UNIVERSITY OF WEST LONDON
The Career University

UWL REPOSITORY

repository.uwl.ac.uk

A peer-led integrated approach for co-existing mental and addictive disorders: a longitudinal qualitative evaluation of the first UK Dual Diagnosis Anonymous

Milani, Raffaella Margherita ORCID: https://orcid.org/0000-0003-1683-2410, Nahar, Keisha, Ware, Daniel and Butler, Alan (2019) A peer-led integrated approach for co-existing mental and addictive disorders: a longitudinal qualitative evaluation of the first UK Dual Diagnosis Anonymous. In: Lisbon Addiction 2019, 23 - 25 Oct 2019, Lisbon. (Unpublished)

This is the Presentation of the final output.

UWL repository link: https://repository.uwl.ac.uk/id/eprint/6709/

Alternative formats: If you require this document in an alternative format, please contact: open.research@uwl.ac.uk

Copyright:

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy: If you believe that this document breaches copyright, please contact us at open.research@uwl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

Ealing Mental Health and Addiction Services Commissioners

DDA UK: an integrated peer-led approach for individuals with co-existing mental and addictive disorders

Dr R Margherita Milani, UWL
Keisha Nahar (RA), UWL

Dan Ware, DDA
Alan Butler, DDA
John O'Donnell, DDA

Extent and impact of comorbidity

- Estimating the prevalence of comorbidity of mental disorders and substance use is complex.
- In Europe, it has been estimated at about 50% (European Monitoring Centre for Drug and Drug Abuse, 2015).
- In the UK , lifetime prevalence of dependence on any substance among people with schizophrenia in the UK is estimated at 35% (much higher than general population) (Carra et al., 2012)
- In 2016/17, there were 7,545 hospital admissions with a primary diagnosis of drug-related mental health and behavioural disorders (NHS Digital, 2018)

Vulnerability

- In comparison with patients with a single disorder, those with comorbid mental and substance use disorders show multiple/ more complex needs and worse treatment outcomes:

- higher psychopathological severity (e.g.Langås et al., 2011; Szerman et al., 2012)
- increased rates of risky behaviour, which can lead to infection diseases such (HIV)/ AIDS and HepC (Khalsa et al., 2008),
- psychosocial impairments (e.g. unemployment, homelessness) and criminal behaviour (Greenberg and Rosenheck, 2014; Krausz et al., 2013).

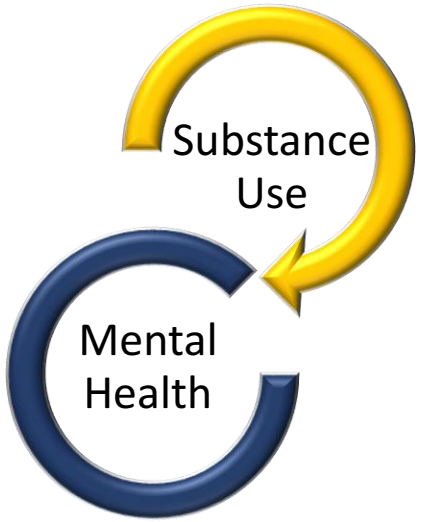
- Mortality rates for mental health service users in England almost four times greater than the general population (Health and Social Care Information Centre, 2013)

Models of treatment

Sequential

Parallel

Integrated



(Laurel et al, 2005; Ezquiaga et al. 2017)

National Institute Health and Care Excellence (2016) *Coexisting severe mental illness and substance misuse: community health and social care services, NICE guideline [NG58].* London: NICE.

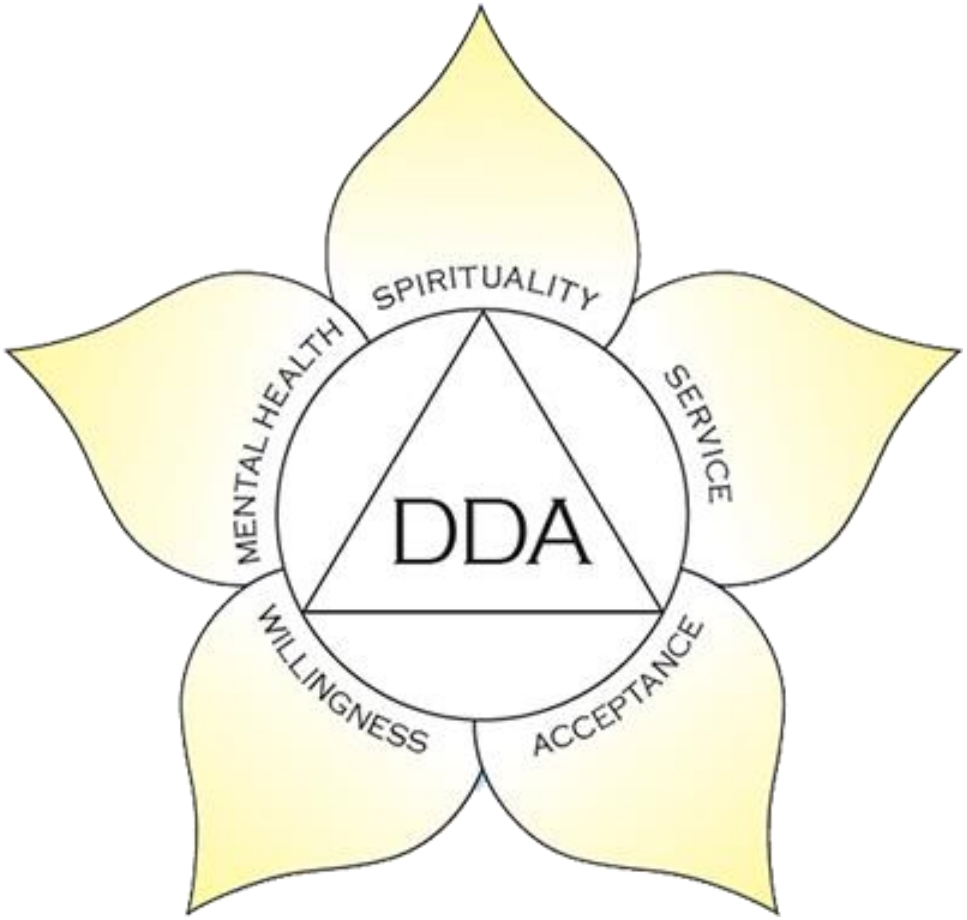
- Do not exclude people with severe mental illness because of their substance misuse.
- Do not exclude people from physical health, social care, housing or other support services because of their coexisting severe mental illness and substance misuse.

"Evidence suggests that people are frequently unable to access care from services, including when intoxicated/experiencing mental health crisis"

Public Health England (PHE, 2017) *Better care for people with co-occurring mental health and alcohol/drug use conditions. A guide for commissioners and service providers.* London, PHE.

Mental Health vs Addiction Services

Dual Diagnosis Anonymous (DDA)



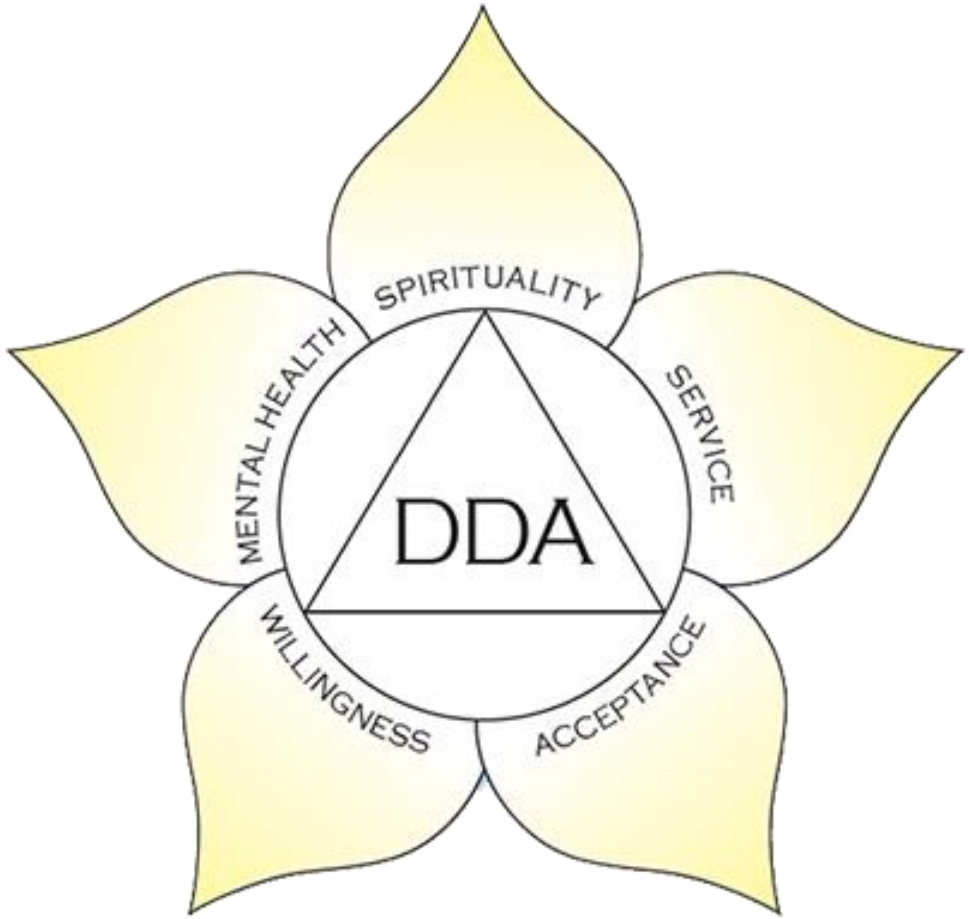
- Dan Ware : Dual Diagnosis from a 'frontline' professional perspective
- DDA in the USA: Corbett Monica and the '12+5 steps'

What's Different?

- 5 steps
- Can talk about both issues
- Feedback allowed
- Rotate chair

www.ddauk.org

Dual Diagnosis Anonymous (DDA)



- Import DDA to the UK!
- Alan Butler: Personal experience
- Setting up DDA in West London (growing Fellowship)
- Joint Commissioning from Ealing

www.ddauk.org

DDA study: Methodology

Part of a mixed method evaluation study (funded by the Sir Halley Stewart Trust)

(questionnaires, qualitative interviews, 4 case studies, observation)

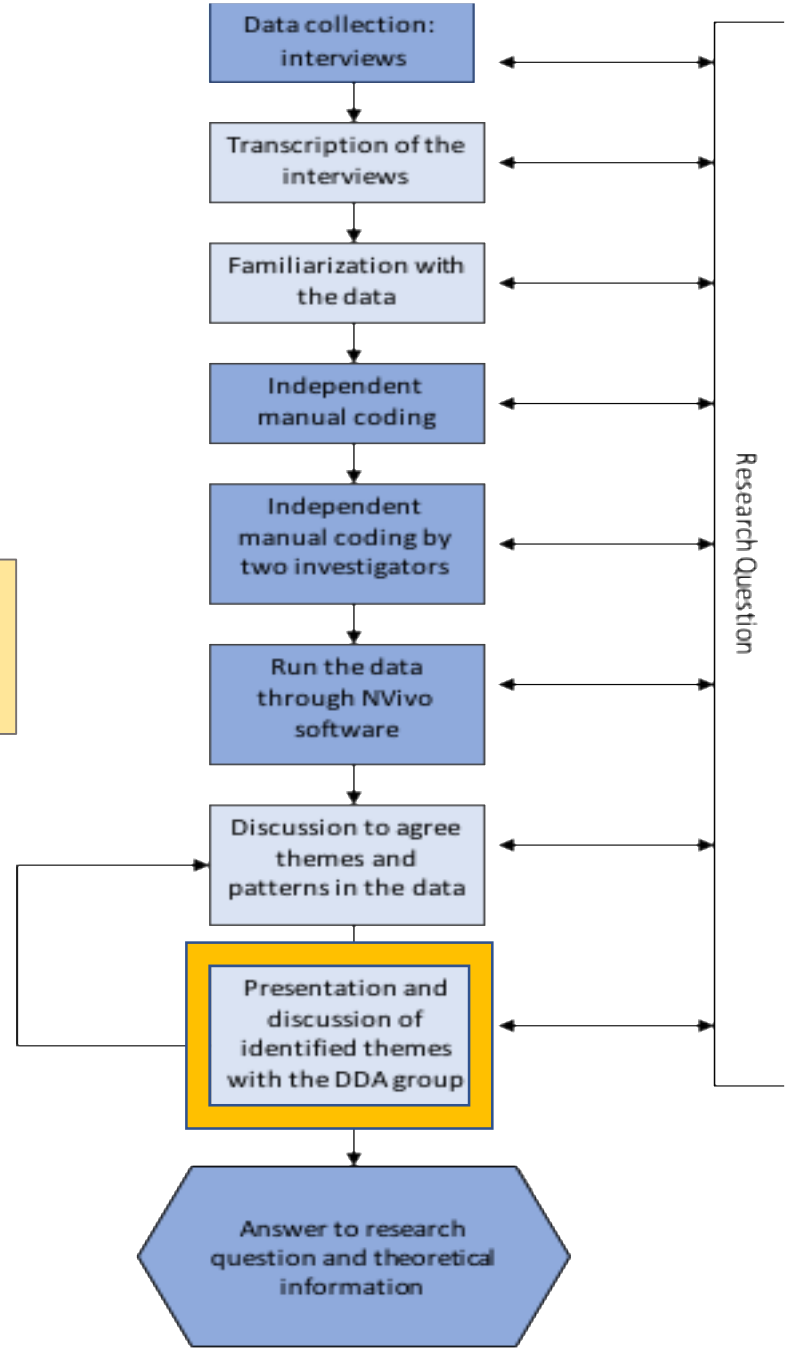
- **Qualitative semi-structured interviews:**
- 6 DDA attendees at 3 points in time over 1 year
- 3 facilitators at 2 points in times
- One commissioner, 18 months after the first DDA meeting

DDA attendees

- **Changes** for the participants since attending DDA (or since the last interview), if any
- **How** the DDA has contributed to these changes, if any
- Whether participants felt there needed to be **improvements**
- Whether they had any **suggestions** into how

Thematic analysis

Trajectory analysis was carried out using an adaptation of the sequential matrices proposed by Grossoehme and Lipstein (2016)



	Sex	Age	Marital Status	Ethnicity	Religious Beliefs	Living Status	Living Arrangements	Employment Status	Occupation	Educational Level	Diagnosis	Addiction	Medication
A	F	43	Single	White British	Christian	Renting	Alone	Unemployed	Volunteer	Undergraduate Degree	-Paranoid Schizophrenia -Severe clinical depression -Psychotic symptoms	Eating disorder not specified – bingeing symptoms	Yes, Paliperidone/ Certraline
B	F	25	Single	African	Muslim	Renting	Alone	Unemployed	Student	BTEC	-Psychosis -Emotionally unstable personality disorder	Alcohol/ Marijuana	Yes
C	M	45	Single	White British	Christian	Renting	Alone	Unemployed	Volunteer	College Diploma	OCD/anxiety	Alcohol/drugs (cocaine and MDMA)	Yes, Mirtazapine / Seroxat
D	M	54	Single	White British	Christian	Renting	Alone	On benefits	Volunteer	Undergraduate Degree	Bipolar Disorder	Alcohol/ Drugs	Yes, Mirtazapine
E	M	36	Single	White British	Christian	Supported housing	Alone	Employed	DJ	Undergraduate Degree	OCD	Drugs/alcohol	Yes
F	M	59	Single	White British	Hindu	Renting	Alone but sometimes stays with Daughter	Employed	IT analyst	A level	Sons's diagnosis: Schizophrenia	Alcohol and cannabis	No

WHAT HAD CHANGED?

Main themes

1. Acceptance
2. Self-development
3. Reduction in symptoms
4. Hope

Acceptance

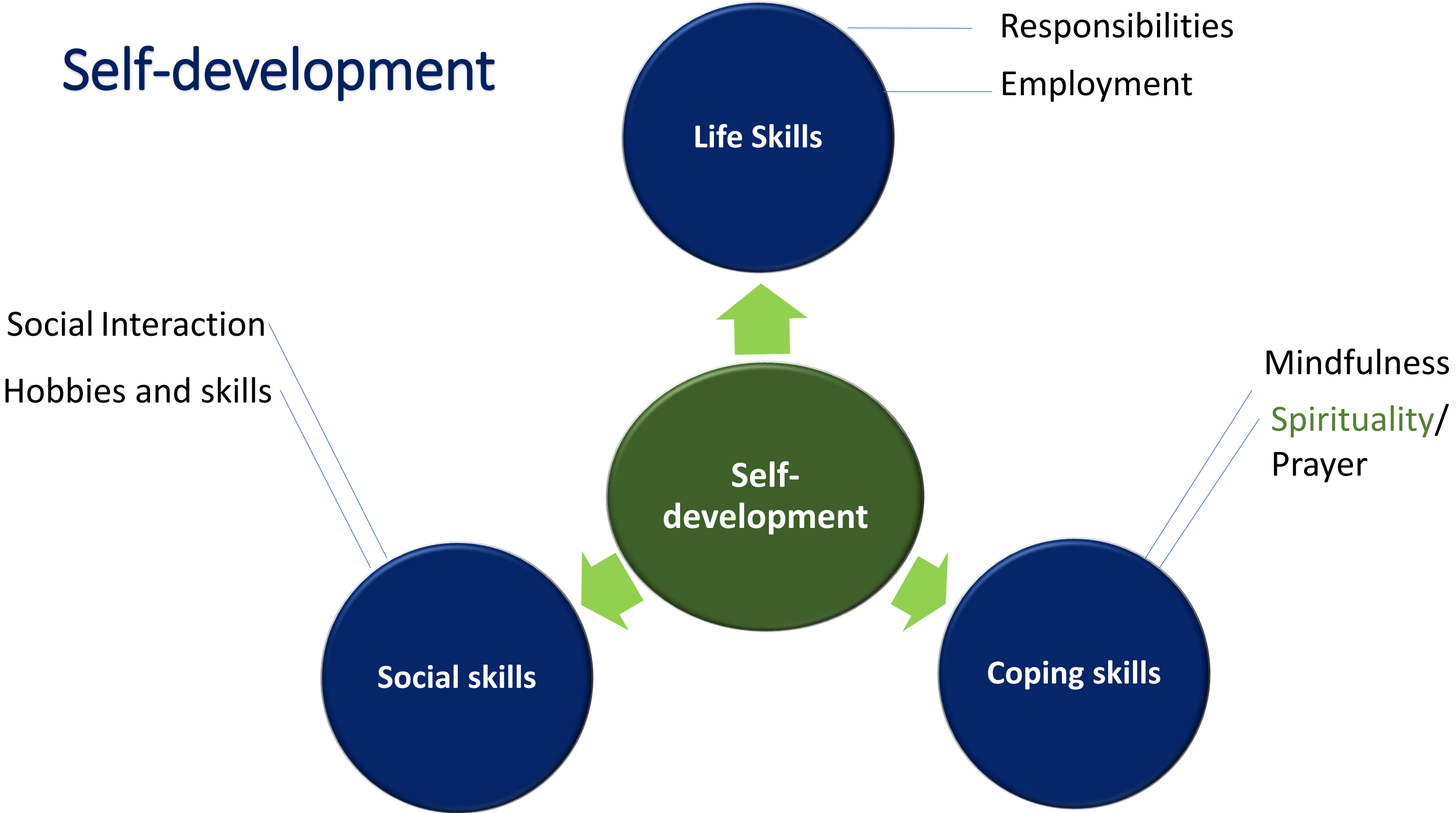

Of Self
From others
Of others
Help
Of Diagnosis
Of Imperfecti on
Acceptance

Acceptance

"I began to **value** other people in the group and **accept** them regardless of their day and in doing so **accepted myself**"

With DDA you are seen as more than your diagnosis

Self-development

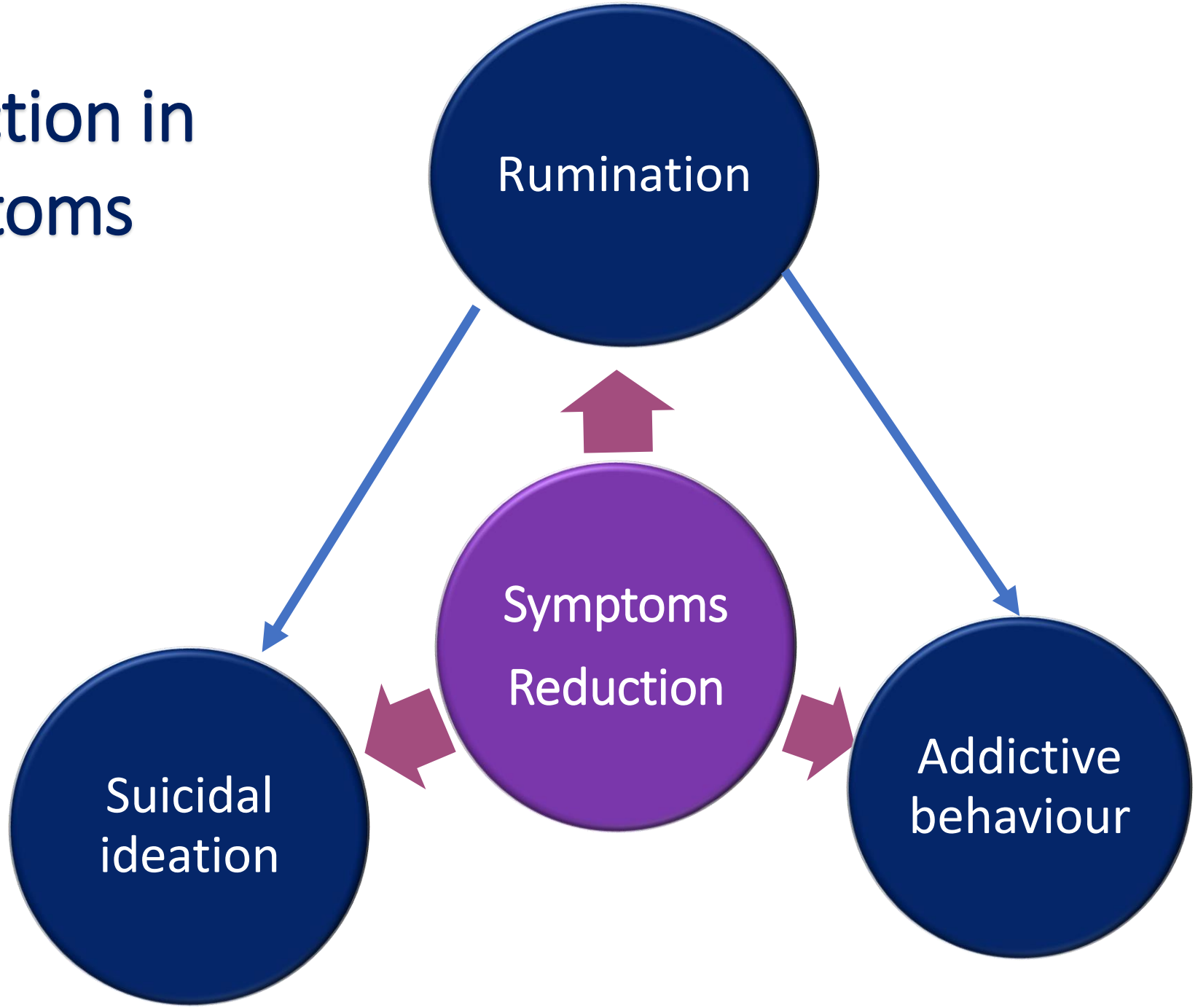


Self-development

“I’m able to **stick to routines** like paying bills
and I’ve also **taken up two new classes**”

> “Before coming here I was also much less social. This group has allowed me to **reconnect** more often with friends outside the DDA…**I feel more able to go out** for coffee, pick up the phone and **reach out to people**”

Reduction in Symptoms

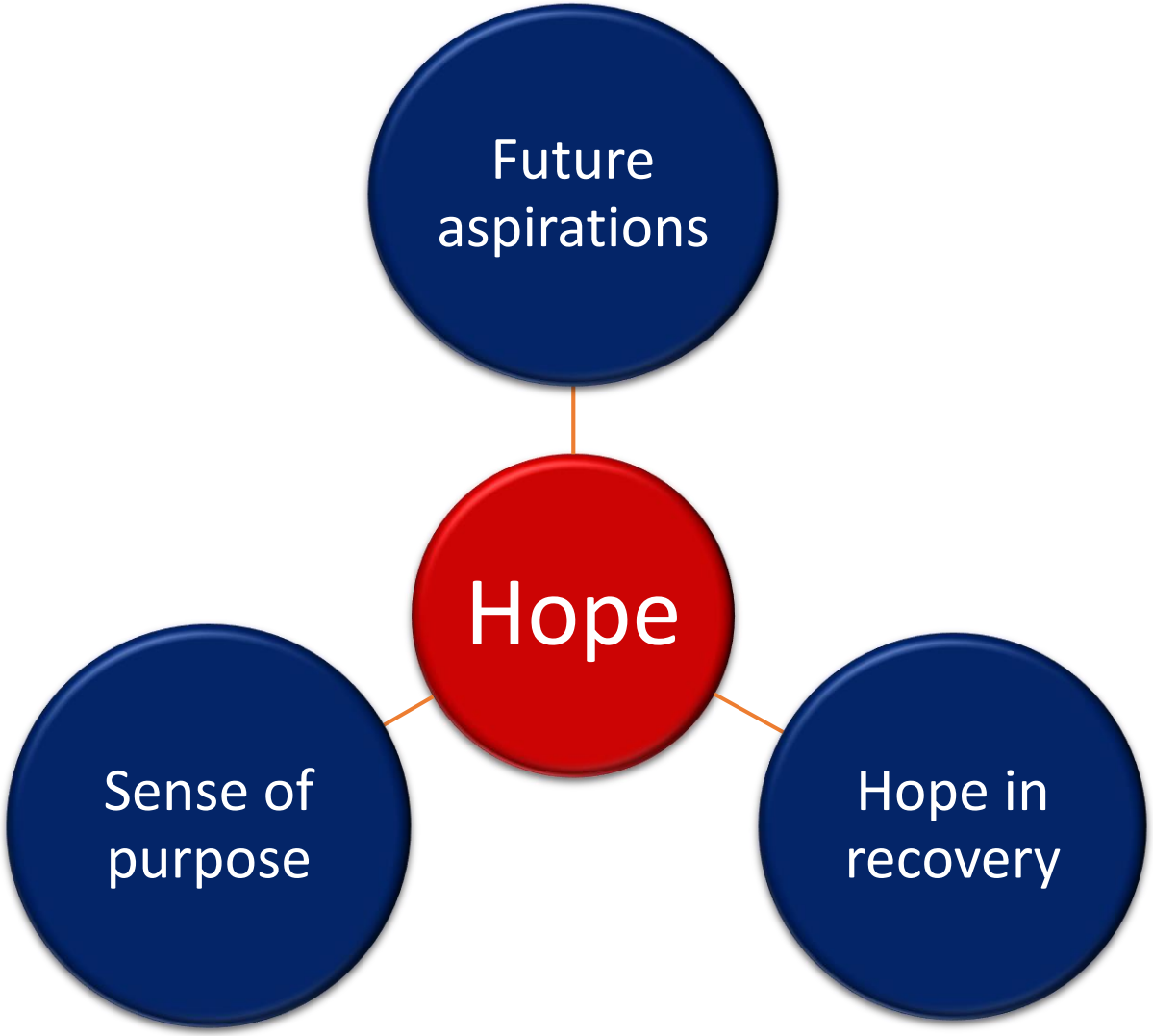


Reduction in Symptoms

"I used to binge on sugary foods but by doing the steps I have now been **absent** from sugar for 16 months"

"I often want to kill myself. But when I feel that way everyone here points out…the good things I don't see…helped give me **self-respect** and **dignity**"

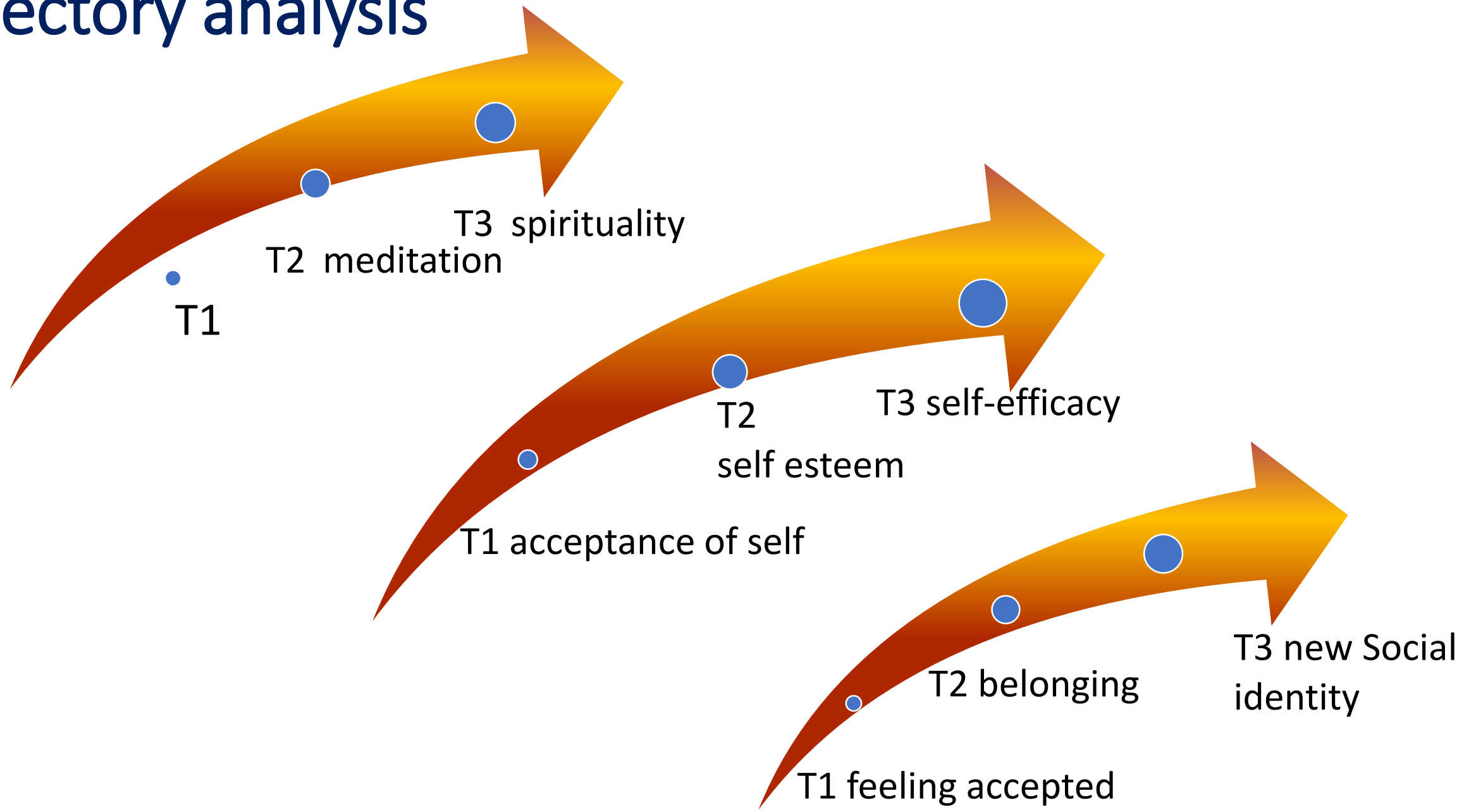
Hope



Trajectory analysis of the themes over the three interviews at T1, T2, and T3 for each participant

Participant	A	B	C	D	E	F
Acceptance	Acceptance **from others,** authenticity and **self-acceptance** Increased from T1, to T2 and T3	Acceptance from others and acceptance **towards others** increased. In T2 feelings of acceptance **from the group** increased. No mention of acceptance in T3 due to relapse.	**Self-acceptance and acceptance from others** and acceptance **of diagnosis** were present at T1, decreased acceptance of self at T2 due to relapse. In T3 as focus was on future plans and aspirations.	Acceptance **of sons' diagnosis and self-acceptance** continued to grow from T1 to T3. Less sense of guilt at T3.	Acceptance wasn't mentioned during T1 but implied from ability to maintain abstinence. It was not mentioned in T2 due to relapse, but increased self-acceptance at T3.	Acceptance **from others** became less important but **awareness of self-acceptance** increased from T1 to 2 and 3.
Self-development	Increased **self-awareness and ability to recognize triggers.** At T3 also **increased faith.**	More awareness of **triggers and coping strategies. Improved time-keeping**. Maintained Employment from T2 to 3.	Increased **educational pursuits** but less engagement **with the DDA** workbook or steps at T2. Continued progress in education at T3.	Consistent use of **coping strategies** and physical activity from T1 to T3.	Increased faith, taken up tasks and responsibilities within DDA and externally.	Consistent engagement in voluntary pursuits and physical activity at T2, took up voluntary work at T3.

Trajectory analysis



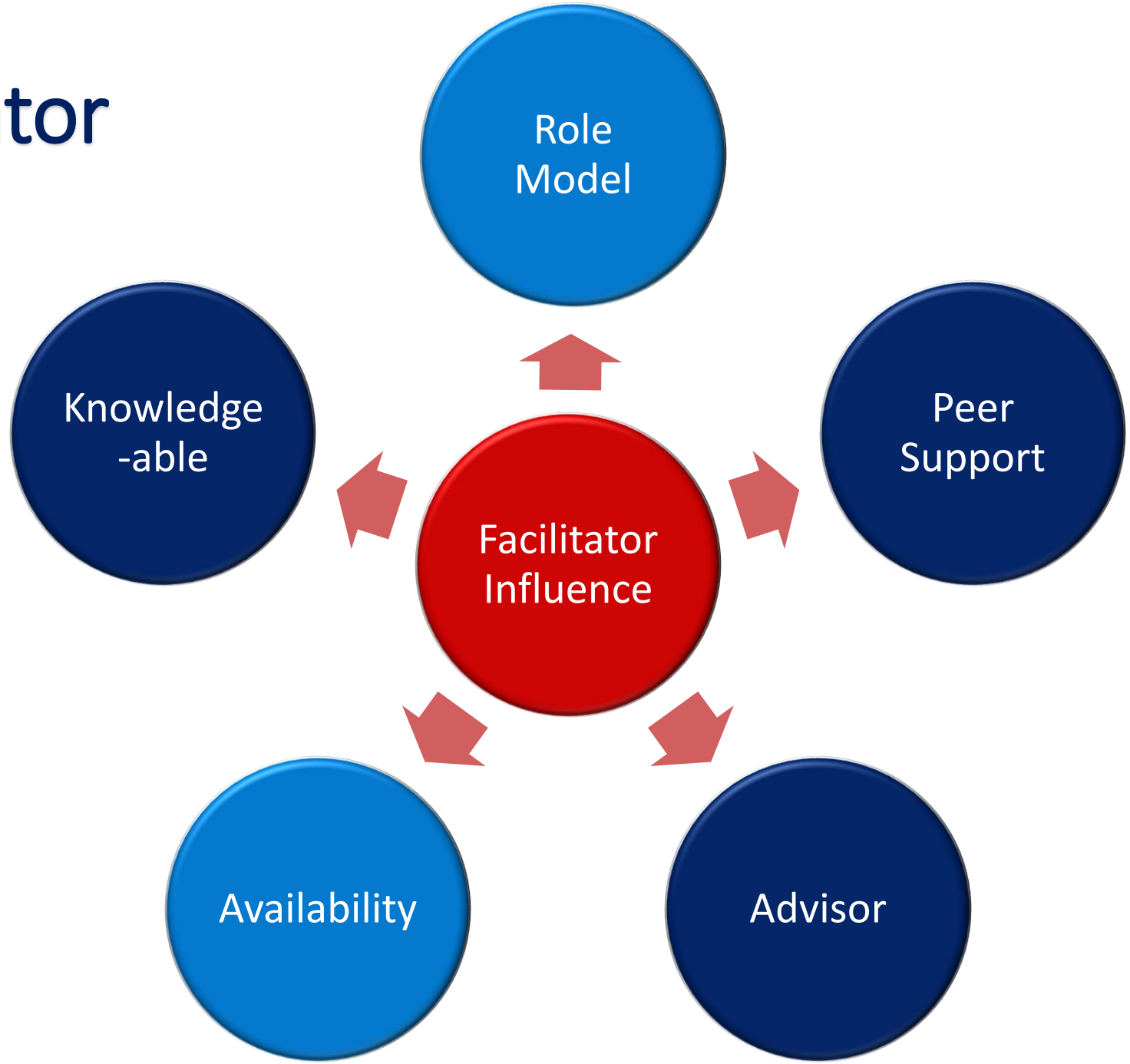
HOW HAS THE DDA CONTRIBUTED TO THE CHANGES?

Main Themes

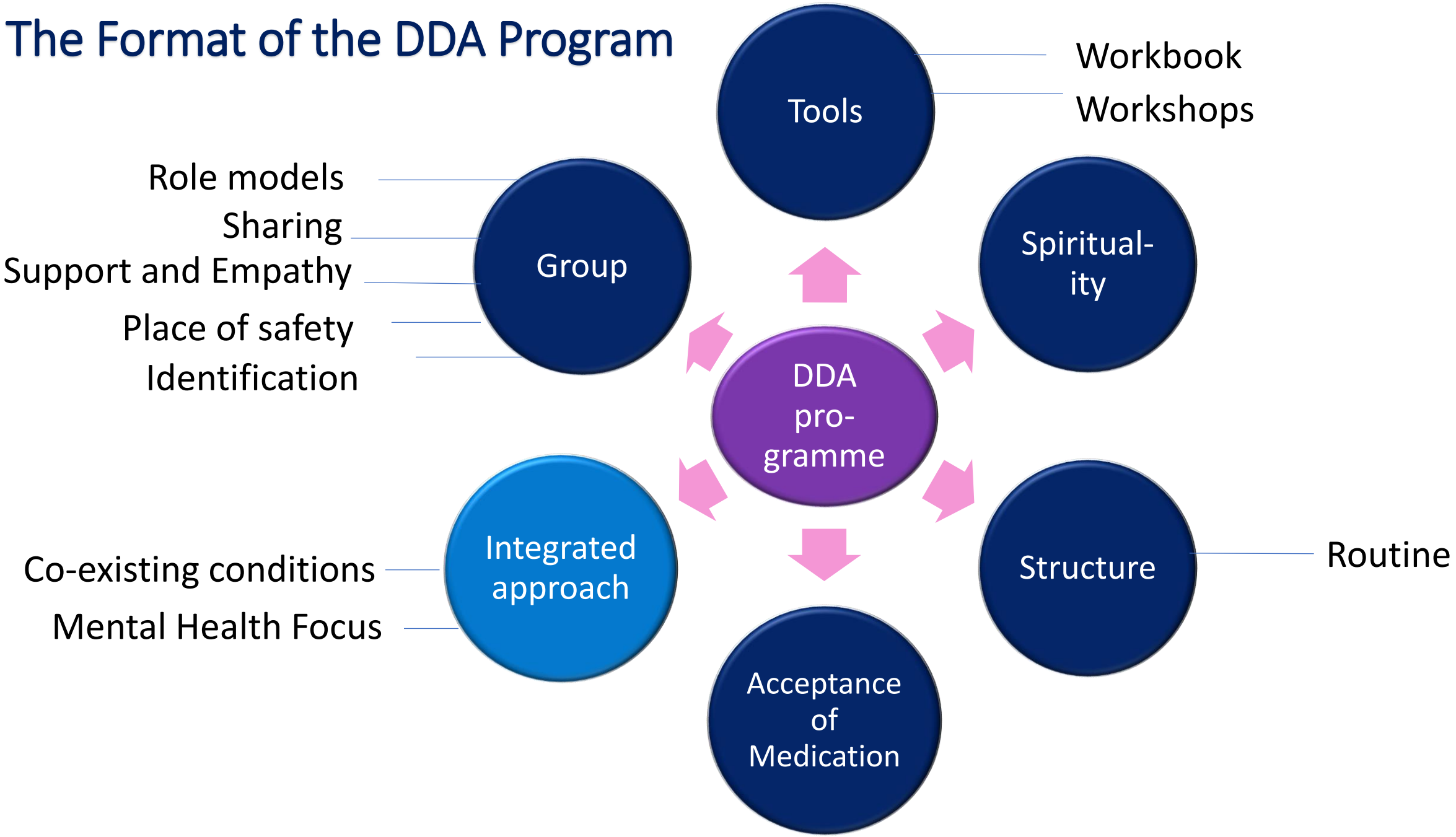
1. The role of the facilitator

2. The format of the program

The Facilitator



The Format of the DDA Program



DDA Programme: Integrated Approach

"I think the fact that you could **talk about your mental health and your substance misuse problem** because a lot of the time if you go to AA or NA…it makes it difficult because…you have to take your medication but they **don't support that**"

"I've been to other groups as well where mental health would never be on the agenda and it was mainly the addiction that would be looked…it could be kind of challenging. I think in other meetings there can be **stigma towards mental health**"

Links to previous literature

➢Confirms results found in DDA Oregon (Roush et al., 2015)

- Feeling accepted by others in the group;
- understanding the interactive nature of dual disorders;
- the open discussions in DDA meetings, and
- a focus on hope and recovery from both illnesses.

➢In line with other research on peer support group (Humphreys et al., 2004)

- Increased self-efficacy
- Strengthened commitment to abstinence
- More active coping
- Enhanced social support
- Greater spiritual and altruistic behavior
- Replacement of substance-using friends with abstinent friends

➢Cost-effective (Humphreys et al., 2007)

➢Importance of Social Identity in the recovery process (Dingle et al., 2015)

Conclusions

- In line with NICE (2016) guidelines
  - integrated approach
  - inclusive
  - no barriers to access
  - there when needed

"DDA fills in the gap between services and the other fellowships "
(DDA member)

- DDA can facilitate reintegration into society by helping people go back to employment or education

Next step

Following this evaluation, based on the feedback from DDA members, Sir Halley Trust granted funding to introduce social activities into the DDA program and evaluate their impact.