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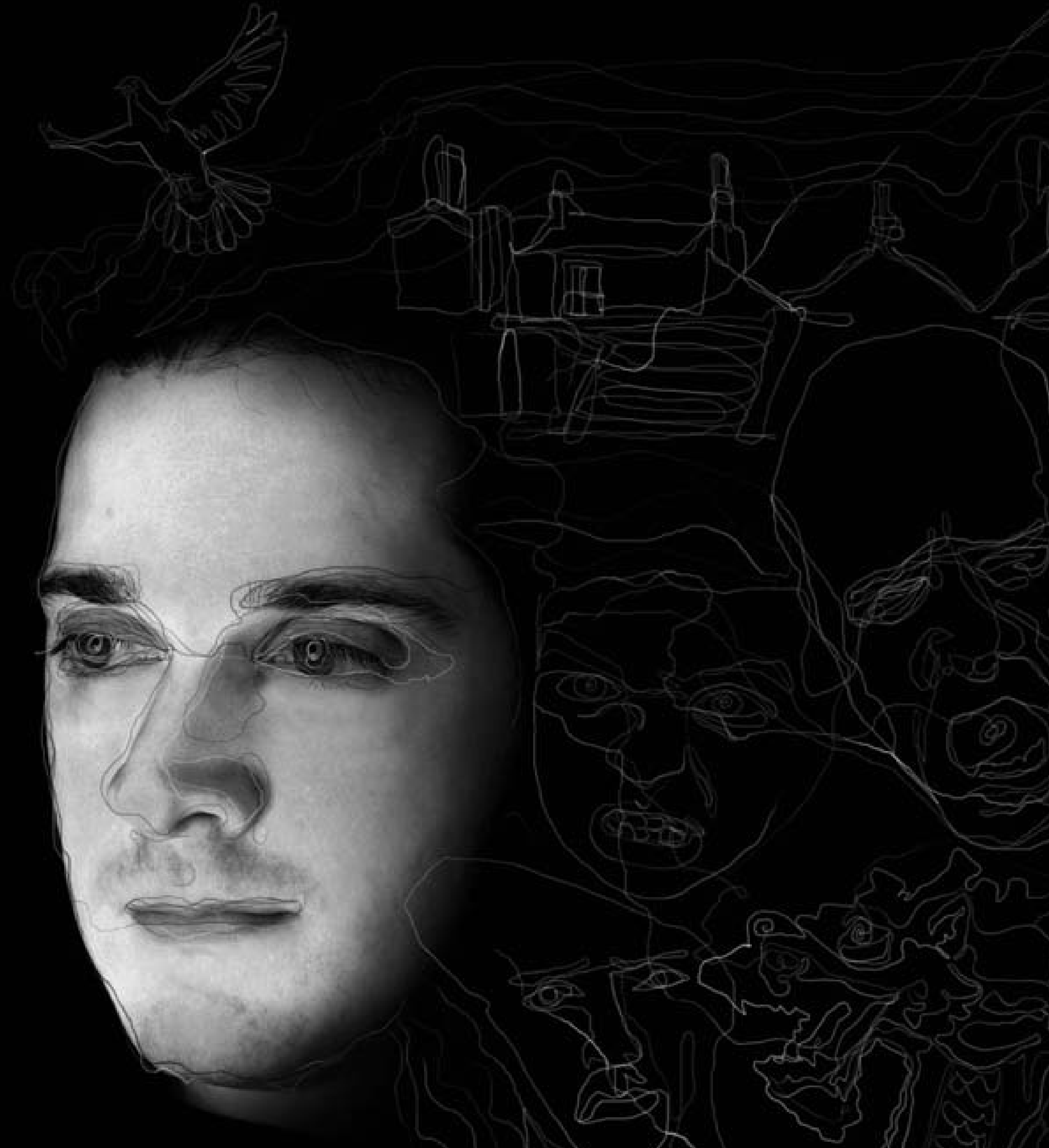
Dual Diagnosis



Dual Diagnosis

Introduction:

Dual Diagnosis is a term used to describe the complex relationship between mental health and substance misuse.

There have long been concerns about the vulnerability of this client group who have been considered difficult to manage and perhaps untreatable. In comparison to people with mental health problems alone, people with co-existing mental health and substance use problems are more likely to:

- Have increased likelihood of suicide
- Have severe mental health problems
- Have increased risks around homelessness and unstable housing
- Have increased risks of being violent
- Have increased incidences of victimisation
- Have frequent contact with the criminal justice system
- Have Family problems
- Have histories of childhood abuse (sexual/ physical)
- Slip through the net of care
- To be less compliant with medication and other treatment

Co-existing Problems of Mental Disorder and Substance Misuse (dual diagnosis) An Information Manual 2002

Traditionally there has been little formal cohesion between services in how they have responded to the needs of this group and whilst there have been pockets of good practice; there have been many incidences throughout the country where those with a dual diagnosis have fallen between services. One of the key issues with dual diagnosis has been the need to co-ordinate services to provide holistic care and ensure that people receive the broad range of services required to facilitate change in their lives.

The Department of Health, Dual Diagnosis Good Practice Guide 2002.

On the 1st May 2002, the Department of Health published the Dual Diagnosis Good Practice Guide. The guide recognised the difficulties services had experienced in offering support to people with a dual diagnosis, particularly where there were several agencies involved in the care.

In an attempt to address these issues the guide made a number of recommendations to enable services to work collaboratively and for staff to be supported and confident in their working practice.

The Norfolk Dual Diagnosis Strategy

In response to the recommendations made by the Good Practice Guide, a specialist post was set up in Norfolk to carry out a needs assessment throughout the county and to develop a local area definition, identify the model of care to be adopted, and to develop a training strategy. Through consultation with local area service providers and service users the steering group presented the following definition for Norfolk:

Vision Statement:

'An individual who presents with co-existing mental health (and/ or Personality Disorder) and substance misuse problems (drugs and/ or alcohol)'

Partnership Statement:

Norfolk DAAT and LIT's support the implementation of provision for this client group using the integrated model of service delivery approach. Integrated care is taken to mean the concurrent provision of both psychiatric and substance misuse services. These services are to be provided in partnership with other organisations to meet the presenting and ongoing needs of the individual

Amongst the recommendations made in the Norfolk Strategy were the following key points:

All staff must recognise that dual diagnosis is commonplace and the responsibility of all providers.

Agencies need to be committed and, where possible, signed up to joint working and information sharing.

Joint screening and assessment tools need to become mainstream for this client group. Requests for a joint assessment should be met promptly by the other agency.

Staff must look to respond to the presenting needs of the individual. The care plan should reflect this need and then be longitudinal and open to revision. Care plans should consider discharge/aftercare provision from the outset.

Care coordination must sit with the statutory services.

Where an agreement cannot be reached upon the appropriate care co-ordinator the management structure of the model may be imposed, or alternatively, statutory mental health and substance misuse services may choose to jointly care coordinate. There should still remain one care plan.

Treatment should be based around, engagement, motivation, harm reduction/minimisation and relapse prevention in the first instance.

Personality Disorder is to be mainstreamed and integrated under the model.

For a full list of recommendations, please refer to the strategy, which can be obtained through the Norwich Primary Care Trust 01603 307397

Why do people with mental health problems use substances?

A Major hurdle in implementing an integrated treatment approach is the attitudes and perceptions of staff. Some clinicians continue to perceive co-existing substance use problems as of the client's own volition, intractable, and feel pessimistic about the effectiveness of any treatment. In addition, some believe that the treatment of substance use is out of their remit and area of expertise (Derricott and McKeowen, 1996)

Substances have been a part of the human experience for thousands of years. From the earliest historical records of their use, through to the present day humans have sought out substances to help them to adapt to their environment.

People use substances for real or perceived benefits, i.e. leaving the individual feeling more relaxed, alleviating symptoms of withdrawal, increasing confidence, alertness or energy, depending on the substance taken. Often when someone has a mental health problem, there is an assumption that their use of substances is automatically out of control and that the reasons they choose to take substances is somehow different from wider society. Ultimately the reasons why people use substances will be as varied as the individuals themselves.

In order to work effectively with people around their substance use there is a need to put our assumptions to one side and develop an understanding of the relationship between the individual, their mood, physiology, the environment and the substances they use.

This takes time and can only be done effectively by building up a trusting relationship with the individual. In line with the harm minimisation message, this may involve not overly focussing on their substance use as the problem per se, and being prepared to offer more practical support.

Self-reported reasons as to why some people with mental health problems take substances:

There are many reasons perceived or otherwise as to why some people with mental health problems are drawn towards substance use. The following list offers a snapshot of some of the reasons described by service users.

Positive effects of substances - simply put, many people enjoy the experiences of taking substances and perceive benefits from them. Experiences of mental health problems can lead to decreased self-esteem, confidence, motivation etc, and it is not difficult to imagine the attractiveness of a substance that would help alleviate some of these negative symptoms, even if the impact is only short term.

Social Network - many people describe the social network and culture around substance use. For people who feel alienated through their experiences of mental health problems this can be appealing.

Substances can help pass the time and relieve feelings of Boredom - Boredom can play a big factor in relapse and without alternative coping strategies and support networks in place it can be difficult to effect long term change.

Side effects of prescribed medication - many people complain about the side effects of psychiatric medication, loss of motivation, libido, weight gain etc. For some people, their substance use may help alleviate some of these side effects.

Block out voices/ management of psychiatric symptoms - some people describe their use of substances in terms of managing their psychiatric symptoms. Their substance of choice may block out symptoms such as voices, or make such experiences more tolerable. This may be the person's perception and may not be backed up by scientific evidence, however any management of long term, sustained change has to start with the individual's perception.

Past experiences of services - For some people, negative past experiences of services might mean they are reluctant to engage with services in the future. Using substances may offer an alternative network of support free from the stigma of being involved in services.

Some people use substances to block out painful memories, i.e. childhood trauma.

Accessibility - For many people in contact with services they may on average spend relatively short periods of time in contact with professionals. An outpatient appointment with a psychiatrist may offer twenty to thirty minutes a year. Contact with a mental health nurse may be more frequent, possibly an hour per week, whilst contact with voluntary sector services may be as much as two or three hours per week. Nonetheless this still represents a short period in a week and does not always cover evenings and weekends. In comparison, access to a drug dealer can be twenty-four hours seven days per week and in times of crisis may offer an individual a short-term solution to their problems, particularly if professionals are unavailable.

Exploitation - Drug dealers are opportunistic and can target people who have mental health problems if they see an opportunity to make money. There have been instances where vulnerable people have their tenancies taken over for the production and supply of substances, leaving the tenant to pick up the pieces when the police become involved. Some areas of the country have developed strategies in conjunction with the police in order to better manage this type of problem, i.e. Kensington and Chelsea's Crack Protocol.

The above list is by no means exhaustive, however it gives a flavour of the scope of issues facing people who have mental health problems and who use substances.

Strategies for working effectively with Dual Diagnosis

There is a broad range of strategies for working with people around their substance use and mental health issues. The following examples work well in conjunction with one another and can ultimately be used to develop the ethos of your organisation or team.

Harm Reduction Psychotherapy

There can often be an over focus by services on substances use being the 'problem', when relating to people who have co-existing mental health problems. Staff can often coerce individuals to become abstinent or try and convince them that they need to recognise the 'problem' in a bid to promote change. Any benefits of this approach are likely to be short term and will ultimately fail.

As workers, we need to become more effective in looking at harm reduction strategies with clients and embracing the underpinning philosophical approach if we wish to encourage sustained changes in people's lives.

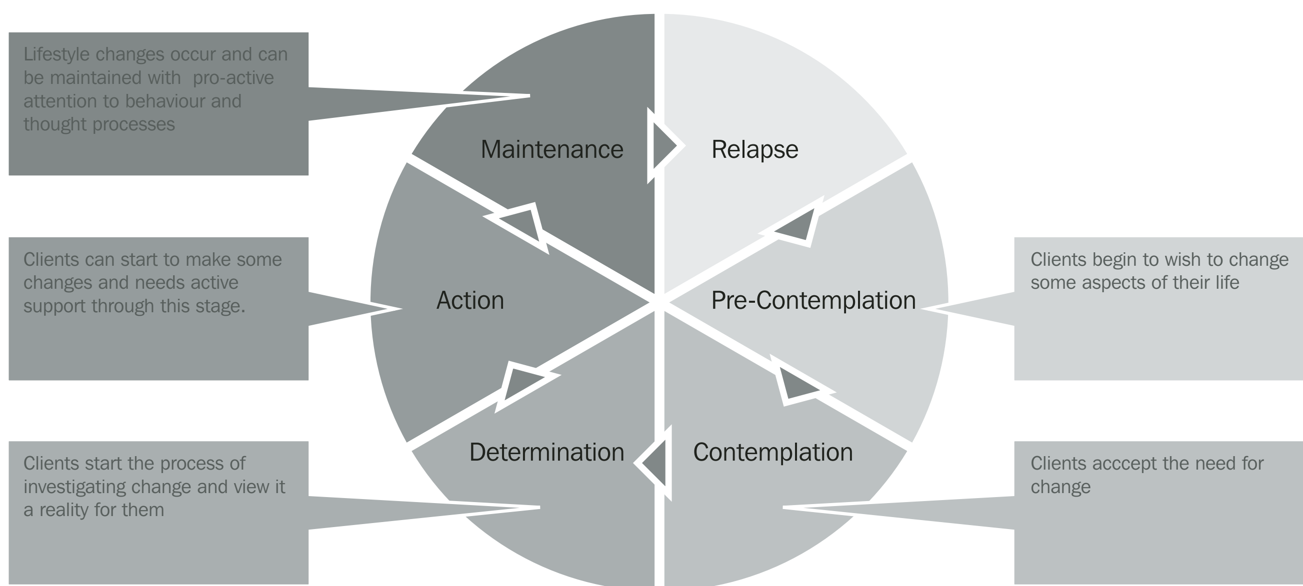
Basic Principles

- There is a spectrum of drug use from non-problematic to extremely problematic with a continuum of harms as well
- Harm Reduction does not debate the view that drug use is pathological – i.e. that drug users are psychologically different from others.

Treatment

- Harm-Reduction is about accepting the person at the stage where they are.
- Focus on reducing the harm caused by drug use not the drug use per se
- Client's can establish their own goals – they are not set by the professional and do not necessarily have to be abstinence based. Safer drug use is an option
- Harm Reduction recognises the right of the individual
- Harm Reduction recognises the cultural, religious and ethnic differences
- Harm Reduction can incorporate advice and interventions from staff
- Harm Reduction is research based
- Harm Reduction recognises that there may be other issues in a person's life that they view as more urgent and problematic than their drug use

The Cycle of Change Model



from Prochaska and Di Clemente Model (1982)

Underpinning this model is the belief that people travel through various stages when considering and implementing change in their lives. Most people travel through the cycle a number of times before making long-term, sustained changes, however there are opportunities to learn with each cycle. Relapse is considered a 'normal' part of change and not as pathological feature of addiction. Clearly relapse is not a desirable outcome however it can be used as part of the overall learning experience.

Equally important within the model, is the need for staff to recognise at which stage a client may be at and to implement appropriate strategies that will promote further change. A pre-contemplative client would be likely to demonstrate resistance if staff were to encourage strategies associated with the action stage, i.e. attending support groups, arranging residential rehab placements etc.

Motivational Interviewing Definition:

Motivational Interviewing is a non-authoritarian approach to helping people free up their *own* motivations through resolving ambivalence.

Foundation Principles

- Therapist style is a powerful determinant of client resistance and change
- Confrontation is a goal, not a style
- Argumentation is a poor method for inducing change
- When resistance is evoked clients tend not to change
- Client motivation can be increased by a variety of therapeutic strategies
- Even relatively brief interventions can have a substantial impact on problem behaviour
- Motivation emerges from the interpersonal interaction between client and counsellor
- Ambivalence is normal, not pathological
- Helping people to resolve ambivalence is a key to change

In order to work effectively with dual diagnosis it is important to look at our own working styles and be willing to adapt our approach. We often expect service users to make all sorts of complex changes in their lives, without being prepared to change our own attitudes and perceptions.

Effective Motivational Approaches

Giving Advice - when asked for. We need to be careful of not overly diagnosing the problem then coming up with the solutions.

Removing Barriers - help identify what gets in the way of making changes.

Providing Choice - encourage people to identify what choices they have.

Decreasing Desirability - the cost benefit analysis can help with this.

Practicing Empathy

Providing Feedback

Clarifying Goals - their goals not ours!

Active Helping - people often value the practical help and support most.

Training in Motivational Interviewing usually comes as a two – three day training course and focuses on asking open-ended questions and reflective listening skills. Resistance to change is not met head on; rather a therapist uses the momentum of a client's argument and acknowledges the dilemmas that they face. As a result a clients often start to confront themselves and start to consider the possibility of change.

Cost Benefit Analysis

A cost benefit analysis is a useful tool for developing an understanding of where substances fit into an individual's life and what is important to them.

The following provides an example of how this can work in practice when trying to identify what motivations a client might have in relation to their substance use:

Pros - cannabis	**Cons** - cannabis
Helps me relax	Sometimes I spend more than I should on it but I never get into debt
The voices don't worry me so much even though they are still there	I get over lethargic – can't be bothered to do things I should be doing
I like smoking with my mates	My parents get on at me
I enjoy skinning up	Very occasionally it makes the voices worse

This exercise can be done in written form or more likely in ongoing discussion. The fact that you are helping to identify the positive aspects of the individual's substance use will help to develop trust. It is important however to allow the individual to compile their own list and not fall into the trap of 'feeding' them what we perceive to be negative aspects of their substance use. Remember people's views on what constitutes a cost can vary dramatically, some costs, for example, an arrest, may just be viewed as an occupational hazard.

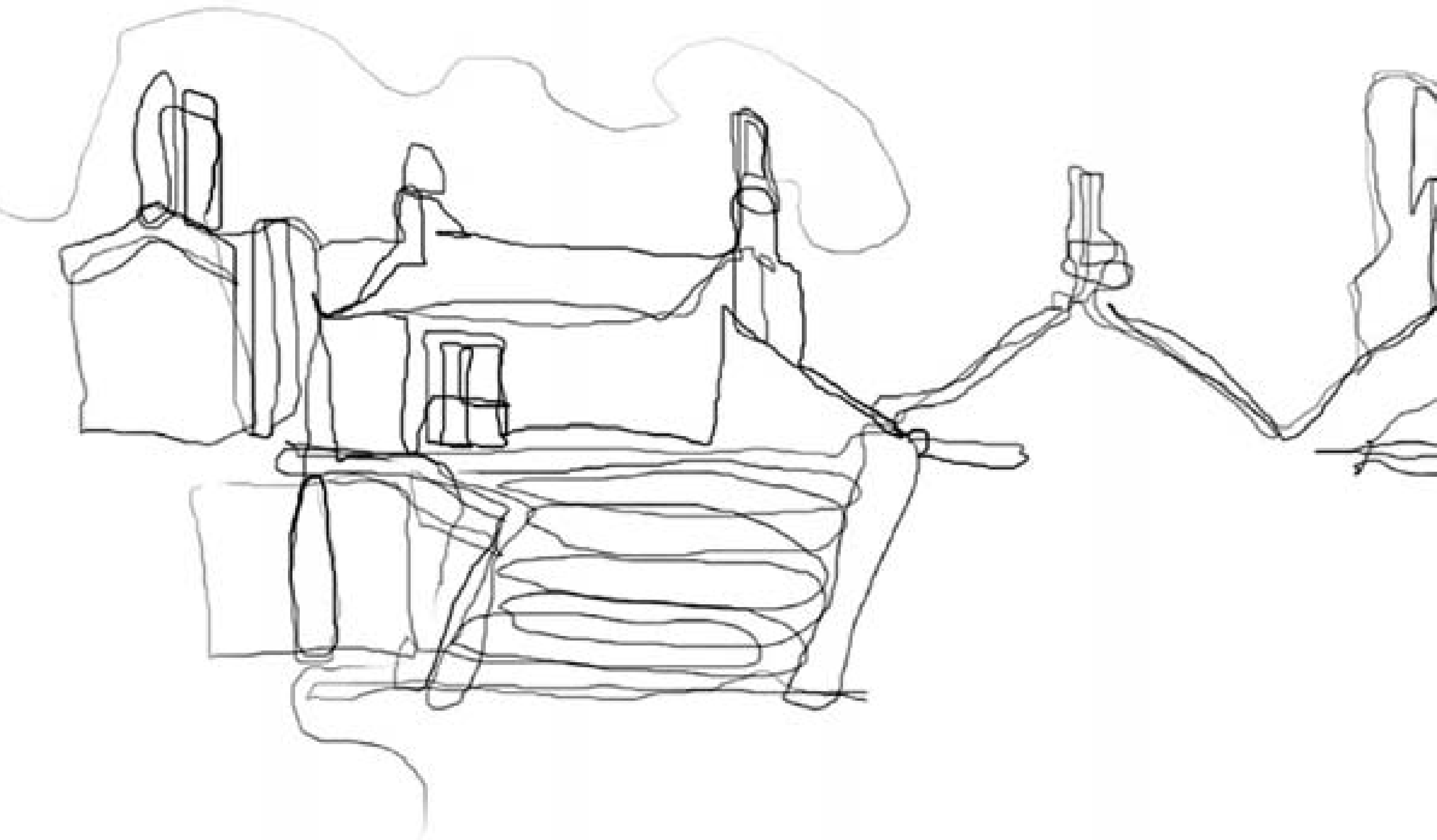
The Strengths Approach

Where complex problems occur in an individual's life there can be a tendency for services to become problem focused. Whilst there is a need to recognise difficulties that service user's might be experiencing and to take into consideration risk management, there is a danger that we can end up overlooking the considerable strengths a person may have developed in their lives. Even when a situation can look incredibly chaotic from the outside, there are often tremendous coping mechanisms at play, which enable the individual at the centre to survive. The following principles have been articulated by Steve Morgan (1996) from the original model by Charlie Rapp, (1993, 1998):

1. The focus of the helping process is upon the service user's strengths, interests, abilities and capabilities, not upon their deficits, weaknesses or problems.
2. All service users have the capacity to learn, grow and change.
3. The 'service user – Assertive Outreach' relationship becomes a primary and essential partnership.
4. The service user is viewed as the director of the helping process.
5. Continuity and acceptance are essential foundations for promoting recovery.
6. The helping process takes on an outreach perspective.
7. The local neighbourhood is viewed as a source of potential resources rather than as an obstacle; natural neighbourhood resources should be considered before segregated mental health services.

Housing

It is essential that any supported housing agency working with Dual Diagnosis develop a drugs policy that is both realistic and workable within the law. Many agencies are anxious about working flexibly with drug use on premises and are not aware that it is possible to provide support without automatically resorting to eviction where substance use occurs. The essential criteria is to respond, however there is a broad spectrum of responses that can be made. It is important to get advice on developing a robust substance use policy and the following agencies can be helpful:



Conclusion

Whilst the Dual Diagnosis Strategy is aimed at creating increased cohesion between services and to provide appropriate levels of training, staff should consider what they could offer themselves alongside the interventions of more specialist services.

It may be necessary to offer an assertive outreach style of working, whereby staff are persistent in their efforts to engage and are able to think creatively about how to go about that engagement process. Engagement can be equally difficult within residential projects, even though the person lives on site, and an assertive outreach style of working may need to be adapted to this environment. Ultimately working with dual diagnosis requires a long-term view and a willingness to accept small gains over long periods of time.

Resources and Information:

'Assertive outreach – A strengths Approach to Policy and Practice', Peter Ryan and Steve Morgan, 2004 Churchill Livingstone

'Motivational Interviewing – preparing people to change addictive behaviour', Miller and Rollnick, 1991, The Guildford Press.

Practicing Harm Reduction Psychotherapy, An alternative approach to addictions, Patt Denning, 2000 The Guildford Press.

Dual Diagnosis Good Practice Guide, Department of Health Publications

Co-existing Problems of Mental Disorder and Substance Misuse (dual diagnosis) An Information Manual, Royal College of Psychiatrists 2002

Kevin Flemen at Kfx www.ixion.demon.co.uk

Simon Floyd at Norcas www.norcas.org.uk

Ben Curran at Julian Housing b.curran@julianhousing.org

Assertive outreach – A strengths Approach to Policy and Practice, Peter Ryan and Steve Morgan, 2004.

In working with dual diagnosis, it is worth considering how we can work towards people's strengths and adapt the language we use to reflect this. This should also be reflected in the paperwork we adopt as a service, for example including a strengths focus to risk assessment and support plans.

For information on the 'Strengths Model' contact

Steve Morgan at Practice Based Evidence www.practicebasedevidence.com

Julian Housing Support www.julianhousing.org

Training Provision

In line with the recommendations on training within the strategy, the following courses have been developed:

5 One day awareness courses on dual diagnosis

2 Five day courses which accredited by the UEA

These courses are running throughout the remainder of 2005, through to July 2006.

For further details contact Janet Dean Janet.dean@norfolk.gov.uk

VHG is also organising relevant training, please contact Fola on fola@vhg-east.org for further information.

Creation & Production: Starfish 01603 414888 www.starfishlimited.com

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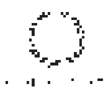

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