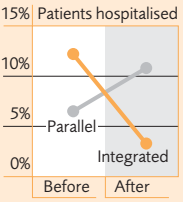
15.5 Integrated dual diagnosis care shows its worth

Findings A rare test of truly integrated substance use and mental health care for severely mentally ill substance users found that it reduced subsequent psychiatric and legal crises.

At three sites in the state, the Texas Dual Diagnosis Pilot Project forged a coalition between a substance use treatment and a mental health service provider. Each coalition developed a programme delivered either by a co-located team of substance misuse and mental health staff, or by mental health staff with substance misuse counselling credentials. The integrated model featured case management to coordinate service provision, assertive engagement, interventions tailored to the degree of engagement, close monitoring to encourage adherence to treatment, and long-term continuing care maintaining a positive outlook ◤ *Additional reading* ❶.

216 clients were allocated (at two sites at random, at the third depending on where they lived) to integrated care or to conventional parallel care from separate substance use and mental health clinics. All suffered from severe and persistent mental disorders and met diagnostic criteria for substance abuse or dependence.

Records of psychiatric admissions and arrests were compared for the year before allocation and the year after. Whilst the proportion of patients admitted and the frequency and lengths of stay increased under conventional care, all three indicators of mental health crises fell under integrated care, creating statistically significant differences between the regimes ◤ *chart*. Relative to virtually no improvement under conventional care, the proportion arrested also fell significantly.



In context This seems only the second such study, so conclusions must be tentative. In the previous study, schizophrenic patients with substance use disorders were retained far better (70% v. 38% at four months) when allocated to coordinated care at the same site, compared to a similar intensity of care but uncoordinated. However, substance misuse and psychiatric symptoms improved to about the same degree regardless, possibly an artifact due to greater loss to follow up in the parallel care group. Whether in the featured study, too, the intensity of care was equivalent is unclear, leaving open the possibility that intensity differences accounted for the outcomes. However, the same staff were involved in both arms of the study.

Other studies have contrasted integrated care with treatment *either* in substance misuse or mental health services rather than parallel care in both. Despite better adherence to treatment, outcomes in terms of psychiatric symptoms and substance use have been variable, perhaps itself due to variations in the relationship between substance use and mental health problems. When mental health problems are primary rather than symptoms of substance use, and more specifically when drugs or alcohol are used by the patient to ameliorate their symptoms, integrated care may have more of a role.

Practice implications A move to integrated specialist teams is seen by some UK observers as unwarranted and/or unworkable, though at regional level it has been envisaged in Scotland for more severely affected patients, and some such services have been developed in the UK. English national guidance sees mental health services taking the lead in provision for severely mentally ill substance users. However, the prevalence of psychiatric problems among their clients (three-quarters in inner city England) means that drug and alcohol services must also develop relevant competencies and programmes. This is partly because in many cases the problems will not be severe enough to qualify for psychiatric services and (unless GPs fill the gap) will otherwise remain untreated. When clients are severely mentally ill, co-working with mental health specialists is good practice. Even if developments fall short of a specialist team, the principles tested in the featured study could profitably inform work in both mental health and addiction services.

LINKS Nuggets 14.9 11.3 4.9 2.12

Featured studies Mangrum L.F. *et al*. "Integrated versus parallel treatment of co-occurring psychiatric and substance use disorders." *Journal of Substance Abuse Treatment*: 2006, 30(1), p. 79–84 DS

Additional reading ❶ Mueser K.T. *et al*. *Integrated treatment for dual disorders. A guide to effective practice*. The Guilford Press, 2003 BS

❷ Co-Occurring Center for Excellence (COCE) web site, www.coce.samhsa.gov.

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