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

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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

Substance Use → Mental Health → Mental Health → Substance Use

(Laural et al, 2005; Ezquiaga et al. 2017)
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”


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)
<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Marital Status</th>
<th>Ethnicity</th>
<th>Religious Beliefs</th>
<th>Living Status</th>
<th>Living Arrangements</th>
<th>Employment Status</th>
<th>Occupation</th>
<th>Educational Level</th>
<th>Diagnosis</th>
<th>Addiction</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>F</td>
<td>43</td>
<td>Single</td>
<td>White British</td>
<td>Christian</td>
<td>Renting</td>
<td>Alone</td>
<td>Unemployed</td>
<td>Volunteer</td>
<td>Undergraduate Degree</td>
<td>Paranoid Schizophrenia - Severe clinical depression - Psychotic symptoms</td>
<td>Eating disorder not specified – bingeing symptoms</td>
</tr>
<tr>
<td>B</td>
<td>F</td>
<td>25</td>
<td>Single</td>
<td>African</td>
<td>Muslim</td>
<td>Renting</td>
<td>Alone</td>
<td>Unemployed</td>
<td>Student</td>
<td>BTEC</td>
<td>Psychosis - Emotionally unstable personality disorder</td>
<td>Alcohol/ Marijuana</td>
</tr>
<tr>
<td>C</td>
<td>M</td>
<td>45</td>
<td>Single</td>
<td>White British</td>
<td>Christian</td>
<td>Renting</td>
<td>Alone</td>
<td>Unemployed</td>
<td>Volunteer</td>
<td>College Diploma</td>
<td>OCD/anxiety</td>
<td>Alcohol/drugs (cocaine and MDMA)</td>
</tr>
<tr>
<td>D</td>
<td>M</td>
<td>54</td>
<td>Single</td>
<td>White British</td>
<td>Christian</td>
<td>Renting</td>
<td>Alone</td>
<td>On benefits</td>
<td>Volunteer</td>
<td>Undergraduate Degree</td>
<td>Bipolar Disorder</td>
<td>Alcohol/ Drugs</td>
</tr>
<tr>
<td>E</td>
<td>M</td>
<td>36</td>
<td>Single</td>
<td>White British</td>
<td>Christian</td>
<td>Supported housing</td>
<td>Alone</td>
<td>Employed</td>
<td>DJ</td>
<td>Undergraduate Degree</td>
<td>OCD</td>
<td>Drugs/alcohol</td>
</tr>
<tr>
<td>F</td>
<td>M</td>
<td>59</td>
<td>Single</td>
<td>White British</td>
<td>Hindu</td>
<td>Renting</td>
<td>Alone but sometimes stays with Daughter</td>
<td>Employed</td>
<td>IT analyst</td>
<td>A level</td>
<td>Sons’s diagnosis: Schizophrenia</td>
<td>Alcohol and cannabis</td>
</tr>
</tbody>
</table>
WHAT HAD CHANGED?

Main themes

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

- Of Self
- From others
- Of others
- Of Imperfection
- Of Diagnosis
- Help
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

“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

Rumination

Suicidal ideation

Addictive behaviour

Symptoms Reduction
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

- Future aspirations
- Sense of purpose
- Hope in recovery
### Trajectory analysis of the themes over the three interviews at T1, T2, and T3 for each participant

<table>
<thead>
<tr>
<th>Participant</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acceptance</strong></td>
<td>Acceptance from others, authenticity and self-acceptance increased from T1, to T2 and T3</td>
<td>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.</td>
<td>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.</td>
<td>Acceptance of sons’ diagnosis and self-acceptance continued to grow from T1 to T3. Less sense of guilt at T3.</td>
<td>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.</td>
<td>Acceptance from others became less important but awareness of self-acceptance increased from T1 to 2 and 3.</td>
</tr>
<tr>
<td><strong>Self-development</strong></td>
<td>Increased self-awareness and ability to recognize triggers. At T3 also increased faith.</td>
<td>More awareness of triggers and coping strategies. Improved time-keeping. Maintained Employment from T2 to 3.</td>
<td>Increased educational pursuits but less engagement with the DDA workbook or steps at T2. Continued progress in education at T3.</td>
<td>Consistent use of coping strategies and physical activity from T1 to T3.</td>
<td>Increased faith, taken up tasks and responsibilities within DDA and externally.</td>
<td>Consistent engagement in voluntary pursuits and physical activity at T2, took up voluntary work at T3.</td>
</tr>
</tbody>
</table>
Trajectory analysis

- T1 acceptance of self
- T2 meditation
- T3 spirituality
- T1 feeling accepted
- T2 belonging
- T3 new Social identity
- T2 self-esteem
- T3 self-efficacy
HOW HAS THE DDA CONTRIBUTED TO THE CHANGES?

Main Themes

1. The role of the facilitator

2. The format of the program
The Facilitator

- Role Model
- Knowledge-able
- Peer Support
- Availability
- Advisor

Facilitator Influence
The Format of the DDA Program

- Role models
- Sharing
- Support and Empathy
- Place of safety
- Identification

Integrated approach

- Co-existing conditions
- Mental Health Focus

- Tools
- Workbooks
- Workshops
- Spirituality
- Structure
- Acceptance of Medication

- DDA programme
- Routine
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 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.

“DDA fills in the gap between services and the other fellowships”

(DDA member)