting. In general however, there is some consensus that if a client still has symptoms of mental illness after four to six weeks of abstinence or reduction in substance use, then specific pharmacological and psychological treatments need to be considered. Although the evidence on pharmacological effectiveness is promising or even in some instances, proven, there is a risk of interaction between medications for dual diagnosis and substances, or with the medication for physical illnesses. The British Association of Psychopharmacology guidelines[24] therefore urge caution by stressing the side effects of toxicity, i.e. cardio toxicity and death in overdose. As a result, motivational interviewing, cognitive behavioural work (individually or in groups), and measures aimed at the family, are the interventions that have been most consistently studied.[103,104,105]

Several key themes are evident in the literature[138] and these include, the need for:

- a flexible, person-centred, empathetic, non-confrontational and non-judgmental approach which is important for maintaining an appropriate intervention programme
- trusting supportive relationships with clinical or social work professionals
- establishing a shared understanding
- promoting optimism and building motivation to deal with substance problems and other associated difficulties
- understanding the chronology of the disorders, but maintaining a holistic focus in addressing the substance misuse, psychological, social and physical health problems
- prioritising problem solving

- a harm reduction approach to substance misuse in the first instance
- advice and information about the impact of substance use.

Motivational enhancement, cognitive behaviour therapy, and contingency management are some of the better established treatments.[94-101] The willingness of services to offer immediate practical support in relation to basic needs (food, shelter) may sometimes improve motivation to engage with services.[26]

A recent systematic review on the psychological and pharmacological treatment of comorbid substance misuse and mental illness identified fifty-nine studies.[24,102] Despite this, the review could not identify treatments that were equally efficacious for substance misuse and psychiatric disorder. It also considered the efficacy of integrated treatment to be unclear, partly through lack of data. However, the review did conclude that existing efficacious treatment for reducing either psychiatric symptoms or substance misuse also work with dual diagnosis patients. Unfortunately, many of the studies reviewed, had no standard classification of dual diagnosis, relied upon small sample sizes, lacked substance use and psychiatric outcome measures, did not take into account interactions between substance use and medication, had not been replicated; lacked measures of overall service utilisation, and provided insufficient information about possible 'racial', cultural and ethnic differences.[107,108] It is therefore acknowledged that a marked improvement in study methodologies is required to ensure rigorous experimental designs with sufficiently large samples, long-term follow up studies with outcome measures for both substance misuse and psychiatric conditions, as well as social and physical functioning, and a focus on different patient categories.[53,108] It is essential that there is a sufficient consideration of social parameters such as culture, ethnicity, class, gender, as well as levels of deprivation, when evaluating the merits of different interventions.[109] However, there is sufficient evidence to support the need for thorough assessment, liaison and joint working between a variety of service providers,[110,111] and it has also been suggested that in light of the positive experience of recovery approaches in mental health services, it is reasonable to conclude that such approaches may prove useful in working with service users who have a dual diagnosis.[30,31,14]

Although there are no clear models and guidance for best practice or best treatment, there are many pointers as to what the elements or components of a less risky and more comprehensive approach should be, though by whom, when, and in what context these components should be delivered is not clear.[112,113,114] Nevertheless, practitioners should, take into account the following points:[115]

- They may need to plan the treatment programme over a prolonged period due to their complexity.
- Service users find stability and continuity of care reassuring and beneficial because of their multiple difficulties.
- There may be a need to accommodate chaotic life styles which make scheduling appointments or engaging in routines challenging.
- Development of mechanisms to pre-empt or manage crises which occur unpredictably.
- The particular needs of more vulnerable groups e.g. homeless people, teenagers, and older people.
- Availability of detailed knowledge of available services and the need for support in accessing them.
- The need for constant review and re-appraisal of the changing situation.
- Active and ongoing engagement and support of families and/or carers.
- Training and supervision of junior or inexperienced staff by experienced practitioners.

- The experience and knowledge of non-statutory organisations in working with people with a dual diagnosis may need to be drawn upon.

Service provision models

Several models have been proposed. One is a 'tiered' or 'stepped' model of care where the least severely affected would be treated in primary care level services, and where specialist substance misuse or mental health services would be utilised according to the predominant issues.[18,19,20,21,13,14] Another suggestion is for specialist dual diagnosis services to treat those people who have severe problems in each of these domains of services, but as there is currently no convincing evidence as to what works best for this heterogeneous group, each local area will have to develop a framework for optimal management depending on the variety and level of resources available to them.

A Scottish study which actively sought the views of service users, commissioners and providers, to explore the health and social care needs of dual diagnosis patients, provided some important information about the organisation of provision and barriers to implementation.[29] The picture that emerged was that those with dual diagnosis struggled with the daily realities of everyday life, and had experienced a series of multiple 'losses' including, for example, routine lifestyle, social networks, employment and security. The study showed that services were often inappropriate and might even further undermine users' fragile self-esteem and coping strategies. It noted the importance of raising awareness about support that was available in order to better help users navigate very complex care pathways (where these existed). Service providers perceived the users as a group as being 'chaotic', and though provision varied from place to place, it was generally inadequate and unsatisfactory. Exceptionally, however, key individuals had established a therapeutic relationship with service users and there were some examples of good practice, though the provision of support within mainstream service provision can only be as good as the expertise of the professionals within these services.[116-118,23]

Training

There is widespread agreement that education and training for service users, carers, health and social care providers, commissioners, and the general public, should prioritise awareness raising.[86,119] There is also a pressing need for training in clinical competence in the management of this group of service users. Many doctors (general practitioners as well as specialists) have a role in the treatment, management and coordination of care.[23,52,86] In addition, some groups require even more coordinated care than others, including the homeless; offenders; those with learning disabilities; women; teenagers; and older people.[53-56,60,65,76-77,82,120-125] Therefore, multi disciplinary training for practitioners should be an essential component from undergraduate level to continuing professional development. Innovative methods for engaging and retaining the interest of the workforce in updating their skills and knowledge is also important.

Implications from the research

For organisations

People who are identified with a dual diagnosis are extremely heterogeneous in terms of their demographic characteristics, individual biographies, family relationships, pathways to comorbidity, and the type and severity of their mental, physical and substance use disorders. Consequently, the developmental trajectories (or histories) of service users with dual diagnosis are not straightforward or linear. The lack of clear and common causal pathways results in a service user group which is so variable that it is often excluded from services because of the concentration and complex combinations of problems.[126,127] Whatever the trajectory, service structures should seek to support rather than exclude potential service users and provide a

coherent response.[128] Services should be working towards enabling those with a dual diagnosis to live as meaningful and satisfying lives as possible – the complexity of problems should not be used an excuse not to pursue recovery.[31] The continuing development of more responsive models of service delivery in terms of self-directed care and personalisation are likely to provide valuable opportunities for recognising and responding to the diversity of individual circumstances and needs. Indeed, lessons from generic mental health and learning disability services may help facilitate much needed cultural change.[31] Despite the recognised benefits of interprofessional working in many areas of health and social care, there is a shortage of coordinated and comprehensive services for those with dual diagnosis that can, paradoxically, lead eventually to increased service utilisation and poorer outcomes.[129-132] Inclusive care pathways need to be developed and it is essential that these include protocols for interprofessional and joint working that translate into something meaningful in the real life situation of the service user and their carers.[14]

For the policy community

Commissioners and policy makers need to be engaged with service provision in a way that ensures they are aware of the multitude of problems that need to be managed without avoiding the challenges that they pose. Research and policy formulation therefore has to both recognise and address such challenges. This client group is, for example, often excluded from research that tends to concentrate upon the less complex problems, such as patients with only one substance problem and no associated disorders. Involvement of service users with a dual diagnosis in the planning, delivery and evaluation of services is vital in addressing such omissions.[14] In addition, policies should acknowledge the needs of practitioners working with service users in ways that provide a sound basis on which to deliver an integrated and appropriate continuous safe rewarding service. Evidence arising from developments in mental health services in regard to the recovery model and the particular needs and problems of people from different ethnic and cultural backgrounds should prompt a re-examination of the assumptions and organisation of services to those who have a dual diagnosis.

For practitioners

Evidence from developments in practice in mental health and learning disability supports the need for a shift from a passive model of care to one that perceives service users as active participants in their own recovery. This requires a shift of emphasis from pathology and morbidity to one that recognises strengths and accepts that recovery may not involve total abstinence.[31] Successful engagement and appropriate ongoing assessment are key processes when working with people who have a dual diagnosis. Training practitioners in the skills of engaging, screening and assessing those with complex needs should be core elements in health and social care education and training. It is important, too, that professional and academic training (i.e. continuing education in all relevant medical, health and social care courses) highlights the problems associated with substance use, mental illness, physical illness and the social ramifications of interaction between them. This capacity has to be increased by in-house training, enhancement of competencies through additional specialist training, and regular supervision. Inter-professional training and working in particular is vital to enable staff from different professions to better understand and respect each other's values, perspectives and skills.[133]

Given the multiplicity of social, familial and economic problems relating to dual diagnosis, social workers are well placed to contribute to multidisciplinary assessments, to work in partnership with and advocate on behalf of service users and their families, and to facilitate their engagement with service provision and planning. A person-centred approach that recognises an individual's unique biography and

circumstances will not only enhance the likelihood of a positive relationship between practitioner and client, but should also provide a secure basis upon which to begin to tailor services to particular needs. Care plans that focus upon outcomes rather than on services, should be holistic and address the totality of service users' lives.[135] The active involvement of service users, families and/or carers at all stages of service delivery is vital, and 'whole family' approaches are much more likely to have better outcomes,[87] though of course, the potentially fluctuating impact of dual diagnosis upon a person's motivation and decision-making capabilities will impact upon the capacity to participate effectively. In the initial stages of contact, services users and their families often respond well to those services/practitioners that are able to offer practical support and immediate help in emergencies.[26] Approaches that focus on recovery, rather than upon adherence to a particular treatment regime, are recommended (see 'Ten Top Tips'[30]), and where possible, opportunities for increased self-direction and personalisation of service should be provided.

For users and carers

It is important for service users and their carers to appreciate that intervention may require a substantial time investment to produce effective results. It is also important to realise that practitioners are likely to offer differing interventions to different groups of people with a dual diagnosis as respond to differing circumstances.[134] In all cases, the underlying unpredictability of the conditions giving rise to dual diagnosis can produce difficulties in implementing programmes and may make it more difficult to provide or sustain choice and self-direction in service provision. Users and carers therefore need to work with practitioners to find ways of meeting these challenges. Obtaining help and advice from available services and support groups is important in achieving optimally effective outcomes for all concerned. Service providers should be sensitive to the particular challenges facing someone living with or supporting a person with dual diagnosis and should not neglect a proper assessment of their needs.

Useful links

American Psychiatric Association

A medical specialty society recognised world-wide. Over 38,000 U.S. and international member physicians work together to ensure humane care and effective treatment for all persons with mental disorder, including mental retardation and substance-related disorders. *Copies of the DSM-IV can be ordered from the website.*
www.psych.org/

Association of Nurses in Substance Abuse

The Association of Nurses in Substance Abuse (ANSA) provides specialist advice, conferences, training and information for professionals, health and social care bodies, and institutions working in the area of substance abuse.
www.ansauk.org

Care Services Improvement Partnership

A partnership of four national programmes jointly commissioned by the Department of Health and the Strategic Health Authorities (SHAs). Established in 2005 by the integration of a number of initiatives supporting the development of health and social care services. They work with communities, systems and organisations that are engaged with the health and social care needs of older people, people with mental health problems and learning disabilities, people in the criminal justice system and children, young people, their families and carers.
www.csip.org.uk

Department of Health

www.dh.gov.uk/en/index.htm

Home Office

www.homeoffice.gov.uk

MIND (National Association for Mental Health)

A major mental health charity in England and Wales working for everyone with experience of mental distress by campaigning to provide equal rights and inclusion through policy change and the development of quality services.
www.mind.org.uk

National Institute of Alcohol Abuse

A US organisation seeking to promote the best science on alcohol and health by increasing the understanding of biological functions and behaviour and improving the diagnosis, prevention, and treatment of alcohol use disorders.
www.niaaa.nih.gov

National Institute of Drug Abuse

A US organisation that aims to provide strategic support and research on drug abuse and addiction across a broad range of disciplines. It also seeks rapid and effective dissemination and use of the results of research to significantly improve prevention, treatment and policy.
www.nida.nih.gov

National Treatment Agency for Substance Misuse

The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by the UK Government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England.
www.nta.nhs.uk

NICE (National Institute for Health and Clinical Excellence)

The National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. It provides guidance in public health, health technologies and clinical practice.
www.nice.org.uk

Rethink

A charity for people affected by severe mental illness by providing services, support groups and providing information on mental health problems. Rethink also carries out research which informs both their own and national mental health policy contributing to active campaigns for change through greater awareness and understanding.
www.rethink.org

Royal College of Nursing

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies. To do so it not only represents the interests of nursing staff but seeks development and implementation of policies which improve quality of patient care; promote professional education and provide resources to support professional development.
www.rcn.org.uk

Royal College of General Practitioners

The UK academic organisation for general practitioners which encourages the maintenance of the highest standards of general medical practice and represents general practitioners on education, training and standards issues. It is composed of a network of doctors who are committed to improving patient care, developing professional skills and developing general practice.
www.rcgp.org.uk

Royal College of Psychiatrists

The professional and educational body for psychiatrists in the United Kingdom and the Republic of Ireland. The college is involved in setting and maintenance of care standards; research and education; professional representation and training; working with patients, carers and their organisations. It also organizes conferences, lectures, professional development activities and publishes reports, books and journals.
www.rcpsych.ac.uk

Sainsbury Centre for Mental Health

An organisation which carries out research, policy work and analysis to improve practice and influence policy in mental health as well as public services. A number of key issues are identified and current priorities are mental health care in prisons and the criminal justice system and employment and mental health.
www.scmh.org.uk

SCAN – Specialist Clinical Addiction Network

A national network for UK addiction specialists, including Consultant Psychiatrists, Specialists Registrars and Associate Specialists who work in the field of addiction. Staff grade doctors in addiction psychiatry may be registered as affiliate members. SCAN's main aims are to provide support and promote networking to enable specialists to maximise treatment effectiveness.
www.scan.uk.net/about

Scottish Advisory Committee on Drug Misuse (SACDM)

Established in 1994 to advise the Secretary of State for Scotland on policy, priorities and strategic planning on drug misuse.
www.drugmisuse.isdscotland.org/sacdm/sacdmhome.htm

Scottish Executive

The devolved Government for Scotland is responsible for issues of day-to-day concern to the people of Scotland, including health, education, justice, rural affairs, and transport.
www.scotland.gov.uk/About

Substance Misuse Management in General Practice

A network supporting GPs and other members of primary health care teams who work with substance misuse in the UK. There is an SMMGP newsletter (Network), an interactive discussion e-forum, & an annual conference 'Managing Drug Users in General Practice'.
www.smmgp.org.uk

Turning Point

A leading social care organisation providing over 250 services for people with complex needs, including those affected by drug and alcohol misuse, mental health problems and those with a learning disability. Services include support with housing, advice, education, counselling, outreach work, family needs, emergency care, employment, prison and probation.
www.turning-point.co.uk

United Kingdom Drugs Policy Commission

Launched in April 2007, the commission is comprised of experts from drug treatment, medical research, policing, public policy and the media. It seeks to provide independent and objective analysis of UK drug policy and use this to encourage a wider, informed debate. Independent of government and special interests in both funding and work programme, the commission is not a campaigning body.
www.ukdpc.org.uk/index.shtml

World Health Organisation

WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.
www.who.int/en
ICD-10 can be found at
www.who.int/classifications/icd/en/bluebook.pdf

Acknowledgements

The Keele Steering Group: Prof. Miriam Bernard (Director, Keele Research Institute for Life Course Studies and Professor of Social Gerontology), Prof. Steve Cropper (Director, Keele Research Institute for Public Policy and Management and Professor of Management), and Prof. Richard Pugh (project co-ordinator and Professor of Social Work).

Related SCIE publications

Research briefing 6: Parenting capacity and substance misuse (2004)

Research briefing 23: Stress and resilience factors in parents with mental health problems and their children (2008)

Research briefing 24: Experiences of children and young people caring for a parent with a mental health problem (2008)

Research briefing 26: Mental health and social work (2008)

References

1. World Health Organisation (1995) ICD-10 classification of mental and behavioural disorders. Geneva, World Health Organisation.
2. American Psychiatric Association (1994) *Diagnostic and statistical manual of mental disorders 4th edition (DSM-IV)*. Washington DC, American Psychiatric Association.
3. Crome, I. B. (1999) Substance Misuse and Psychiatric Comorbidity: towards improved service provision. *Drugs: Education, Prevention and Policy*, 6 (2), pp.151–174.
4. Crome, I. B. (1999) Overview: Psychiatric Comorbidity and Substance Misuse: What Are the Issues? *Drugs: Education, Prevention and Policy*, 6 (2), pp.149–150.
5. Frisher, M., Crome I., Macleod, J., Millson, D., and Croft, P. (2005) Substance abuse and psychiatric illness: Prospective observational study using the General Practice Research Database. *Journal of Epidemiology and Community Health*, 59, pp.847–850.
6. Frisher, M., Collins, J., Millson, D., Crome, I., and Croft, P. (2004) Prevalence of comorbid psychiatric illness and substance misuse in primary care in England and Wales. *Journal of Epidemiology and Community Health* 58, pp.1034–1041.
7. Weaver, T., Madden, P., Charles, V., Stimson, G., Renton, A., Tyrer, P., Barnes, T., Bench, C., Middleton, H., Wright, N., Paterson, S., Shanahan, W., Seivewright, N., and Ford, C. (2003) Comorbidity of substance misuse and mental illness in community mental health and substance misuse services, *The British Journal of Psychiatry*, 183 (4), pp.304–313.
8. Macleod, J., Oakes, R., Copello, A., Crome I., Egger, M., Hickman, M., Oppenkowski, T., Stokes-Lampard, H., and Davey Smith, G. (2004) Psychological and social sequelae of cannabis and other illicit drug use by young people; a systematic review of longitudinal, general population studies. *The Lancet*, 363, pp.1579–1588.
9. Crawford, V., Clancy, C., and Crome, I. B. (2003) Co-existing problems of mental health and substance misuse (Dual Diagnosis): a literature review. *Drugs: Education, Prevention and Policy*, 10 (Suppl.), pp.S1–S74.
10. Department of Health (1999) *Mental Health: National Service Framework*, London, Department of Health.
11. Department of Health (2006) *Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings*, London, Department of Health.
12. Department of Health (2002) *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide*, London, Department of Health.
13. Joint Working Group of the Scottish Advisory Committee on Drug Misuse and the Scottish Advisory Committee on Alcohol Misuse (2003) *Mind the Gaps: Meeting the needs of People with Co-occurring Substance Misuse and Mental Health Problems, Report of the Joint Working Group*, Edinburgh, Scottish Executive.
14. Watson, S. and Hawkings, C. (2007) *Dual Diagnosis: Good Practice Handbook*, London, Turning Point.
15. Crome I. B. (2006) An epidemiological perspective of psychiatric comorbidity and substance misuse: The UK experience/example, in Baldacchino, A. and Corkery, J. (Eds.) *Comorbidity: Perspectives Across Europe (ECCAS Monograph No. 4)* pp.45–60.
16. Advisory Council on the Misuse of Drugs (2006) *Pathways to Problems: Hazardous use of tobacco, alcohol and other drugs by young people in the UK and its implications for policy*, London, Crown Copyright.

17. Advisory Council on the Misuse of Drugs (2008) *Cannabis: Classification and Public Health*, London, Home Office.
18. Department of Health and National Treatment Agency for Drug Misuse (2006) *Models of Care for Alcohol Misusers* (MoCAM), London, National Treatment Agency for Substance Misuse.
19. National Treatment Agency (2002) *Models of Care for Treatment of Adult Drug Misusers, Part 2: Full Reference Report*, London, National Treatment Agency for Substance Misuse.
20. National Treatment Agency (2002) *Models of Care for Treatment of Adult Drug Misusers Part 1: Summary for commissioners and managers responsible for implementation*, London, National Treatment Agency for Substance Misuse.
21. National Treatment Agency for Substance Misuse (2006) *Models of Care for Treatment of Adult Drug Misusers: Update 2006*, London, National Treatment Agency for Substance Misuse.
22. Department of Health (England) and the Devolved Administrations (2007) *Drug Misuse and Dependence: Guidelines on Clinical Management 2007*, London, Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive.
23. Royal College of Psychiatrists and Royal College of General Practitioners (2005) *Roles and Responsibilities of Doctors in the Provision of Treatment for Drug and Alcohol Misusers*, CR131, London, RCP/RGP
24. Lingford-Hughes, A. R., Welch, S., and Nutt, D. J. (2004) Evidence-based guidelines for the pharmacological management of substance misuse, addiction and comorbidity: recommendations, *British Association for Psychopharmacology* 18, pp.293–335.
25. Holt, M., Treloar, C., McMillan, K., Schultz, L., Schultz, M., and Bath, N. (2007) *Barriers and Incentives to Treatment for Illicit Drug Users with Mental Health Comorbidities and Complex Vulnerabilities*, Barton Australia, Australian Government Department of Health and Ageing.
26. Hawkings, C. and Gilbert, H. (2004) *Dual Diagnosis Toolkit: a practical guide for professionals and practitioners*, London, Rethink and Turning Point
27. Goldberg, J. F., Garno, J. L., Leon, A. C., et al. (1999) A history of substance abuse complicates remission from acute mania in bipolar disorder, *Journal of Clinical Psychiatry*, 60, pp.733–740.
28. Hipwell, A. E., Singh, K., and Clark, A. (2000) Substance misuse among clients with severe and enduring mental illness: service utilisation and implications for clinical management, *Journal of Mental Health*, 9, pp.37–50.
29. Hodges, C-L., Paterson, S., Taikato, M., McGarrol, S., Crome, I., and Baldacchino, A. (2006) *Co-morbid Mental Health and Substance Misuse in Scotland*, Edinburgh, Scottish Executive.
30. Shepherd, G., Boardman, J., and Slade, M. (2008) *Making Recovery a Reality, London*, Sainsbury Centre for Mental Health.
31. Scottish Advisory Committee on Drug Misuse (2008) *Essential Care: A report on the approach required to maximise opportunity for recovery from problem substance use in Scotland*, Edinburgh, Scottish Government.
32. Banerjee, S., Clancy, C., and Crome, I. B. (2002) *Co-existing Problems of Mental Disorder and Substance Misuse (Dual Diagnosis): An Information Manual (2nd edition)*, London, College Research Unit and Royal College of Psychiatrists.
33. Hogg, C. (1997) *Drug Using Parents: Policy Guidelines for Interagency Working*, London, Department of Health.

34. Arendt, M. (2005) Cannabis-induced psychosis and subsequent schizophrenia-spectrum disorders: follow-up study of 535 incident cases, *British Journal of Psychiatry*, 18, 6, pp.510–515.

35. Bott, K., Meyer, C., Rumpf, H-J., Hapke, U., and John, U. (2005) Psychiatric disorders among at-risk consumers of alcohol in the general population, *Journal of Studies on Alcohol*, 66 (March), pp.246–253.

36. Cantwell, R. and Scottish Comorbidity Study Group. (2003) Substance use and schizophrenia: effects on symptoms, social functioning and service use, *British Journal of Psychiatry* 182, pp.324–329.

37. Moran, P. (2006) Personality and substance use disorders in young adults. *British Journal of Psychiatry*, 188, 4, pp.374–379.

38. European Monitoring Centre for Drugs and Drug Addiction (2007) *The State of the Drugs Problem in Europe (Annual Report)*. Luxemburg, EMCDDA.

39. Murphy, R. and Roe, S. (2007) *Drug Misuse Declared: Findings from the 2006/07 British Crime Survey – England and Wales*, London, Home Office.

40. Lader, D (2008) *Smoking-related behaviour and attitudes, 2007: A report using the National Statistics Omnibus Survey produced on behalf of the NHS Information Centre for health and social care*, Newport, Office for National Statistics.

41. British Medical Association Science and Education Department and BMA Board of Science (2007) *Fetal Alcohol Spectrum Disorders: A Guide for Healthcare Professionals*, London, British Medical Association.

42. British Medical Association Science and Education Department and BMA Board of Science (2008) Alcohol Misuse: Tackling the UK Epidemic. London, British Medical Association.

43. Cabinet Office (2004) *Alcohol Harm Reduction Strategy for England*, London, Cabinet Office.

44. NHS Information Centre (2008) *Statistics on Alcohol: England 2008*, London, NHS Information Centre.

45. Strathdee, G, Manning, V. and Best, D. (2002) *Dual Diagnosis in a Primary Care Group* (PCG), London, Department of Health.

46. Hoff, R. A. and Rosenheck, R. A. (1998) Long-term patterns of service use and cost among patients with both psychiatric and substance abuse disorders, *Medical Care* 36 (835), p.843.

47. Hoff, R. A. and Rosenheck, R. A. (1999) The cost of treating substance abuse patients with and without comorbid psychiatric disorders, *Psychiatric Services*, 50, pp.1309–1315.

48. Weaver, T., Stimson, G., Tyrer, P., Barnes, T., and Renton, A. (2004) What are the implications for clinical Management and service development of prevalent comorbidity in UK mental health and substance misuse treatment populations, *Drugs: Education, Prevention and Policy* 11, 4, pp.329–348.

49. Weaver, T., Hart, J., Fehler, J., Metrebian, N., D'Agostino, T., and Benn, P. (2007) *Are Contingency Management Principles Being Implemented in Drug Treatment in England?*, Research Briefing 33, London, National Treatment Agency for Substance Misuse.

50. Marsden, J., Gossop, M., and Stewart, D. (2000) Psychiatric symptoms among clients seeking treatment for drug dependence: Intake data from the National Treatment Outcome Research Study, *British Journal of Psychiatry*, 176, pp.285–289.

51. Stewart, D., Gossop, M., Marsden, J., and Rolfe, A. (2000) Drug misuse and acquisitive crime among clients recruited to the National Treatment Outcome Research Study (NTORS), *Criminal Behaviour and Mental Health*, 14, pp.S31–S36.

52. Crome I.B. and Ghodse, A-H. (2007) Drug misuse in medical patients, in Lloyd, G. and Guthrie, E. (Eds.), *Handbook of Liaison Psychiatry*, pp.180–220, Cambridge, Cambridge University Press.

53. Boys, A., Farrell, M., Taylor, C., Marsden, J., Goodman, R., Brugha, T., Bebbington, P., Jenkins, R., And Meltzer, H. (2003) Psychiatric morbidity and substance use in young people aged 13-15 years: results from the Child and Adolescent Survey of Mental Health, *The British Journal of Psychiatry*, 182, 6, pp.509–517.

54. Crome, I. B. (2004) Comorbidity in young people: perspectives and challenges, *Acta Neuropsychiatrica*, 16, pp.47–53.

55. Crome I. B. (2004) 'Psychiatric comorbidity' in Crome I.B., Ghodse, A-H., Gilvarry, E. (Eds.), *Young People and Substance Misuse*, pp.72–84. London, Gaskell.

56. Crome, I. B. and Bloor, R. (2005) Substance misuse and psychiatric comorbidity in adolescents, *Current Opinion in Psychiatry*, 18, pp.435–439.

57. Chiang, Shu-Chuan, Chen, Shaw-Ji, Sun, Hsiao-Ju, Chan, Hung-Yu, and Chen, Wei J. (2006) Heroin use among youths incarcerated for illicit drug use: psychosocial environment, substance use history, psychiatric comorbidity and route of administration, *American Journal on Addictions* 15 (May-June), pp.233–241.

58. Bernstein, D. P., Stein, J. A., and Handelsman, L. (1998) Predicting personality pathology among adults with substance use disorders: effects of childhood maltreatment, *Addictive Behaviours*, 23, pp.855–868.

59. Jarvis, T. J. and Copeland, J. (1997) Child sexual abuse as a predictor of psychiatric co-morbidity and its implications for drug and alcohol treatment, *Drug and Alcohol Dependence* 49, pp.61–69.

60. Kang, S-Y., Magura, S., Laudet, A. B., and Whitney, S. (1999) Adverse effects of child abuse victimization among substance-using women in treatment, *Journal of Interpersonal Violence*, 14, pp.657–670.

61. Booth, B. M., Curran, G. M., and Han, Xiaotong (2004) Predictors of short-term course of drinking in untreated rural and urban at-risk drinkers: effects of gender, illegal drug use and psychiatric comorbidity, *Journal of Studies on Alcohol* 65 (January), pp.63–73.

62. Brady, K. T. and Sinha, R. (2005) Co-occurring mental and substance use disorders: The neurobiological effects of chronic stress, *American Journal of Psychiatry*, 162, pp.1483–1493.

63. Swanson, J., Borum, R., Swartz, M., and Hiday, V. (1999) Violent behaviour preceding hospitalisation among persons with severe mental illness, *Law and Human Behaviour* 23, pp.185–203.

64. Penk, W. E., Flannery, R. B., Irvin, E., Geller, J., Fisher, W., Hanson, M.A. (2000) Characteristics of substance abusing persons with schizophrenia: The paradox of the dually diagnosed, *Journal of Addictive Diseases*, 19, pp.23–30.

65. Scott, H., Johnson, S., Menezes, P., Thornicroft, G., Marshall, J., Bindman, J., P Bebbington, P. and Kuipers, E. (1998) Substance misuse and risk of aggression and offending among the severely mentally ill, *British Journal of Psychiatry* 172, pp.345–350.

66. Taylor, P. J. (2004) Mental disorder and crime, *Criminal Behaviour and Mental Health* 14 (S31), p.S36.

67. Linszen, D. H., Dingemans, P. M., and Lenior, M. E. (1994) Cannabis abuse and the course of recent-onset schizophrenia, *Archives of General Psychiatry*, 51, 4, pp.273–279.

68. Swofford, C., Kasckow, J., Scheller-Gilkey, G., and Inderbitzin, L. B. (1996) Substance use: a powerful predictor of relapse in schizophrenia, *Schizophrenia Research*, 20, 1-2, pp.145–151.

69. Haywood, T. W., Kravitz, H. M., Grossman, L. S., Cavanaugh, J. L. Jr., Davis, J. M., and Lewis, D. A. (1995) 'Predicting the 'revolving door' phenomenon among patients with schizophrenic schizoaffective, and affective disorders, *American Journal of Psychiatry* 152, 6, pp.856–861.

70. Hunt, I., Kapur, N., Robinson, J., Shaw, J., Flynn, S., Bailey, H., Meehan, J., Bickley, H., Parsons, R., Burns, J., Amos, T., and Appleby, L. (2006) Suicide within 12 months of mental health service contact in different age and diagnostic groups: national clinical survey, *British Journal of Psychiatry* 188, 2, pp.135–142.

71. Joe, S. and Neidermeier, D. (2008) Preventing suicide: a neglected social work research agenda, *British Journal of Social Work*, 38, pp.507–530.

72. Appleby, L., Shaw, J., Kapur, N., Windfuhr, K. (2006) *Avoidable Deaths: Five Year Report by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, London, HMSO Department of Health

73. Erkiran, M., Ozunalan, H., Evren, C., Aytaclar, S., Kirisci, L., and Tarter, R. (2006) Substance abuse amplifies the risk for violence in schizophrenia spectrum disorder, *Addictive Behaviors*, 31, 10, pp.1797–1805.

74. Hoaken, P. N. S. and Stewart, S. H. (2003) Drugs of abuse and the elicitation of human aggressive behaviour, *Addictive Behaviors*, 28,9, pp.1533–1554.

75. Neale, J. (2004) Gender and Illicit Drug Use, *British Journal of Social Work*, 34, 6, pp.851–870.

76. Lewis, G. (2007) The Confidential Enquiry into Maternal and Child Health (CEMACH), *Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer, 2003-2005: The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom*, London, CEMACH

77. Johnson, A.K. and Cnaan, R.A. (1995) Social work practice with homeless persons: state of the art, *Research on Social Work Practice* 5, 3, pp.340–382.

78. McMurran, M. (2002) *Expert Paper: Dual Diagnosis of Mental Disorder and Substance Misuse*, London, Department of Health.

79. Frisher, M., Crome I., Martino, O., Bashford, J., and Croft, P. (in press) Epidemiology of Co-morbidity in General Practice and Primary Care, *Responding to Drugs Misuse: Research and Policy Priorities in Health and Social Care*. London, Routledge.

80. Farrell, M., Boys, A., Bebbington, P., Brugha, T., Coid, J., Jenkins, R., Lewis, G., Meltzer, H., Marsden, J., Singleton, N., and Taylor, C. (2002) Psychosis and drug dependence: results from a national survey of prisoners. *British Journal of Psychiatry* 181(11), pp.393–398.

81. Baldacchino, A. and Corkery, J. (2006) *Comorbidity: Perspectives across Europe. London*, International Centre for Drug Policy.

82. Crome, I. B., Bloor, R., and Thom, B. (2006) Screening for illicit drug use in psychiatric hospitals: Whose job is it?, *Advances in Psychiatric Treatment*, 12, pp.375–383.

83. O'Hare, T., Sherrer, M.V., LaButti, A., and Emrick, K. (2004) Validating the Alcohol Use Disorders Identification Test with persons who have a serious mental illness, *Research on Social Work Practice* 14, 1, pp.36–42.

84. Aitken, C., Wain, D., Lubman, D. I., Hides, L., and Hellard, M. (2008) Mental health screening among injecting drug users outside treatment settings – implications for research and health services, *Mental Health and Substance Use: Dual Diagnosis* 1, 2, pp.99–103.

85. Cohen, Z.A. (2003) The single assessment process: an opportunity for collaboration or a threat to the profession of occupational therapy?, *British Journal of Occupational Therapy* 66, 5, pp.201–208.

86. Crome, I. B. and Bloor R. (2007) 'Training in Co-existing Mental Health and Drug and Alcohol Problems: High Priority in Policy Requires Resources' in Baker, A. and Velleman, R. (Eds.) *Clinical Handbook of Co-existing Mental Health and Drug and Alcohol Problems*, pp.351–370, London, Routledge.

87. Repper, J., Nolan, M., Grant, G., Curran, M., and Enderby, P. (2007) *Family carers on the Margin: Experiences of Assessment in Mental Health; Report to the National Co-ordinating Centre for NHS Service Delivery and Organisation*, London, London School of Hygiene and Tropical Medicine.

88. Advisory Council on the Misuse of Drugs (2003) *Hidden harm: Responding to the needs of children of problem drug users*, London, Home Office.

89. Home Office (2008) *Drugs: Protecting Families and Communities: The 2008 Drug Strategy*, London, Home Office.

90. HM Government (2005) *Every Child Matters: Change for Children – Young People and Drugs*, London, HMSO.

91. DFES (2006) *Working Together to Safeguard Children*, London, HMSO.

92. Department of Health (2001) *National Service Framework for Older People*, London, Crown Copyright.

93. McGrath, A., Crome, P., and Crome, I. B. (2005) Substance misuse in the older population, *Postgraduate Medical Journal*, 81, pp.228–231.

94. Bellack, A., Bennett, M. E., and Gearon, J. S. (2007) *Behavioral Treatment for Substance Abuse in People with Serious and Persistent Mental Illness: A Handbook for Mental Health Professionals*, New York, Routledge

95. Substance Abuse and Mental Health Services Administration (2005) *Substance Abuse Treatment for Persons with Co-occurring Disorders. Treatment Improvement Protocol* (TIP) 42, Rockville, M.D., US Department of Health and Human Services

96. Parker, A. J. R., Marshall, E. J., and Ball, D. M. (2008) Diagnosis and management of alcohol use disorders, *BMJ*, 336, pp.496–501.

97. National Institute for Health and Clinical Excellence (2007) *Naltrexone for the Management of Opioid Dependence. NICE Technology Appraisal Guidance 115*, London, National Institute for Health and Clinical Excellence.

98. National Institute for Health and Clinical Excellence (2007) *Drug Misuse: Opioid Detoxification. NICE Clinical Guideline 52*, London, National Institute for Health and Clinical Excellence.

99. National Institute for Health and Clinical Excellence (2007) *Drug Misuse: Psychosocial Interventions. NICE Clinical Guideline 51*, London, National Institute for Health and Clinical Excellence.

100. National Institute for Health and Clinical Excellence (2007) *Methadone and Buprenorphine for the Management of Opioid Dependence. NICE Technology Appraisal Guidance 114*, London, National Institute for Health and Clinical Excellence

101. Raistrick, D., Heather, N., and Godfrey, C. (2006) *Review of the Effectiveness of Treatment for Alcohol Problems*, London, National Treatment Agency for Substance Misuse.

102. Tiet, Q. Q. and Mausbach, B. (2007) Treatments for patients with dual diagnosis: A review, *Alcoholism: Clinical and Experimental Research*, 31, pp.513–536.

103. Farber, M.L.Z. and Maharaj, R. (2005) Empowering high-Risk families of children with disabilities, *Research on Social Work Practice* 15, 6, pp.501–515.

104. Dumaine, M.L. (2003) Meta-analysis of interventions with co-occurring disorders of severe mental illness and substance abuse: implications for social work practice, *Research on Social Work Practice*, 13, 2, pp.142–165.

105. DiNitto, D.M., Webb, D.K., and Rubin, A. (2002) The effectiveness of an integrated treatment approach for clients with dual diagnoses, *Research on Social Work Practice* 12, 5, pp.621–641.

106. Ley, A., Jefferey, D. P., McLaren, S., and Siegfried, N. (2002) *Treatment programmes for People with Both Severe Mental Illness and Substance Misuse (Cochrane Review), The Cochrane Library* (1).

107. Kelly, T. M., Cornelius, J. R., and Clark, D. B. (2004) Psychiatric disorders and attempted suicide among adolescents with substance use disorders, *Drug and Alcohol Dependence*, 73, pp.87–97.

108. Littlejohn, C., Bannister, J., and Baldacchino, A. (2004) Comorbid chronic non-cancer pain and opioid use disorders, *Hospital Medicine*, 65, 4, pp.210–214.

109. Nutt, D., Robbins, T. W., Stimson, G. V., Ince, M., and Jackson, A. (2007) *Drugs and the Future: Brain Science, Addiction and Society*, London, Academic Press.

110. Kelly, J. F., McKellar, J. D., and Moos, R. (2003) Major depression in patients with substance use disorders: relationship to 12-step self-help involvement and substance use outcomes, *Addiction*, 98, pp.499–508.

111. King, R. D., Gaines, L. S., Lambert, E. W., Summerfelt, W. T., and Bickman, L. (2000) The co-occurrence of psychiatric and substance use diagnoses in adolescents in different service systems: frequency, recognition, cost and outcomes, *The Journal of Behavioral Health Services and Research*, 27, 4, pp.417–430.

112. Padgett, D.K., Gulcur, L. and Tsemberis, S. (2006) Housing First Services for people who are homeless with co-occurring serious mental illness and substance abuse, *Research on Social Work Practice*, 16, 1, pp.74–83.

113. Peled, E. and Sacks, I. (2008) The self-perception of women who live with an alcoholic partner: dialoging with deviance, strength, and self-fulfillment, *Family Relations*, 57, 3, pp.390–403.

114. Specialist Clinical Addiction Network (SCAN) (2006) *Inpatient Treatment of Drug and Alcohol Misusers in the National Health Service*, London, SCAN Consensus Project

115. Watson, H., Maclaren, W., Shaw, F., and Nolan, A. (2003) *Measuring Staff Attitudes to People with Drug Problems: The Development of a Tool*, Glasgow, Scottish Executive Drug Misuse Research Programme.

116. Audit Commission (2002) *Changing Habits: The Commissioning and Management of Community Drug Treatment Services for Adults*, London, Audit Commission for Local Authorities/NHS.

117. Campbell, A., Finch, E., Brotchie, J., and Davis, P. (2007) *The International Treatment Effectiveness Project: Implementing Psychosocial Interventions for Adult Drug Misusers*, London, National Treatment Agency for Substance Misuse.

118. Curran, V. and Drummond, C. (2007) Psychological Treatments of Substance Misuse and Dependence, in Nutt, D., Robbins, T. W., Stimson, G. V., Ince, M., and Jackson, A (Eds.) *Drugs and the Future: Brain Science, Addiction and Society*, pp.209–240. Oxford, Academic Press.

119. Hughes, E. (2006) A pilot study of dual diagnosis training in prisons, *Journal of Mental Health Workforce Development, 1, 4*, December 2006, pp.5–14.

120. Todd, J., Green, G., Harrison, M., Ikuesan, B. A., Self, C., Pevalin, D. J., and Baldacchino, A. (2004) Social exclusion in clients with comorbid mental health and substance misuse problems, *Social Psychiatry and Psychiatric Epidemiology*, 39, pp.581–587.

121. Crome I. and Bloor R. (2006) Older substance misusers *still* deserve better treatment interventions – An update (Part 3), *Reviews in Clinical Gerontology*, 16, pp.45–47.

122. Crome I. and Bloor R. (2006) Older substance misusers *still* deserve better diagnosis – An update (Part 2), *Reviews in Clinical Gerontology,* 15, pp.255–262.

123. Crome I. and Bloor R. (2005) Older substance misusers still deserve better services – An update (Part 1), *Reviews in Clinical Gerontology*, 15, pp.125–133.

124. Soyka, M. I. C. H. (2000) Substance misuse, psychiatric disorder and violent and disturbed behaviour, *The British Journal of Psychiatry*, 176, 4, pp.345–350.

125. Swartz, M. S., Swanson, J. W., Hiday, V. A., Borum, R., Wagner, H. R., and Burns, B. J. (1998) Violence and severe mental illness: the effects of substance abuse and nonadherence to medication, *American Journal of Psychiatry*, 155, 2, pp.226–231.

126. Macleod, J., Oakes, R., Oppenkowski, T., Stokes-Lampard, H., Copello, A., Crome I.B., Hickman, M., and Judd, A. (2004) How strong is the evidence that illicit drug use by young people is an important cause of psychological or social harm? Methodological and policy implications of a systematic review of longitudinal, general population studies, *Drugs: Education, Prevention and Policy* 11, 4, pp.281–297.

127. Taylor, A., Toner, P., Templeton, L., and Velleman, R. (2006) Parental alcohol misuse in complex families: the Implications for engagement, *British Journal of Social Work*, Advance Access, 20 December.

128. Abdulrahim, D. (2001) *Substance Misuse and Mental Health Co-Morbidity (Dual Diagnosis): Standards for Mental Health Services*, London, The Health Advisory Service.

129. Rizzo, V.M. and Fortune, A.E. (2006) Cost outcomes and social work practice, *Research on Social Work Practice*, 16, 1, pp.5–8.

130. Dickey, B. and Azeni, H. (1996) Persons with dual diagnoses of substance abuse and major mental illness: their excess costs of psychiatric care, *American Journal of Public Health*, 86, 7, pp.973–977.

131. McCrone, P., Menezes, P. R., Johnson, S., Scott, H., Thornicroft, G., Marshall, J., Bebbington, P., and Kuipers, E. (2000) Service use and costs of people with dual diagnosis in South London, *Acta Psychiatrica Scandinavica*, 101, 6, pp.464–472.

132. Ries, R. K., Russo, J., Wingerson, D., Snowden, M., Comtois, K. A., Srebnik, D., and Roy-Byrne, P. (2000) Shorter hospital stays and more rapid improvement among patients with schizophrenia and substance disorders, *Psychiatric Service*, 51, pp.210–215.

133. Taylor, I., Sharland, E., Sebba, J., Leriche, P., Keep, E., and Orr, D. (2006) *SCIE Knowledge Review 10: The Learning, Teaching and Assessment of Partnership Work in Social Work Education*, London, Social Care Institute of Excellence.

134. Crome, I. B. (2007) An Exploration of Research Into Substance Misuse and Psychiatric Disorder in the UK: What Can We Learn From History? *Criminal Behaviour and Mental Health*, 17, pp.204–214.

135. Glendinning, C., Clarke, S., Hare, P., Krotchetkova, I. Masson, J. Newbronner, L. (2006) *Outcomes-Focused Services for Older People*: SCIE Knowledge Review 13.

136. Ray, M., Pugh, R. with Roberts, D and Beech, R. (2008) *Mental Health and Social Work*, SCIE Research Briefing 26.

137. Roberts, D., Bernard, M., Misca, G. and Head, E. (2008) *Experiences of Children and Young People Who Care for Parents with Mental Health Problems*, Research Briefing 24, London: Social Care Institute for Excellence

138 Cleary, M., Hunt, G.E., Matheson, S.L., Siegfried, N. & Walter, G. (2008) Psychosocial interventions for people with both severe mental illness and substance misuse. /Cochrane Database of Systematic Reviews/, 1. DOI: 10.1002/14651858.CD001088.pub2.

About SCIE research briefings

This is one of a series of SCIE research briefings that has been compiled by Keele University for SCIE. SCIE research briefings provide a concise summary of recent research into a particular topic and signpost routes to further information. They are designed to provide research evidence in an accessible format to a varied audience, including health and social care practitioners, students, managers and policy-makers. They have been undertaken using the methodology described by Keele in consultation with SCIE, which is available at **www.scie.org.uk/publications/briefings/methodology.asp** The information upon which the briefings are based is drawn from relevant electronic bases, journals and texts, and where appropriate, from alternative sources, such as inspection reports and annual reviews as identified by the authors. The briefings do not provide a definitive statement of all evidence on a particular issue.

SCIE research briefings are designed to be used online, with links to documents and other organisations' websites. To access this research briefing in full, and to find other publications, visit **www.scie.org.uk/publications**

SCIE research briefings

1 Preventing falls in care homes
2 Access to primary care services for people with learning disabilities
3 Communicating with people with dementia
4 The transition of young people with physical disabilities or chronic illnesses from children's to adults' services
5 Respite care for children with learning disabilities
6 Parenting capacity and substance misuse
7 Assessing and diagnosing attention deficit hyperactivity disorder (ADHD)
8 Treating attention deficit hyperactivity disorder (ADHD)
9 Preventing teenage pregnancy in looked-after children
10 Terminal care in care homes
11 The health and well-being of young carers
12 Involving older people and their carers in after-hospital care decisions
13 Helping parents with a physical or sensory impairment in their role as parents
14 Helping parents with learning disabilities in their role as parents
15 Helping older people to take prescribed medication in their own homes
16 Deliberate self-harm (DSH) among children and adolescents: who is at risk and how it is recognised
17 Therapies and approaches for helping children and adolescents who deliberately self-harm (DSH)
18 Fathering a child with disabilities: issues and guidance
19 The impact of environmental housing conditions on the health and well-being of children
20 Choice, control and individual budgets: emerging themes
21 Identification of deafblind dual sensory impairment in older people
22 Obstacles to using and providing rural social care
23 Stress and resilience factors in parents with mental health problems and their children
24 Experiences of children and young people caring for a parent with a mental health problem
25 Children's and young people's experiences of domestic violence involving adults in a parenting role
26 Mental health and social work
27 Factors that assist early identification of children in need in integrated or inter-agency settings
28 Assistive technology and older people
29 Black and minority ethnic parents with mental health problems and their children
30 The relationship between dual diagnosis: substance misuse and dealing with mental health issues

Social Care Institute for Excellence
Goldings House
2 Hay's Lane
London
SE1 2HB

tel: 020 7089 6840
fax: 020 7089 6841
textphone: 020 7089 6893
www.scie.org.uk

Registered charity no. 1092778 Company registration no. 4289790

RB3009