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Improving the life of people with co-existing mental health disorders and substance misuse problems

There is a strong connection between mental health and substance use. Substances can trigger or exacerbate pre-existing psychiatric problems and psychiatric symptoms can develop as a result of withdrawals, as acute effects while intoxicated by drugs or alcohol (for example, cannabis or amphetamine induced psychosis), or can follow long-term use or dependence. Substance Use and Misuse Studies (SUMS) courses at UWL have contributed to enhancing knowledge and competence in practitioners working with clients with co-morbid mental health and substance use problems.

A report commissioned by the Department of Health found that 75% of users of drug services and 85% of users of alcohol services were experiencing mental health problems. It is also estimated that a third of patients in mental health services have a substance misuse problem. Substance misuse is under-diagnosed in psychiatric patients and a large number of individuals in addiction services who suffer from moderate mental illness are not diagnosed with a psychiatric disorder. A recent study conducted by Denis Mirlesse, whilst he was a UWL student on the Graduate Diploma in Psychology, assessed 100 participants who were in treatment for substance misuse and found that they suffered from significantly higher levels of depression, anxiety, stress and overall negative affect than the non-clinical population; however the psychological distress was often not identified nor addressed. Patients with 'dual diagnosis' are one of the most vulnerable groups in society, with high risk of poor physical health, high risk of suicide, high levels of personality disorder, great levels of disability and a low quality of life. Moreover, because mental illness and substance misuse are conditions that have historically been associated with a sense of blame, shame or secrecy, individuals with co-morbidity are often affected by double stigmatisation, which may prevent them from seeking help and from having a fulfilling professional and social life.

Often practitioners are faced with the 'chicken and egg' dilemma: what comes first? Are the psychiatric symptoms a result of drug use, or is substance use a

self-medication strategy to cope with a primary mental disorder? Most of the time the answer is not straightforward: the relationship between the two disorders is complex, especially in long-term conditions. While, in some cases the answer may not be clinically important; what is certain is that substance misuse affects mental health recovery and vice versa. It is becoming apparent that common risk factors, such as trauma, domestic violence or pre-existing predisposition, can underpin both mental disorders and substance misuse and, while practitioners are trying to unravel the knot, clients may fall between the gaps.

The best treatment that can be offered is where mental health and substance misuse services work together in a coordinated manner, although currently this model is far from being implemented effectively. In 2007 the Drug Misuse and Dependence: UK Guidelines on Clinical Management expressed concern about lack of specified core competencies, inadequate assessment and poor integrated care. Despite progress having been made, the newly published Five Year Forward View for Mental Health recognises the need to develop the workforce so it can respond more effectively to substance misuse. Judgmental attitudes of healthcare professionals towards clients with substance misuse problems have also been identified as creating a barrier to effective treatment.

Dr Raffaella Margherita Milani in the School of Human and Social Sciences was recently offered the opportunity to be involved in an exciting and promising approach that will be rolled out for the first time in the UK in West London. The programme is called Dual Diagnosis Anonymous (DDA) and is based on the AA 12-step model, with the addition of five steps geared towards supporting the specific needs of dual diagnosis clients.

Funding was secured for a 12-month pilot, which started in summer 2016. Dr Milani had the opportunity to participate in a group that has recently adopted the DDA model and was impressed by the way participants felt free to share their feelings and emotions regarding their everyday struggles, and their successes in dealing with their mental illness and substance use. The group offered a space where attendees were listened to in a non-judgemental, empathetic and respectful manner. A reccurring topic was the crucial role that the group had for them in achieving and sustaining recovery. One young participant who attended the DDA group for the first time left with a smile saying "this is the first time that I have connected with a group".

Dr Milani experienced first-hand the power of peer support when she facilitated groups of families with alcohol and drug related problems. Self-help groups cannot and should not substitute the work of professionals, but they certainly offer an on-going, invaluable and cost-effective resource that can improve the life of individuals and people around them. It is the hope that the evaluation of the DDA pilot will help the programme spread in London and other parts of the UK.

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