

Dual Diagnosis

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Dual diagnosis has become a critical issue for both drug and mental health services. The complexity of problems experienced by clients belies the simplicity of the classification of merely the co-existences of problematic substance use alongside a mental health 'disorder'. Indeed we must acknowledge that the actual concept of mental health disorder is a contested one, but even with definitions utilised within services it is necessary to also incorporate wider social functioning such as personality disorder and learning disability. One only has to consider the legions of permutations of possible chemical and behavioural dependencies that could partner an equally diverse range of mental health disorders to comprehend the challenge that dual diagnosis poses to treatment services. The difficulty of working effectively and therapeutically with such service users leads many agencies to create boundaries based on single diagnoses, thus causing the rejection of those with more complex problems.

The variety of pathways resulting in a dual diagnosis, and the wide range of mental health symptoms and types and levels of drug use the term may encompass brings enormous complications to diagnosis and treatment. The general confusion about the whole concept of dual diagnosis has led to reluctance by any service to accept responsibility for this group. Consequently, there is as yet no concerted service response to dual diagnosis in the U.K.

Many mental health agencies exclude clients who are actively misusing substances, and substance misuse agencies often cannot offer the levels of support needed to work with the more disturbed clients with mental health problems. Attitudinal barriers remain and are reflected in the reluctance of psychiatric services to embrace contemporary models of drug use such as harm minimisation in favour of an insistence on abstinence with the threat of rejection from services if clients are unable or unwilling to comply. The lack of integration between mental health and

substance misuse services seriously compromises attempts to deal with the issue effectively. The difficulty in dealing with dual problems within separate specialised services results in many individuals 'falling between the cracks' or having one of their problems ignored. The fragmented package of care resulting from the involvement of two distinct services which tend to have conflicting philosophies, approaches and expectations exacerbates the difficulties in maintaining contact with a notoriously 'difficult to engage' client group.

One of the main challenges regarding work with dually diagnosed clients is that they are reputedly difficult to engage and retain in services and consistently fail to comply with treatment programmes. One might wonder how hard services have actually tried to 'engage and retain' clients since evidence suggests they are frequently passed between services who do not wish to accept responsibility for them. However, if clients with dual diagnosis do fail to engage with services, or disengage too quickly, it is important to examine the possible reasons why.

Disengagement from services while the person is still experiencing problems may mean the development or exacerbation of other social problems such as homelessness. In addition, disengagement from services at an early stage of treatment is likely to lead to a 'revolving door' syndrome whereby clients relapse periodically and require hospital admission. This may be the reason why people with a dual diagnosis are known to make heavy use of acute services compared with clients who have a mental health problem alone. There seems to be an assumption that problems of engagement and treatment compliance are an inherent part of the complexity of the dual disorder. It is far easier to assume that unreliability is a feature of the chaotic nature of many clients' lives rather than consider the possibility that clients may disengage because they find current service approaches unacceptable.

There are many possible reasons why prospective clients might resist involvement with traditional services such as being aware of the potentially punitive responses (such as being reported to the police) they might face. Withdrawal of a person's drugs may be even more frightening for a person with mental health problems who may be using drugs in an attempt to alleviate psychological symptoms, pain or distress, or to provide a means of escape. Although clients may be aware of the

destructive nature of their drug use in the long-term, in the short-term they may be too scared to lose the security of their chosen substance. Consequently, a service approach which is more accepting and understanding of the role of drugs in a person's life might be more successful in at least maintaining contact with the person with the long-term aim of helping them to develop healthier coping strategies and a more positive life-style to reduce their need for drugs.

There is a particular problem for clients with a dual diagnosis gaining access to residential treatment facilities which will often refuse to admit people with serious mental health problems because the treatment approaches used are seen as inappropriate for people who are psychologically more fragile. Specialist drug rehabilitation programmes are often too confrontational for the seriously mentally ill who may experience them as highly stressful since the emotional temperature of the group sessions can be high. The emphasis on group work in itself may prove difficult for people who find social interactions difficult. In addition, there is often a requirement for residents to abstain from all substances prior to treatment, including medication prescribed for the control of psychotic symptoms. This would obviously be unhelpful for a person with schizophrenia. Residential facilities often have strict limits on tolerance of relapse, and failure to adhere to the high expectations of the facility may mean that a person is discharged while in a psychologically vulnerable state.

The central organisational challenge in working with people with dual or multiple needs is to develop a holistic service within a fragmented culture of care. Organisation of services tends to be divided in terms of commissioning structures, professional disciplines and the specialisation of service providers. These barriers affect clients with multiple disorders, a lack of integration between mental health and substance misuse services is seriously hindering attempts to support this client group.

Some advocate specialist dual diagnosis services as the simplest way to provide continuity of care, but there are disadvantages to this approach. For example, if the rates of dual diagnosis are as high as published reports suggest, then substance misuse among people with a mental illness is usual rather than exceptional. A

specialist service would quickly become swamped and would ultimately have to be very selective. Services would quickly develop barriers, taking on the most chaotic clients who have the greatest needs. Concentration of expertise within one specialist service may also perpetuate the already existing belief among both mental health and substance misuse services that people with a dual diagnosis are not their responsibility and therefore they do not need to develop the skills to deal with them. The perceived need for yet another specialism will further diminish the confidence of staff in existing services.

There are several issues services must address if they are to begin meeting the needs of people with dual diagnosis. Firstly, services need to have an awareness of the widespread nature of a problem which is currently fairly well hidden. The possibility of substance misuse is not automatically considered in initial assessments despite the fact that statistics show that substance misuse is usual rather than exceptional. In addition, the punitive rather than therapeutic responses towards people who misuse drugs, for example the threat of expulsion or even police involvement, make it unlikely that clients will honestly admit they have a substance misuse problem. There is clearly a need for a change in attitude in mental health services. Its current standpoint on the issue of drug misuse is the expectation of immediate abstinence from drugs or exclusion from service support. This contrasts starkly with contemporary models of drug use which emphasis harm reduction. Mental health services may have to accept the reality that many of their clients are using drugs and it is surely unethical to refuse to treat the symptoms of psychological distress for essentially moral reasons. There is a clear need for new assessment instruments which look at the impact of an individual's drug use upon their mental health symptoms rather than assessing the two disorders in isolation from the influences of the other. A person with a mental health problem may be affected by relatively small quantities of a substance which would not meet the criteria for a substance misuse disorder when taken in isolation. The interaction of the two disorders needs to be assessed.

Secondly, although causal factors are obviously important, these should not be attended to at the expense of immediately dealing with all the presenting problems. As the new model services are beginning to discover, causal effects in dual

diagnosis are often difficult to untangle, and outcome of treatment is often the most reliable indication of causality. The high demands dually diagnosed people place on services are in many ways due to the revolving door syndrome. When clients are discharged early from services or disengage themselves because they don't find the approaches acceptable, there is a greater likelihood of relapse requiring regular acute admissions. Greater efforts to engage with this group through assertive outreach and long term casework are necessary to engage and retain these vulnerable clients in services. This will only be possible if workers adopt a non judgemental attitude towards clients, recognising the important role drug use plays in their lives, often as a coping strategy or a means of treating symptoms of psychological distress. Non-compliance issues may be less of a problem if workers build relationships with clients based on empathy and respect, and work in partnership with them to define goals and achieve change based on clients perception of their needs rather than the assumptions of service professionals. This contrasts with the current ethos of psychiatric units, which make demands for compliance irrespective of the person's wishes or ability to immediately abstain from drug use.

The failure of services to integrate when necessary will only lead to more clients falling between the cracks as they are shuttled between services. Often dually diagnosed people who have the most complex needs and pose the greatest risks to themselves and others are the very people who are allowed to disengage from services sometime resulting in tragic yet avoidable incidents.

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