

Co-existing Problems of Mental Disorder and Substance Misuse (dual diagnosis)

An Information Manual - 2002

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Editors

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Foreword

The complex challenges presented by substance misuse among those with mental disorder and mental health problems among substance misusers have become increasingly clear in the last decade. Current research and clinical experience suggests that co-morbid mental disorder and substance misuse is associated with serious clinical and social problems, and increased service utilisation. The phenomenon is increasingly recognised, but there is marked variability in definitions of 'dual diagnosis', in the role of clinical staff, in treatment models and service configuration. Even the most conservative estimates of the prevalence of comorbidity require that mainstream services need to evolve to ensure effective assessment and treatment.

To date the majority of information and research on the subject of dual diagnosis has been taken from the experience of other countries, primarily North America. While these studies are an important element of the evidence base and provide examples of good practice, their conclusions may not be directly generalisable to the UK. There is at present a lack of practical information for practitioners in the field which can help to ensure a shared basic level of knowledge on the subject both within and between services.

In recognition of the situation the Department of Health funded the Royal College of Psychiatrists' Research Unit to produce a series of publications, of which this manual is one. These publications aim to offer the reader information in a manageable form on safe and effective clinical experience derived from users of services and professionals working with people with dual diagnosis. Its overall purpose is to give the reader a chance to consider their practice in relation to the assessment and care of people with dual diagnosis. The target audience is wide and multidisciplinary and levels of knowledge will vary markedly. It is likely that all readers will know some of what is in this manual but we hope that most readers will gain some new knowledge. It is also important to acknowledge that the evidence base is fairly sparse and the subject is in an exciting period of change, so this manual may also help to stimulate local discussion about how best to meet the needs of complex groups. It is difficult to create a document of use to a newcomer to the field as well as to experienced practitioners, but this is the target we have set ourselves.

The following are some of the potential limitations of this manual:

- The manual has been written primarily for professionals working directly or indirectly with people who have co-occurring problems with mental disorder and substance misuse. However, it is also hoped that anyone with an interest in the area of dual diagnosis, in particular, carers or users of services, may find the manual informative and of some assistance.
- The manual addresses the adult population of working age only. The specific needs of young people and older adults may differ. But it is hoped that some of the general principles outlined here will be of relevance.
- This manual is not a systematic review or a clinical guideline. We have been sparing with references and with descriptions of the evidence base in order to maximise readability. However, practitioners need to base their practice on evidence and there are two companion pieces of work in this series which may be of help. The first is a detailed literature review offering a comprehensive account of the current evidence available. The second is an abstract catalogue providing over 1,000 abstracts, which have been collated by theme and cross-referenced alphabetically.
- The content includes illustrative vignettes, questions and suggestions rather than simple plain text. We hope that this interactivity will help in the reader's critical consideration of the issues and ideas presented here.

The manual is organised into seven sections: (1) conceptual & theoretical issues; (2) introduction to current problems in service provision; (3) ethical issues and the Mental Health Act; (4) assessment; (5) interventions; (6) organisational issues and (7) information sources. The appendices contain detailed complementary information on basic drug and mental health awareness and a training pack, which can be used in conjunction with the manual. The training pack offers practical tips for the trainer on how to prepare, run and evaluate a piece of in-house training, with some examples of content for a presentation.

This manual is part of a series of publications by the College Research Unit addressing dual diagnosis. The 'architects' of this project are Dr Tim Kendall and Adrian Worrall, without whose efforts and support this project would not have been possible. The manual was prepared by a

skilled multidisciplinary team of experts in the area of dual diagnosis in an iterative process involving consultation with a large number of other informants and experts from a wide range of disciplines (please see Annex C for details). We would like to express our sincere thanks to them all for the immense amount of detailed high quality work which they completed in a very limited amount of time. We would also like to acknowledge the project administrator Sena Quayle, who was intrinsically involved at all stages of the process, and without whose help the project would have been a great deal more challenging.

Finally, we acknowledge (and anticipate) that the information within this manual may be superseded as clinical experience and research gathers momentum. Despite this we hope it offers the reader an overview of the key issues currently facing practitioners in the UK and can contribute towards improved care for people with dual diagnosis.

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- A Literature Review
- A Catalogue of Literature Abstracts
- A Training Needs Analysis

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Contents

Conceptual & Theoretical Issues	1
Practice & Policy Issues	11
Ethical Issues & the Mental Health Act	19
Assessment	31
Interventions	57
Organisational Issues	87
Information Sources	95
Glossary & Abbreviations	101
References	108
Appendix A: Basic Drug and Mental Health Awareness	113
Appendix B: Training Materials	135
Appendix C: Delegates at consultation weekend	143

SECTION 1 - Conceptual and Theoretical Issues

Learning Objectives:

1. To identify the pros and cons of the term dual diagnosis.
2. To be aware of the prevalence of dual diagnosis.
3. To understand the possible underlying causes of dual diagnosis.
4. To understand possible consequences of dual diagnosis.
5. To be aware of the roles and responsibilities of key service providers.

Definitions of dual diagnosis

The term “dual diagnosis” has been applied to a number of different groups of people with two co-existing conditions such as personality disorder and mental health problems and learning disability and mental disorder. However, the term is also used to refer to a group of people who have co-existing problems of mental disorder and substance misuse.

Other terms which have been used to describe this population, include:

- Mentally ill chemical abuser (MICA)
- Chemically addicted mentally ill (CAMI)
- Co-morbidity of substance misuse and mental disorder
- Co-occurring addictive and mental disorders (COAMD)
- Coexisting problems of mental health and substance misuse

It is important to be clear that dual diagnosis is therefore not a diagnosis in itself, instead it simply describes the fact that an individual has both mental health and substance misuse disorders. Diagnosis will involve the identification of the nature of each of the elements. Some of the difficulties, which are inherent in the use of this term, include the following:

1. People given the label “dual diagnosis” typically have **complex needs** rather than two distinct problems. Services involved may try to split the problems in order to deal with both in parallel, but the problems are likely to be intertwined within that individual. The focus on substance misuse and mental health problems may mean that other areas of concern are missed such as history of childhood sexual abuse, housing issues, or child protection issues.

2. Those labelled as having dual diagnosis are a very **mixed group**. For example, someone with a bipolar disorder who is also alcohol dependent will have very different treatment needs compared with someone who has schizophrenia and smokes cannabis a few times per week. People also differ in level of motivation or “readiness to change”. Different approaches will be required for someone who does not recognise their use of drugs to be a problem compared with a person who has made changes and wants help to maintain them. Questions have been raised concerning the usefulness of grouping very different cases together under a single label.
3. There are numerous **different operational definitions** of dual diagnosis used in different clinical and social settings, which may complicate and confuse communication.
4. Mental disorder and substance misuse sit on separate dimensions each with its own **continuum of severity** from mild to severe levels. At what point does an individual cross a threshold on each of these dimensions to be considered as having a dual diagnosis? These thresholds will be partly determined by existing beliefs about the benefit of therapeutic input, what constitutes harmful substance misuse, and what is meant by mental disorder.
5. The label of having dual diagnosis itself can lead to the individual experiencing **prejudice and stigma**, and may even act as a barrier to care.

These difficulties raise the question of what definition and terminology to use in this manual. While acknowledging all these problems inherent in the term and concept of dual diagnosis we have chosen to use this term as a shorthand for those with **co-existing problems of mental disorder and substance misuse (which includes both drugs and alcohol)**. Our main reasons are that this is the term that is most commonly used in practice and that spelling out “those with co-existing problems of mental disorder and substance misuse (which includes drugs and alcohol)” is more than a little clumsy and would compromise the readability of the text.

We will not be focussing on people with personality disorder or people with learning disabilities, who do not have other mental disorders. People with personality disorder are at high risk of substance misuse and are at greater risk of mental illness. They also have difficulty in forming trusting and supporting relationships. This makes working with them a particular challenge. The

specific issues raised by these conditions when they co-exist with substance misuse disorders are beyond the scope of this work. However, much of its content will be of relevance to these groups.

In each local area, health, social care, housing, criminal justice and voluntary sector agencies need to consider how they operationally use the term dual diagnosis, to identify service roles and capacity, and to ensure that it is not used to exclude people from getting the help they need.

Why is there concern about this group?

Despite being perceived as a difficult to manage group, and perhaps untreatable, those with dual diagnosis are a needy and vulnerable group. Although the exact nature of the interaction will vary, people with dual diagnosis, compared to people with mental disorder alone, seem to have a worse prognosis, with high levels of service use and particularly heavy use of expensive resources such as emergency services and inpatient beds (where they typically spend twice as long). More effective ways of managing people with dual diagnosis therefore have the potential to reduce crises and to be more cost effective. In addition, when compared with people who have a mental health problem alone, people with dual diagnosis are more likely to have:

- Increased likelihood of suicide
- More severe mental health problems
- Homelessness and unstable housing
- Increased risk of being violent
- Increased risk of victimisation
- More contact with the criminal justice system
- Family problems
- History of childhood abuse (sexual/physical)
- More likely to slip through net of care
- Less likely to be compliant with medication and other treatment.

How common is dual diagnosis?

In the past 20 years there has been an increasing recognition of the high level of dual diagnosis in mental health service populations across the world (Table 1). This may be due to an increase in drug consumption in the general population or increased recognition of the co-existence of mental

disorder and substance misuse disorder. If you do not ask the questions you cannot gain the information. In the UK it is estimated that approximately one third of psychiatric patients with serious mental illness have a substance misuse problem. In drug and alcohol services approximately a half of clients also have some form of mental health problem (most commonly depression or personality disorder). There are consistent reports of increased prevalence in forensic mental health services and inpatient psychiatric units.

Table 1: Prevalence of dual diagnosis

Authors	Date	Country and location	Population investigated	Lifetime rate of substance use problems	Current rate of substance use problems
Drake&Wallach	1989	USA, community mental health centre	Chronic mental health problems		32%
Regier et al	1990	USA	Households those diagnosed with schizophrenia		47%
Barbee	1989	USA emergency mental health service	All patients		47%
Duke	1994	UK, outpatient clinic	Schizophrenia and alcohol	22%	
Menezes	1996	UK Inner city Mental hospital	Psychosis	32%	36.6%
Fowler	1998	Australia, psychiatric outpatients	Schizophrenia	27%	60%
Scott	1999	UK Suburban Community mental health service	Psychosis		
Cantwell	1999	UK Early onset service	Psychosis		37% 20% drugs 12% alcohol
Wright	2000	UK Suburban Community mental health service	Psychosis	33%	13%

It appears that working with people who have dual diagnosis is now part of routine work in any field of mental health and social care as well as drug use services. Therefore everyone needs to be equipped to identify, assess and help those with dual diagnosis.

Why is it so common?

Aetiological theories

It is clear that mental illness is a risk factor for developing drug problems, and likewise, drug problems are a risk factor for mental health problems. Therefore there are a number of aetiological

pathways, which could lead to an individual having dual diagnosis. Given the clinical heterogeneity of the population of people with dual diagnosis the pattern of causation will vary between and within the different subgroups of people with dual diagnosis.

Does having a mental health problem lead to substance misuse?

Three theories seek to explain how having a mental illness could precipitate and perpetuate substance use; these are the self-medication, social vulnerability and coping strategy theories:

Self-medication

- For psychiatric symptoms (e.g. use of amphetamines to alleviate low mood as a result of negative symptoms of psychosis)
- To counter the side-effects of medication (e.g. use of cannabis as a way of combating muscle stiffness experienced by those taking anti-psychotic medication, or use of stimulants such as caffeine and nicotine to counteract sedation caused by high doses of anti-psychotics).

However, when patterns of substance use are investigated there seems to be little relationship between the use of particular drugs and specific symptoms. There are reports that some people actually reduce drug intake during periods of worsening mental state.

Social vulnerability

The indirect consequences of experiencing mental health difficulties could lead to substance use. One possibility is that people with mental health problems are introduced to drugs and alcohol by people who also attend mental health services or live in the same neighbourhood. People with mental health problems have low levels of social support and often lose touch with family and friends. They become very socially isolated. Therefore being accepted is particularly important and it may be that use of drugs and alcohol maintains their sense of belonging to a group of other similar people facing similar problems.

Substance use as a coping strategy

Drugs and alcohol may be used as a way of coping with experiences directly due to mental disorder or its consequences. The person with mental disorder may believe that substance use helps dealing with

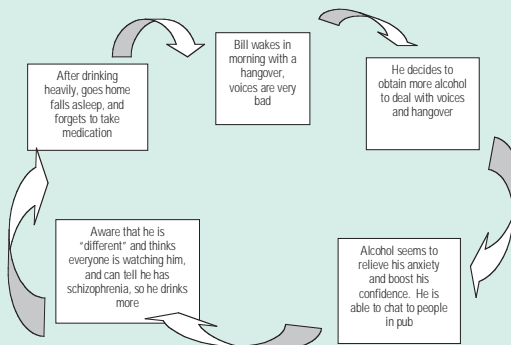
symptoms such as social anxiety and persecutory beliefs or painful memories, stress, and boredom.

Does using substances lead to mental health problems?

Heavy and long-term use of drugs can result in physical and mental health problems. All psychoactive substances have effects that mimic or exacerbate psychiatric symptoms. Long term alcohol consumption produces a depressant effect on mood that can be very difficult to distinguish from clinical depression. The after-effects (comedown or hangover) of substances may also have a powerful effect on mental state. Alcohol withdrawal can precipitate confusion, extreme anxiety and psychosis. Amphetamine use can lead to symptoms, which can be very similar to schizophrenia. Stopping the use of amphetamine can lead to depression and in some cases, suicide. However, in most cases these effects are usually transient, lasting a few hours and very rarely more than a few days.

It is a possibility that those who experience long-term psychiatric effects from using drugs and alcohol have an underlying vulnerability to mental disorder, which is precipitated by substance use. This is likely to explain at least in part the observed association between drug use and first episode and relapse of mental disorder. It has also been suggested that some people with severe mental health problems are “supersensitive” to the effects of illicit drugs, so that relatively small amounts can have a powerful effect. Taking the evidence as a whole, substance use may well exacerbate existing mental disorder or trigger a first episode of mental health problems but is unlikely to be the sole cause, except of intoxication or brain damage as in alcohol related cognitive impairment (see Figure 1).

Figure 1: Illustration of the relationship of drug use and mental disorder



Is there an underlying factor that leads to both substance use and mental disorder in people with dual diagnosis?

There are clear specific genetic (inherited) and environmental (acquired) risk factors for the development of individual mental disorders. Similarly there are well-defined genetic and environmental factors (e.g. *in utero* effects of mother's drug use or learned response to stress as a result of observing parental behaviour) which are associated with addictive behaviours. This will account for the finding of a positive family history for mental disorder and/or substance misuse in those with dual diagnosis. But it is much less clear whether there are underlying factors that may account for the co-existence of mental disorder and substance misuse. Past traumatic events are associated with the development of mental disorder and substance use disorders; the prevalence of past sexual abuse is high in people who seek help for mental health problems and among those who are using drugs in a harmful way. The prevalence of past sexual abuse in people with dual diagnosis may be particularly high with up to a half of women with dual diagnosis reporting some experience of sexual abuse. It is important to make the distinction between association and causation in that the fact that a factor frequently occurs in a particular disorder does not mean that that factor causes the disorder. However, whatever its role in the aetiology of dual diagnosis, the high prevalence of sexual abuse makes clear the need to consider whether therapeutic work on sexual behaviour and relationships may be helpful. Issues of sexually transmitted diseases may need to be considered as well as providing advice on safer sex and drug use.

Barriers to provision of effective services

Service and professional responsibilities

Mental health services have undergone a shift in the last ten years with an increasing focus on people with severe and enduring mental illnesses such as schizophrenia and bipolar affective disorder. This appears to have been prompted by the finding that those with severe mental health problems, with multiple treatment needs and lacking motivation to take up treatments, were not receiving the treatment they needed. Mental health services have also developed a commitment to take on longer-term work with the mentally ill. The Mental Health Act 1983 can be used to admit to hospital those with mental disorder who are a risk to themselves or others for the purposes of assessment and treatment. Alternatives to admission may include referral to an assertive outreach team (if such a service is locally available), which can work intensively with that person in their own environment. People with severe mental illness are often kept under review by clinical teams where risk is a concern, even when they do not wish to receive a service.

In contrast substance misuse teams primarily focus on people with severe and dependent use of alcohol and drugs (typically opiates). Individuals are expected to take most of the responsibility for seeking help and maintaining their position in treatment. If someone lacks motivation to change, and does not see the need for help around their drug use, then they will generally not continue to be actively followed up by substance use services. The balance of responsibility expected of the person is therefore different between mental health and substance misuse services, and this may produce obstacles to effective joint working with those with dual diagnosis.

Attribution of primary problem

As each service, either mental health or substance use, tends to focus on specific groups as identified in national and local policy, it is often the case that those making initial assessments spend time trying to decide whether mental health problems are primary or a result of drug use. Attribution will depend on the knowledge and experience of the assessor, and the method of assessment. One concern is that staff from mental health services may be more likely to attribute presenting problems to substance use and vice versa so shifting responsibility for the case from themselves to the other service.

Training and confidence of staff to deal with dual diagnosis

Staff in mental health services (doctors, nurses, social workers, occupational therapists, psychologists etc) typically have little or no formal training in harmful substance use. This lack of knowledge can feed into and compound the unhelpful attitudes about drug and alcohol users commonly found in the general population. Therefore when a mental health client discloses problematic drug use it may cause some anxiety and perhaps reluctance to provide care. Conversely, substance misuse services may wrongly assume that drug users with mental health problems will take personal responsibility for their treatment. There is an instinct to refer service users to a service perceived as more competent to deal with unfamiliar issues. This may be seen as removing the need to formulate immediate treatment plans or intervening in the condition. There may also be misconceptions about what each service can offer and where their priorities lie. In addition where a person with dual diagnosis is not ready actually to reduce or stop, they may be quite resistant to a referral to substance misuse services. This may lead to the possibility that the person may be assessed as an inappropriate referral by both mental health and drug services leading to the individual receiving no active care.

Ways forward

- Acceptance that dual diagnosis is part of mainstream work, not a specialist area.
- Creation of clear roles and agreed responsibilities across key service providers.
- Provision of cross training between local services to enhance multi-agency relationships and share expertise.
- Provision of training to meet the specific needs of groups of professionals e.g. mental health awareness for drug workers; drug awareness for mental health staff; issues concerning the management of intoxication and withdrawal for police; child protection issues for mental health staff.
- Creative use of limited resources to meet the needs of this client group. This may include joint working between agencies.
- Acceptance that clients have different levels of motivation and willingness by services to adapt approaches and treatment options as appropriate.

Summary

- People with dual diagnosis are a highly vulnerable group who often fail to receive appropriate care.
- This is in part to do with the separate nature and ethos of services involved in the management and care of this group.
- Mental health services prioritise those with serious and enduring mental health problems (excluding those with primary substance use problems).
- Substance use services prioritise people with severe drug (often opiate) and alcohol problems (usually dependent use). This is likely to exclude those with sporadic use of other substances such as stimulants and cannabis.
- Different service priorities determine different processes of assessment, which can lead to disagreements about what is the primary or the main problem.
- Mental health services acknowledge a duty to provide long term care for people with serious mental health problems, sometimes in the absence of consent.
- Substance use services expect a desire and motivation for change in drug or alcohol using behaviour. If someone does not want treatment, there is no compulsion or expectation that services should follow him or her up.

SECTION 2 - Practice and Policy Issues

This is a vignette describing six views of the same scenario, touching on the complexity of service provision for people who have mental health and substance use problems. What is going wrong here and what should be done?

Police: We are called to an incident, and we find someone clearly disturbed, intoxicated with alcohol and threatening to kill themselves. We have no choice but to take them to the psychiatric hospital as a place of safety. The staff never seem too happy to see the same man over and over again, but what other option do we have? We just don't feel competent to manage this kind of situation in the cells. Mentally ill people should be locked up in hospital. They need treatment.

Psychiatric hospital ward staff: We're getting fed up of seeing this man coming in drunk and hostile. He always abuses us. The police just seem to dump him on us, and leave us to pick up the pieces. He sobers up and then won't stay in hospital. We can't section him. I don't think he has a true mental illness; he just gets symptoms when he drinks. Why can't the police sober him up in the cells then pass him on to the alcohol service?

Psychiatrist: This man clearly has a major alcohol problem, which the alcohol services need to deal with. We haven't the resources or the skills to deal with substance misusers as well as all the mentally ill population of this area. The services are already over-stretched as it is. We have decided that he is not to be admitted unless I authorise it. I have written to William to inform him of this. I strongly advised him to accept he has an alcohol problem and deal with it. I am certainly not wasting a community psychiatric nurse's time following up this man who doesn't show any signs of wanting to help himself.

Alcohol service: We keep getting calls from the staff from the psychiatric hospital about a man who drinks heavily and has psychotic episodes. We have offered countless appointments, which he never keeps. We can't offer any more to him unless he accepts he has a problem and is prepared to engage in treatment. We certainly haven't got the resources to chase up a man who doesn't want help. I wouldn't be happy to see someone

who experiences psychotic symptoms and is suicidal unless the mental health services were also involved.

Housing worker: I see William regularly maybe once or twice a week. We get on very well, and he tells me a lot about how he's feeling and what he's experiencing. This does concern me and I have rang the local psychiatric service to tell them my concerns. They never seem to do anything though. A community psychiatric nurse used to come and see him at home now and again, but they have stopped as the service feels that his main problem is alcohol. I'm anxious as I'm the only person he has any contact with, and I don't know who to turn to help me in this matter.

William: My life is a complete mess; I know my drinking is out of control, but it's all I have now. I have such horrible stuff going on. The man who abused me is almost constantly shouting in my ears, telling me how useless I am and how I should be dead. I try to fight it, but I can't handle it; sometimes I just want to die. I have tried to kill myself loads of times with pills and stuff, but it never seems to work. Drinking is the only thing that keeps it all at bay. Sometimes the pressure gets so bad I explode. I keep getting dragged to hospital by the police. The staff are horrible to me. They don't want to know; all they care about is the drink. I've told them I don't want to go to the alcohol service. I'm not an "alcoholic". I need someone to talk to. I get wound up when they don't listen and I blow my top. I just have to leave. Nothing has ever worked and I reckon things will just get worse. The only person who listens is my housing worker, but he's only young and I think he gets a bit upset when I tell him stuff about my life. I thought that services were there to help people like me. Now the psychiatric services have written a letter saying I haven't got mental health problems so I can't keep going into hospital. Perhaps nothing can be done.

Diagnosis and primacy of problem

Services often argue about the primary problem of someone with co-occurring mental health and drug/alcohol problems. This is likely to be futile, because in the majority of cases, it is not possible to decide without doubt that one problem is a direct consequence of the other. Services may have conflicting views on what constitutes "dual diagnosis". Services and teams are set up to work with a specific group (e.g. psychiatric services to provide a service to those with severe

and enduring mental illness; substance misuse services to provide a service for those with chronic and complex substance use problems) and so will have different priorities. Their assessment processes in part serve to identify if the person meets the service's inclusion and exclusion criteria. A shift to focusing on the person's own perspective of problems and presenting features, and identification of needs may assist in concentrating responses not on who is responsible for the patient but more on what care package best meets the range of needs identified.

Some of the challenges facing clinical services and staff are described below, with each challenge raising a question. These questions can be used to prompt and structure further discussion within individual teams or across different teams or services, to help develop a framework for local response.

Lack of knowledge, confidence and skills

Staff generally agree, wherever they work and whatever their role, that they do not have the knowledge, skills and confidence to deal with dual diagnosis. They say they need someone with "more expertise". People with dual diagnosis can cause a great deal of anxiety for staff who want to help, but who are not clear about what their role should be or what constitutes good practice. Should all staff be competent to work with dual diagnosis or should specialist services be developed to work specifically with this group?

Communication

It has been highlighted that inadequate communication between services is a factor in serious incidents and poor risk management. Given the co-existence of mental disorder and substance misuse needs in those with dual diagnosis, how can interagency communication be improved?

Risk

People with co-occurring problems represent a group at high risk of self-harm, harm to others and neglect. Continuing assessment of risks and effective management of those risks needs to occur. In order to do this effectively, services must have a clear idea of roles and responsibilities, and efforts must be made to engage and maintain contact with the person. How can risk be managed for this group?

Engagement

People with dual diagnosis can be difficult to engage for a number of reasons. They may have experienced judgmental or unhelpful attitudes from staff, they may not wish to stop using substances at this point in time, they may not identify themselves with mental health or addictions services, and they may have fears around the consequences for them of being in contact with services. These fears may include being detained, interference with their role in childcare, or being arrested. Engagement and co-operation are crucial for the success of any intervention. In what way can services adapt to improve engagement?

The way forward.

The National Service Framework for Mental Health clearly identifies those with dual diagnosis as a vulnerable population whose needs must be addressed and who should not be denied access to care. It is clear that many services as they currently stand are not working effectively to reduce the impact of co-existing problems for both the individuals affected and services. How can we resolve the issues (and questions) identified above? This manual is intended to give information with which to help address these issues and questions. What happens in your service depends on the needs of the local population, the configuration of local services and on you.

Services often operate on the basis of inherited traditions and myths, which can be powerful enough to prevent the development of more appropriate services. Some common myths around dual diagnosis are listed below. A potentially useful exercise is to list the beliefs about people with dual diagnosis held by your service and compare yours with the ones listed.

Myths around dual diagnosis

Drug use is a direct cause of long term mental health problems

There is little evidence that drug use alone causes long-term mental health problems. Taking the evidence as a whole, substance use may well exacerbate existing mental disorder or trigger a first episode of mental health problems but is unlikely to be the sole cause, except of intoxication or of alcohol related brain damage and cognitive impairment. Alcohol and drug use can certainly make mental disorder more difficult to manage.

People with dual diagnosis bring on all their problems because of their substance misuse

It is more complex than this. Sometimes substance misuse is a consequence of other difficulties relating to mental health problems. Therefore removal of the substance does not always resolve all the problems. In some cases it can even make things worse if people have not developed other coping mechanisms and support.

If they stopped using drugs then all their symptoms of mental disorder would remit

For many people, the mental health problem is likely to be enduring and long term. Stopping drug use may improve prognosis, but not necessarily lead to cessation of symptoms.

People have to “hit rock-bottom” before they will change their substance use. Without this therapeutic interventions will not make a difference

People with dual diagnosis can work on important areas of their life without reaching “rock-bottom”. For people with long term mental health problems, reaching this point may only exacerbate hopelessness and can make change less likely.

It is impossible to assess and work with someone therapeutically if they use substances

People who are intoxicated may be in a clearer mental state than someone who is undergoing withdrawal. There is no reason to discount the benefits of working therapeutically with someone whilst they are still using. It may be that they are more comfortable in expressing themselves whilst using.

People who use substances will lie and manipulate to get what they want from treatment

People will say what is expected of them in order to get access to services. This may mean that a service that aims at abstinence may inadvertently encourage service users to say that this is what they want even when it might not be. Likewise people will lie about their drug use if they fear the consequences of such a disclosure.

There is no point in wasting money on someone who will just relapse

Relapse is a normal part of the change process for any health behaviour. However, each attempt at change may well reap some short, medium and long-term benefits. People with dual diagnosis should not be excluded per se from getting an assessment for housing support or rehabilitation. Decisions should be based on assessment of each individual with supporting information from all agencies concerned.

It is important for someone with dual diagnosis to accept that they are an addict before they can benefit from treatment

Labelling is not associated with positive outcomes; i.e. it is not a requirement in the process of change to accept this label. For some people it is helpful to adopt this. For people who already have a stigmatising label of "mentally ill" a further label may be of more harm than good to that person's sense of self and self-esteem.

Small amounts of cannabis will make little difference to someone with schizophrenia

People with serious mental health problems such as schizophrenia are often highly sensitive to small amounts of psychoactive substances. Therefore small amounts of cannabis can have a huge impact on their wellbeing. However not all people will react in the same way. This needs to be considered on an individual basis.

It is not possible to work therapeutically with people who are on prescribed medication for mental disorder

There is no good evidence that taking antidepressants or anti-psychotics gets in the way of any form of psychotherapeutic work. In fact adequate pharmacological treatment of mental disorder may be needed in order to enable people to engage in and benefit from therapy. Withdrawing these medications may lead to relapse.

The current policy context in relation to dual diagnosis in the United Kingdom

Meeting the needs of those with dual diagnosis is explicitly a national policy priority. This agenda is set out in the following documents:

- 'Personal Social Services' White Paper and 'Performance Assessment Framework',
- 'Modernising Mental Health Services',
- 'Mental Health National Service Framework',
- and the developing agenda of the 'Drugs Strategy' implementation.

The issues raised in the 'Mental Health National Service Framework' are an example of the policy guidance, this includes:

"Specialist services, including social care, should ensure effective and timely

interventions for individuals whose mental health problems cannot be managed in primary care alone, for example, patients with severe depression or psychotic disorders. Specialist services are essential when these problems coexist with substance misuse - co-morbidity or dual diagnosis.”

A number of key areas are raised that relate to those individuals with dual diagnosis:

- The importance of ‘evidence-based interventions’
- Addressing ‘self-harm interventions’
- Proper ‘assessment’ - that should cover co-morbidity
- Use of the Care Programme Approach - this equally applies to people with dual diagnosis in mental health and drug and alcohol services
- Importance of attending to ‘engagement’ including those with co-morbidity
- ‘Assertive Outreach Services’ - will deal with some of those with dual diagnosis
- ‘Crisis resolution’ - dual diagnosis will present particular challenges and opportunities

In December 1997 the Department of Health set up a dual diagnosis steering group to develop policy on ‘dual diagnosis’ in the context of the Department of Health’s National Service Framework for Mental Health. Policy contributions from this group and an expert seminar in 1998 have significantly influenced policy development since then. Targeted funding was made available for service developments and a mapping exercise. These were evaluated by the Sainsbury Centre for Mental Health and Alcohol Concern respectively and have contributed further to inform policy development. The direction of policy is to include responsibility for addressing the needs of those with dual diagnosis (in particular those with severe mental illness) within mainstream mental health services, whilst recognising the role specialist substance use services may play in this and recognising that such specialist services also need to respond to the needs of those with dual diagnosis within their care. This mainstream approach is seen as key to responding to the level of need presenting in mainstream mental health services.

The task of taking this policy direction forward is being supported by the Department of Health’s Dual Diagnosis Steering Group, which is now working under the auspices of the Serious Mental

Illness Project in the Department of Health, reporting to the Mental Health Task Force. Current Department of Health funded policy research will contribute to improving the evidence base and assist in service and policy development. Four current projects are:

- A National Epidemiological Study of Dually Diagnosed Substance Misuse and Psychiatric Disorders between 1993 and 1998 using the General Practice Research Database - led by Martin Frischer, Keele University.
- Co-morbidity in the National Psychiatric Morbidity Surveys - led by Francis Keaney, National Addiction Centre.
- Co-morbidity of Substance Misuse and Mental Health Problems: a Study of the Prevalence and Patterns of Co-morbidity and the Need for Services Amongst Treatment Populations - led by Tim Weaver, Imperial College.
- Dual diagnosis in a Primary Care Group: A Step-by-Step Epidemiological Needs Assessment and Design of a Training and Service Response - led by Dr Geraldine Strathdee, Oxleas NHS Trust.

It is anticipated that there will be further guidance - expanding on the current available guidance - on ways to enhance working with this varied group of individuals. Advice to the general mental health field needs to be consistent with guidance to those working in the drug and alcohol field. The Dual Diagnosis Steering Group has wide representation in order to be able to ensure these issues can be addressed to support high quality development in all areas. The key principles asserting the priority of this issue are the importance of working with individuals in response to their needs and the importance of 'working together'; these have been developed in the policy documents above. It seems likely these considerations will continue to underpin future policy development.

The National Treatment Agency, a Special Health Authority from April 2001, has responsibility for guidance on treatment for the drug sector and hence its activity will also have relevance to this area. The production of this manual (and the associated literature review of the current evidence concerning dual diagnosis) is a part of these developments in this area and has been supported by the Department of Health.

SECTION 3 - Ethical Issues & Mental Health Act

Learning Objectives:

- To be aware of common ethical problems when working with people with a dual diagnosis.
- To be aware of the role of the Misuse of Drugs Act in providing care for people with dual diagnosis.
- To be aware of the role of the 1983 Mental Health Act in the care and treatment of people with mental disorder.
- To understand professional roles in conducting Mental Health Act assessments.
- To understand the grounds for compulsory detention under the Mental Health Act.

Legal aspects of drug use

The main legislation affecting someone using illegal drugs is the Misuse of Drugs Act, 1971. It places drugs into three Classes, which determine the maximum penalties for offences relating to a drug in that Class. For most drug users, the offences they are most likely to be charged with are 'possession' and 'possession with intent to supply'. Cultivation of cannabis is also an offence.

Table 2: Summary of the Classes of the Misuse of Drugs Act, 1971

Class	Main drugs in each class	Maximum penalties for possession	Maximum penalties for possession with intent to supply
A	Heroin, cocaine (and crack cocaine): ecstasy, LSD, methadone, morphine, opium, dipipanone, pethidine, derivatives of cannabis including cannabinal. Class B drugs when prepared for injection become Class A.	Six months or a fine of £5,000 or both (in a magistrate's court) Or, in a trial by jury Seven years or an unlimited fine or both	Six months or a fine of £5,000 or both (in a magistrate's court) Or, in a trial by jury Life or an unlimited fine or both.
B	Amphetamines, barbiturates, cannabis ¹ (herbal and resin), codeine, dihydrocodeine and methylamphetamine.	Three months or a fine of £2,500 or both (in a magistrate's court) Or, in a trial by jury Five years or an unlimited fine or both.	Six months or a fine or of £5,000 or both (in a magistrate's court) Or, in a trial by jury 14 years or an unlimited fine or both.
C	Benzodiazepines, buprenorphine, diethylpropion, anabolic steroids	Three months or a fine of £1000 or both (in a magistrate's court) Or in a trial by jury Two years or an unlimited fine or both.	Three months or a fine of £2,500 or both (in a magistrate's court) Or, in a trial by jury 5 years or an unlimited fine or both.

1 Cultivation of the cannabis plant carries a maximum penalty of six months or a fine of £5,000 or both in a magistrate's court, or in a trial by jury, 14 years or an unlimited fine or both.

Drugs are sometimes described as being of Schedule 1, 2, 3, 4 or 5. This relates to the Misuse of Drugs Regulations, 1985, which mainly concerns their medical use. It ensures that drugs prepared for medical use are exempt from certain aspects of the 'Misuse of Drugs Act'.

Table 3: Summary of Schedules of the Misuse of Drugs Regulations, 1985

Schedule	Main drugs included	Restrictions
1	LSD, ecstasy, raw opium, psilocin, cannabis (herbal and resin).	Import, export, production, possession and supply only permitted under Home Office licence for medical or scientific research. Cannot be prescribed by doctors or dispensed by pharmacists.
2	Heroin, cocaine, methadone, morphine, amphetamine, dexamphetamine, pethidine and quinalbarbitone.	May be prescribed and lawfully supplied and possessed when on prescription. Otherwise, supply, possession, import, export and production are offences except under licence. Particular controls on their prescription, storage and record keeping apply.
3	Barbiturates, temazepam, buprenorphine, pentazocine and diethylpropion	These drugs which can only be possessed lawfully by a person with a prescription containing the name and address of the prescriber. Temazepam prescription requirements are less stringent than for the other drugs in this Schedule.
4	Benzodiazepines (except temazepam), pemoline and anabolic steroids.	May be lawfully possessed by anyone, even without a prescription, provided they are in the form of medicinal products.
5	Compound preparations such as cough mixtures which contain small amounts of controlled drugs such as morphine. Some may be sold over-the-counter.	Authority needed for their production or supply but can be freely imported, exported or possessed (without a prescription).

In this chapter there are three scenarios presented to illustrate some of the general and specific ethical and legal issues in managing people with dual diagnosis. The questions posed can be used to generate discussion or considered while reading the chapter.

Scenario 1: You are the care co-ordinator for three people admitted on a psychiatric ward. All three people have been selling and using non-prescribed substances. One of them is an informal patient and two of them are detained under the Mental Health Act. Each has relatives that bring them substances. Other patients on the ward and some staff ask you what you are going to do about it. What do you do? If you discharge them they will become more ill. Do you treat the detained people any differently from the voluntarily admitted people? Is it alright not to discharge them and do nothing?

Drug dealing on premises

One provision of the Misuse of Drugs Act that has recently become particularly relevant to people working with drug users is Section 8. This makes it an offence for someone concerned with the management of premises knowingly to permit or suffer those premises to be used for the supply of any controlled drug or smoking of cannabis. Section 8 has recently (May 2001) been extended so that a person concerned with the management of premises, on which any controlled drug is taken, and not just dealt, can be culpable. However, the Government has agreed not to put into force this change until after a consultation with services likely to be affected and will be producing guidance regarding its implementation.

Because of the Wintercomfort trial, where two charity workers were imprisoned following drug dealing in the Cambridge homeless drop-in centre for which they were responsible, the organisation *Release* has produced a 'Section 8 Card' which provides guidance on dealing with drug-related incidents on premises. This is available on their website www.release.org.uk. *Release* has also published more detailed guidance entitled *Room For Drugs: Drug Use On Premises: Guidelines For Direct Access Services* (Flemen, 1999). The report provides practical information and advice to providers of direct access services to help in addressing the multiple needs of homeless young people who use drugs. It is directly relevant to night-shelters, hostels and day care centres.

Substance misuse and driving

Particular restrictions apply to patients using alcohol and illicit drugs or prescribed substitute drugs regarding their driving licences. With respect to alcohol misuse, persistent alcohol misuse confirmed by medical enquiry and/or by evidence of otherwise unexplained abnormal blood markers, requires licence revocation or refusal until a minimum six month period of controlled drinking or abstinence has been attained, with normalisation of blood parameters. Individuals are recommended to seek advice from medical or other sources during the period off the road. Alcohol dependency, confirmed by medical enquiry, requires licence revocation or refusal until a one-year period free from alcohol problems has been attained. Abstinence will normally be required, with normalisation of blood parameters, if relevant. Licence restoration will require satisfactory medical reports from the person's own doctor(s) and may require independent medical examination and blood tests, arranged by the Driver and Vehicle Licensing Authority (DVLA). Medical Consultant support and or referral may be necessary.

For cannabis, amphetamines, ecstasy, and other psychoactive substances including LSD and hallucinogens, the persistent use of or dependency on these substances, confirmed by medical enquiry, will lead to licence revocation or refusal until a six month period free of such use has been attained. Independent medical assessment and urine screen arranged by DVLA, may be required.

For heroin, morphine, methadone, and cocaine, persistent use of, or dependency on these substances, confirmed by medical enquiry, will lead to licence refusal or revocation for a minimum one year period free of such use has been attained. Independent medical assessment and urine screen arranged by the DVLA, may be required. In addition a favourable Medical Consultant or Specialist report may be required on reapplication. Applicants or drivers complying fully with a Medical Consultant supervised oral methadone maintenance programme may be licensed, subject to annual medical review and favourable assessment.

Further details can be obtained from the DVLA Drivers Medical Unit and from their website www.dvla.gov.uk.

Substance misuse on psychiatric wards

A full discussion of the ethical dilemmas around admissions to psychiatric wards and the use of drugs is beyond the scope of this publication. These issues are well discussed in Cohen et al (1999). In addition the Department of Health (DH) will be issuing specific guidance on this issue. A reference to this document will be placed on the DH website (www.drugs.gov.uk or via www.doh.gov.uk/drugs) on its release.

Scenario 2: A 22 year old woman with whom you are working because of her mental illness tells you that she is using a number of drugs. You realise that this may explain recent relapses. You want to help and feel she needs admission to hospital. Do drugs always make mental illness worse? Can people use drugs without affecting their illness? How can you help her? Does she need to be admitted to hospital against her will? Will she benefit?

The Mental Health Act & people with dual diagnosis

The misuse of alcohol or drugs is not considered to be a mental disorder within the current Mental Health Act in its own right and there are no grounds for detaining a person in hospital for the sole treatment of their alcohol or drug dependence. However, whilst 'dependence on alcohol or drugs' is excluded from the provisions of the Act this exclusion does not rule out the possibility of a person being detained on the grounds of a mental disorder arising from, or suspected to arise from, alcohol or drug dependence. In other words if a person is suffering from a mental disorder, which pre-exists, or is prompted by, the use of alcohol or drugs, he/she should be assessed in the usual way. Drug and alcohol use can contribute to both acute and chronic mental health problems.

As discussed in the previous chapter, associations between substance use and mental disorder are common. There are four groups of people who fall under the umbrella of dual diagnosis. The first is those who develop mental health problems and have a history of substance use which has a bearing on their clinical presentation. The second group includes those whose first episode or recurrence of mental disorder is precipitated by substance use. The third group is those whose mental disorder leads to substance use. Additionally, mental disorder may exist in parallel to substance use without having any causal interaction. For practitioners it is often necessary to acknowledge uncertainty between what is cause, what is effect, and what is coincidence.

People with a dual diagnosis tend to have complex needs (Hunt & Ashenurst, 2000). Relative to groups with just one of these problems in isolation, their difficulties with homelessness, unemployment, poor educational attainment, physical and sexual abuse and diminished social support, combined with physiopathological and neurological damage, are likely to be much greater.

Scenario 3: John, a 30 year old suffering from schizophrenia, becomes more ill when he uses drugs. He stops taking his prescribed medication and you are concerned about how unwell he is. He is frightening you and you are not sure what to do. When can you use the Mental Health Act and how do you do this?

Assessment under the Mental Health Act

There are a number of issues, which contribute to 'good practice' in assessing the person with a dual diagnosis under the Mental Health Act. Some of the main issues are discussed below.

The objectives of assessment under the Mental Health Act

Compulsory detention under the Mental Health Act is a serious action; it constitutes the removal of a person's civil liberty and excludes them from a range of activities, which a free person takes for granted. All those assessing for possible admission under the Act should ensure that:

- They take all relevant factors into account
- They consider, and where possible implement, appropriate alternatives to compulsory admission
- They comply with the legal requirements of the Act

Factors taken into account at assessment

In judging whether compulsory admission is appropriate, those concerned should consider not only the health and safety of the patient, but also:

- The patient's wishes and view of his or her own needs
- Social and cultural background
- The nature of the illness and substance misuse history
- What may be known about the patient by his or her 'nearest relative', any other relatives or friends and professionals involved, assessing in particular the reliability of this information
- Other forms of care or treatment including, where relevant, consideration of whether the patient would be willing to accept treatment in hospital informally or as an outpatient
- The needs of the patient's family or others with whom the patient lives
- The need for others to be protected from the patient
- The impact compulsory admission would have on the patient's life after discharge from detention
- The burden on those close to the patient of a decision *not* to admit under the Act

Ordinarily, only then should the applicant (in conjunction with the other professionals) judge whether the criteria stipulated in any of the admission Sections of the Mental Health Act are satisfied, and take the decision accordingly. In certain circumstances the urgency of the situation may curtail detailed consideration of all these factors.

Protection of others

In considering the 'protection of other persons' it is essential to assess both the nature and likelihood of risk and what level of risk others are entitled to be protected from, taking into account:

- Reliable evidence of risk to others
- Any relevant details of the patient's medical history and past behaviour including criminal history
- The degree of risk and its nature (too high a risk of physical harm, or serious persistent psychological harm to others, are indicators of the need for compulsory admission)
- The willingness and ability to cope with the risk, by those with whom the patient lives
- Consider also the effect of detention on dependants (eg children, elderly parents, vulnerable adults). These groups may be at risk if the person is not detained, but may also be at risk if the person to be detained is an essential carer.

Scenario 3 continued: You talk to his local mental health team. They say they can not do anything until the John is more ill than he appears to them. What can you do?

Relapse and managing it

The assessment of a patient may legitimately involve consideration of future deterioration in mental health based on the known history of the individual's mental disorder. Those assessing the patient must consider:

- The reliability of such evidence
- The views of the patient and any relatives or friends living with the patient about his possible future deterioration
- The impact that any future deterioration would have on relatives/friends (especially those living with the patient) including an assessment of their ability and willingness to cope
- Whether there are other methods of coping with such deterioration

Scenario 3 continued:

John says he will not come into hospital. Then he changes his mind. This happens several times. Can John consent to informal admission? The mental health team of a social worker, a doctor and a nurse keep discussing it. How can this be resolved?

Consent to medical treatment

Consent is the voluntary and continuing permission of the patient to receive a particular treatment based on adequate knowledge of the purpose, nature, likely effects and risks of that treatment including the likelihood of its success. Competent adults who are not acting under duress are assumed to be giving their consent. Permission given under unreasonable pressure is not consent. In some circumstances the law allows action to be taken which dispenses with the right of the person concerned to refuse that action.

The fact that a person is suffering from a mental disorder does not mean that he or she is incapable of giving consent. Mentally ill people are capable of making informed decisions; even when very ill and the ability to consent is impaired, they still retain the right to be consulted and to be involved in decisions which affect their welfare. Mental vulnerability often increases the likelihood of things being done to rather than by the person. The consent issue tends to be particularly complex around those with a disorder, which is not stable - where the illness fluctuates and symptoms differ from day to day.

Those compulsorily detained in psychiatric hospital are at a higher risk of being treated against their will since this may be the reason for detention under the Mental Health Act. It is particularly important when treating a detained patient to ensure that they are consulted about treatment alternatives *as far as practicable and possible*. The person still has the right to receive information, to be consulted and to be a part of the decision making process about their care and treatment. It is the duty of those proposing to give treatment to use reasonable care and skill, not only in giving information prior to seeking a patient's consent but also in meeting the continuing obligation to provide the patient with adequate information as treatment progresses or changes.

In hospitals, when working with those with behavioural problems detained under the Mental Health Act, patients may require medication to be given against their will. Whilst there are

occasions when it will be necessary to give someone a drug against their will, consent should still be sought.

What to do if someone with a dual diagnosis needs an assessment under the Act?

- If a decision is required as to whether a person with a dual diagnosis needs to be admitted to hospital for assessment or treatment the first port of call will be the person themselves. They may be willing to be admitted to hospital informally especially if they are able to discuss this with a trusted professional. *Try and involve the person with the dual diagnosis at all times.*
- If concern remains and the person refuses admission then a Mental Health Act assessment may need to be arranged.
- The 'nearest relative' may also request an assessment. *Who is the nearest relative?* The relative living with patient or normally caring for the patient qualifies as the nearest relative. If this applies to more than one person or no one qualifies then the following list applies. It is presented in order of dominance and the older of a pair comes first eg if a mother is older than a father, the mother is the nearest relative. Those under 18 years of age are excluded. The Approved Social Worker (ASW) needs to find out if any of the following are alive and normally resident in the United Kingdom, Channel Islands or Isle of Man: husband and wife unless permanently separated; son or daughter; father or mother; brother or sister; grandparent; uncle or aunt; nephew or niece; anyone else with whom the person has ordinarily resided for five years.
- The request for an assessment under the Mental Health Act will usually need to be made to the local Social Services Department. The Social Services Department in partnership with two doctors must then either assess the patient's mental state or respond in writing outlining why they do not consider it necessary. If there is an assessment, the authorities may not detain a patient if he or she does not warrant this.
- If concerns remain and the person cannot be persuaded to seek help despite the above actions having been taken, there is little else to be done legally. It is

important that there is on-going encouragement for the individual to engage in treatment and for the situation to be discussed and reviewed by the multi-disciplinary team involved. The situation may deteriorate or risks may become clearer in which case a further assessment for admission under the Mental Health Act can be convened.

- If someone is vulnerable and at risk of violence or abuse by the person with dual diagnosis and they are unable to access help via the Mental Health Act, it may be appropriate for the police to be involved or seek protection for any vulnerable individual or children to be sought elsewhere. The Police and local Social Services Department will be able to advise on this.

Informal admission

Where admission to hospital is considered necessary and the patient is willing to be admitted informally this should, in general, be arranged. Compulsory admission should, however, be considered where the patient's current mental state or reliable evidence of past experience, indicates a strong likelihood that he or she will change his or her mind about informal admission prior to the actual admission to hospital with a foreseeable risk to the individual's health and/or safety or risk to others.

The process of compulsory assessment

In addition to the patient, there are two key roles involved in the process of assessment under the Act the 'applicant' and the doctor(s). There are two people who can 'apply' - or take forward - an assessment; they are the ASW and the 'nearest relative'. Doctors 'recommend', on the basis of their medical opinion, whether a person with a mental disorder should be admitted on a compulsory basis and the ASW or 'nearest relative' then 'applies' for the admission.

Whilst the law allows for the nearest relative to hold the right of application, good practice recommends that wherever possible an ASW should apply for compulsory detention. This avoids family conflict and ensures that the patient's rights are fully attended to.

For more detailed descriptions and discussion of the Mental Health Act 1983 readers are referred

to the Code of Practice (Brown, 1987; DHSS, 1989; DHWO, 1990). Jones (1990) has also produced a detailed manual of the Mental Health Act.

The Mental Health Act is currently being reviewed and so the procedures mentioned above are likely to change. Details of the proposed reforms to the Mental Health Act can be found on the DH websites: <http://www.doh.gov.uk/menhlthref.htm>; <http://www.doh.gov.uk/mentalhealth.htm>). One proposal is that substance dependence is no longer excluded from the Mental Health Act with the focus more on risks than diagnosis.

Summary

- There are ethical dilemmas facing professionals when they work with people with dual diagnosis
- Professionals must weigh up the needs of the individual, the public and other people whom they are supporting. This should be done irrespective of the agency within which they work
- The Mental Health Act may be used only when it is the least restrictive way of intervention and where there are risks to the health or safety of the individual to be detained, or risks to the public because of a mental health problem.
- The presence of substance misuse alone is not an indication for detention, unless there are signs of co-existent mental illness for which the usual criteria for detention must apply
- Doctors and Approved Social Workers have a legal role in the assessment of people who might be detained
- If uncertain, consult with someone who has knowledge of the Mental Health Act
- The Mental Health Act is under review. The existing exclusion of dependence on drugs and alcohol may be changed.

SECTION 4 - Assessment

Learning Objectives

- To understand challenges in the assessment of individuals with a dual diagnosis
- To understand the inter-relatedness of signs and symptoms of mental illness and substance use (intoxication or withdrawal)
- To understand the importance of maintaining an 'index of suspicion' when assessing individuals with severe and relapsing mental health problems
- To understand the factors that are important when assessing mental health status in individuals with dual diagnosis
- To understand the factors that are important when assessing substance use in individuals with a dual diagnosis
- To recognise the common psychiatric and medical emergencies that might arise among people with mental health problems who also use drugs in a harmful way

Introduction

Accurate assessment is fundamental to the effective management of people with dual diagnosis. The aim of a good assessment is to give the practitioner a clear picture about what is going on for that person and what is contributing to their distress. The assessment of people with a dual diagnosis can be a daunting process due to the sheer number of problem areas and treatment needs.

Mental health workers are accustomed specifically to assessing an individual's mental health history and mental state at first presentation to the service. The issue of substance use often only forms a small part of the team's intake assessment, and may only be considered if the substance misuse is overt. Conversely, a client's presentation at a substance misuse service, would imply that either the individual or someone with a link with them (for example, their family or the probation service), has identified that the person could have a problem with substance use. Workers in substance misuse services are highly skilled in the assessment of an individual's substance use, taking a drug and alcohol history, the impact of substance use on the individual's life and well-being and also the person's motivation to engage in treatment to change the substance using

behaviour. As part of the intake assessment, a mental health assessment should be completed. However, because this is not the primary focus of the assessment, it is possible for mental health problems not to be detected at the initial assessment and only to come to light after the individual has had a sustained level of contact and observation by the service.

For individuals with dual diagnosis neither of the above assessment techniques serves them particularly well. If assessment is to lead to meaningful treatment planning, monitoring or evaluation then the whole complexity of the individual's presentation needs to be assessed. The interaction between substance use and mental state is complex and will be unique to the individual. In order to gain an understanding of the precipitants of both or either, (mental state and drug), their inter-relationship and the difficulties posed by both needs to be investigated.

Challenges in the assessment of individuals with a dual diagnosis

Irrespective of service setting, clinicians generally find the assessment of individuals with dual diagnosis intimidating. A major problem is the difficulty in distinguishing the effects of drug or alcohol use on the individual's mental state from symptoms of a mental illness.

As mentioned before, clinicians often get caught up in the pursuit of using assessment to ascertain the 'primary problem'. This is seen as crucial to service delivery as drug services will generally screen out of their service individuals who display a primary mental health problem whilst mental health services will generally screen out individuals who present with a primary substance use problem. Assessment may therefore become focussed on the need to establish primacy rather than the pursuit of meeting the individual's needs.

Individuals with dual diagnosis may have difficulty accessing drug services whose entry requirements include evidence of 'substance dependence'. However, drug use without dependence can still be associated with marked disturbances of mental function. In such situations the individual may frequently not recognise their drug use as problematic, especially if they are only using the same or even less of the substance when they compare themselves to their peers. Thus drug use will probably be under-reported by such people during the assessment process and will not generally be readily linked to relapses in the individual's mental state. The interaction between substance use and mental state, particularly for people with severe and enduring mental disorder, is complex. Assessment should aim to cover as many domains as possible within both the

substance use and mental health arenas. Assumptions cannot be readily made about the direct causal effects of either the drug or the co-existing symptoms of mental illness. Assessment therefore needs to move beyond the ideas associated with primary and secondary diagnosis to encompass the range of biological, psychological and social needs.

The first hurdle in a comprehensive assessment is the detection of substance use in the first place. In general, people may find disclosure of drug or alcohol misuse to those they perceive as being in a relative position of power, to be problematic. This is socially driven to avoid condemnation and to conceal illegal acts. The disclosure of illegal drug use may further be avoided because of fears that include confidentiality and the reaction of the professional hearing the disclosure.

Difficulties in communication, memory and perception that may be a major part of an individual's mental health problem making information gathering difficult. This may be further compounded by the attitudes that the person holds about their substance use and perceptions of stigma surrounding both mental illness and substance use. Rates of self-reported substance use in people with a mental disorder will therefore generally be lower than the actual numbers using drugs. Thus, assessment should not only rely on self-report.

More structured methods of assessment such as validated assessment schedules may have their uses with this client group, but they also have their problems. Most notably there is a dearth of structured assessment measures that have been validated with a dual diagnosis client group. Standardised drug measures, or standardised measures of mental health problems, may be reduced in terms of reliability and validity, yielding false positives and false negatives for individuals with concurrent mental health problems and substance misuse.

For the mental health team detection of drug use may be problematic if there is a lack of awareness of the high rates of drug use in the general psychiatric population. The clinician's own attitudes and beliefs surrounding drug use may also impinge on their assessment. For workers with greater clinical experience of working with drug use there may be a tendency to view low to moderate amounts of drug use as generally non-problematic, particularly where the individual's self report minimises the potential harm. This may lead to collusion with individuals who deny, minimise or fail to see any links between their drug use and their mental health. There are many additional impediments (i.e. service, clinical and process) which can impact on the assessment

process which need to be discussed by treatment teams, when considering reviewing their dual diagnosis screening and assessment protocols, some of the key areas for consideration are outlined in Table 4.

Table 4 - Some of the factors which can impact on dual diagnosis assessment

Systems Impediments	Clinical Impediments	Process Impediments
<ul style="list-style-type: none"> • Parallel vs sequential vs integrated treatment approaches • Philosophy issues • Lack of training • Debate over focus of care (i.e. Responsible Medical Officer) • Transcultural issues • Protocols, procedures and policies 	<ul style="list-style-type: none"> • Understanding the nature of the symptoms and presentation • Assessment tools - reliability, validity and utility • Client's mental state - issue of stability, intoxicated/withdrawing, cognitive impairment • Reliance of self-report • Client's motivation /preparedness, insight • Perception of risk 	<ul style="list-style-type: none"> • Setting • Confidentiality • Access • Time frame • Trust • Poor previous experience (client & staff) • Protocols, procedures and policies • Interview skills • Consent • Collateral informants • Resources e.g. laboratory tests

Index of suspicion

It has been suggested that all workers in contact with individuals with relapsing symptoms of severe mental illness adopt an 'index of suspicion' of substance use during their assessment and day-to-day working. Research has identified factors that correlate with substance use. These are detailed below in Table 4 and 5. Whilst such lists can be useful in guiding the clinician, care must be taken to ensure that individuals who do not meet the profile are also adequately assessed.

Table 5: An index of suspicion: characteristics associated with harmful drug use (Mueser et al, 1992)

- 1/2 of all individuals with a severe mental illness
- Young
- Male
- Family history of substance abuse
- Homelessness
- Disruptive behaviour
- Poor family relationships
- Repeated hospitalisations
- Legal difficulties

Table 6: Statements or observations that may warrant further investigation for detection of dual diagnosis

- Drug use blocks out unpleasant thoughts, memories or feelings.
- Drug use helps alleviate symptoms of mental health problems.
- Drug use helps cancel or balance out unwanted side-effects of medication.
- Individual appears 'low in mood' for long periods of time in the absence of obvious stressors.
- Frequent mood swings from 'high' to 'low' in the absence of a diagnosis of bipolar disorder.
- Individual no longer appears to enjoy activities that they once found enjoyable or has lost contact with friends and peers.
- Appears over suspicious and/or discloses strange thoughts or speech patterns.
- Recent weight gain or loss of more than 15% of body weight.

Key principles for assessing dual diagnosis clients

- It is unlikely that a full assessment can be completed in one session, this may take weeks of continued work.
- The purpose of the assessment is to gather sufficient and relevant information about the client's mental health and substance use problems with the intention of understanding the inter-related nature of both conditions.
- Assessments should be intra- and inter-agency in nature.

The initial/screening assessment

While assessment should be an ongoing process throughout the individual's period of contact with the service, the initial or screening assessment should be structured to provide as much information, systematically obtained, about the individual as is needed. This can take the form of a service-specific screening tool that might then indicate areas where further investigation is needed.

The basis for the initial assessment will generally be: a direct interview with the presenting individual; self-report or structured interview schedules; and information from collateral sources

such as family, friends, service providers, or the police to build up a full picture of what is going on for the individual. One of the critical elements when screening for substance use within a general psychiatric population, is an awareness by the interviewer that the client may be reluctant to disclose their substance use. In such circumstances, beginning with general questions about their use of licit substances (i.e. tobacco and alcohol) and prescribed medications, can open the subject area in a non-threatening manner. Gradually, the interviewer can ask about the use of other substances which clients use (including over the counter medications (OTC)), and street drugs. For clients who have difficulty remembering or who suffer cognitive impairment, offering them a pre-typed list of all substances on an A4 sheet of paper, can facilitate their ability to recall, and avoid the interviewer having to laboriously run through (or remember) each likely substance.

Assessing psychiatric problems in people with dual diagnosis

The assessment of a person's mental health problems is traditionally divided into two parts: an assessment (including taking a history and making an examination e.g. of mental state, physical health, psychological function) and making a diagnosis. The assessment should highlight the person's problems, needs, wishes and strengths including how psychosocial and contextual factors might contribute to the presentation. Taken with the diagnosis these should point to what management strategies might need to be deployed to enable the development and delivery of a comprehensive treatment plan.

Internationally there are two major diagnostic systems - DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) (American Psychiatric Association 1994) and ICD 10 (International Classification of Diseases) (World Health Organisation 1992). They use a system of axes to record information. The DSM IV employs a system of five axes that reflect the complexity of describing the health of individuals:

Axis 1 - major mental disorders including substance use disorders

Axis 2 - personality and developmental disorders

Axis 3 - medical disorders

Axis 4 - stressors, including the social environment, legal system and crime

Axis 5 - global assessment of functioning

The process of obtaining enough information for a confident diagnosis can be time consuming; the

individual must be seen to have demonstrated certain symptoms over a set period of time. Using these systems, there are operationalised criteria that must be met before a diagnosis is made. A firm psychiatric diagnosis will often include the assessment by a psychiatrist and a period of observation, in conjunction with a good history, including collateral sources of information. It is important that presenting behaviours and needs are tackled immediately, offering the individual the degree of support that they need from the outset. Furthermore ensuring any delay in arriving at a definitive diagnosis should not delay the deployment of strategies to engage the patient or the offering and implementing of necessary interventions. For example, a homeless person is likely to need help with housing irrespective of whether he has depression or is using alcohol in a harmful way.

A mental health assessment aims to include a comprehensive assessment of biological, psychological and social factors. The assessment should incorporate a factual history, a mental state assessment, a substance use assessment, a strengths assessment and a risk assessment, all of which are described in more detail below (see table 7).

Table 7: Elements of a mental health assessment

- Problem/s.
- Developmental history-early milestones, personality, relationships
- Educational and vocational history
- Ethnicity and culture
- Spiritual belief systems
- Individual's history of mental health problems including physical trauma resulting from head injury, accidents or surgery
- Family history of mental health problems
- Current levels of drug use
- History of drug use
- Family history of drug use
- Relapse indicators for mental health problems
- Relapse indicators for drug use
- Individual's history of treatment for mental health and/or harmful drug use.
- Social support systems

- Financial status
- Legal status including contact with the criminal justice system, past and present along with any criminal activity not detected by the police
- Individual's needs
- Individual's strengths
- Individual's limitations
- Mental state examination
- Physical examination
- Specialist assessments eg nutritional assessments where there is recent extreme weight loss or gain not directly attributable to change in diet

An in-depth history is essential to facilitate the production of a differential diagnosis. Use of collateral sources such as family or friends is of primary importance to ensure a valid assessment.

Mental state examination

The mental state examination moves away from the developmental and functional perspectives of the psychiatric assessment into the 'here and now'. The mental state examination is a systematic procedure based on observation and interview focussing on a person's appearance, thoughts, feelings and behaviours (see Table 7).

Table 7: Elements of the mental state examination

- Attitude towards the interview and rapport
- Appearance and behaviour including psychomotor activity
- Speech
- Mood
- Thought processes, including suicidal ideas plans and intentions
- Delusions
- Perceptual disturbances and hallucinations
- Cognition including orientation, attention, concentration and memory, and intelligence
- Judgement and capacity to consent to treatment
- Insight

Assessment of substance use in individuals with dual diagnosis

It is important when assessing levels of substance use that self-report is backed up with independent corroborating measure (e.g. urine toxicology). Key areas to explore (irrespective of substance used) are set out below:

Immediate/current use

1) Pattern of use of individual substances

Ask which drugs are used (offering clients a pre-typed list of all substances on an A4 sheet can facilitate recall). The more substances being used increases the risks. Where the substance is being regularly used asking about the pattern of use is important e.g. daily versus weekly use. This should assist in differentiating between experimental, recreational and dependent use. To assist in assessing the client's level of tolerance and/or dependence, it is necessary to enquire from the client whether they currently experience any withdrawal effects, and/or need to use increasing amounts of the substance to achieve the desired effect. This line of enquiry is particularly important in determining current level of intoxication and for assessing the need for a medically supervised detoxification.

2) Quantities of substances used

The ways in which clients describe the amounts of substances they use are manifold. Drug use may be described in terms of weight or amount of money spent.

3) Route of use

It is important to establish how the client takes the substances e.g. oral, injecting, smoking, and sniffing. If injecting there needs to be some clarification about which site is being used e.g. arms, groins, neck. Intravenous and intramuscular use carry increased associated risks.

4) Source

There is a need to establish where the client is getting the substances from e.g. illegal, prescribed or over the counter (OTC). Identifying that the source is illegal indicates a higher risk in procuring and maintaining supply and therefore greater negative consequences.

5) Reason for and consequences of use

Establishing reason for use and continued use can offer insight into the client's understanding of the benefits and negative consequences of their substance use on their mental health (Table 8)

Table 8: Associations with substance use

- Loss of control
- Psychological problems
- Social problems
- Legal problems
- Family problems
- Medical problems
- Employment problems

6. Previous substance use

Having established that the client is currently using substances, previous history of substance use needs to be explored. For example, establishing when substance use first started (age of onset), and when regular use and subsequent dependent use (if relevant) occurred. Periods of abstinence (offset), either voluntary or involuntary, and past treatment episodes needs clarification. In addition to gaining a greater understanding of the client's substance use problem, it will allow the treatment team to explore more fully the onset and offset of the substance use in relation to the client's previous and presenting mental health problem and possible inter-related nature of both conditions, i.e. whether the substance use is a primary or secondary condition.

Criteria for substance related disorders in DSMIV and ICD10

Table 9 and 10 outline the DSM IV and ICD10 criteria which must be met before a diagnosis for a substance related disorder can be made. These criteria can be helpful in assisting the assessment team in determining key areas which need to be addressed in the interview.

**Table 9 - Criteria for substance ABUSE (DSMIV)
and HARMFUL USE (ICD10)**

DSMIV	ICD10
(A) A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a 12-month period	(A) A pattern of psychoactive substance use that is causing damage to health; the damage may be to physical or mental health
(1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home	
(2) Recurrent substance abuse in situations that are physically hazardous	
(3) Recurrent substance-abuse-related legal problems	
(4) Continued substance abuse despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance	
(B) Has never met the criteria for substance dependence for this class of substance	

Table 10 - Criteria for DEPENDENCE in DSMIV and ICD10

DSMIV	ICD10
(A) Diagnosis of dependence should be made if three (or more) of the following have been experienced or exhibited at any time in the same 12-month period	(A) Diagnosis of dependence should be made if three or more of the following have been experienced or exhibited at some time during the last year
(1) Tolerance defined by either need for markedly increased amount of substance to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount of the substance	(1) A strong desire or sense of compulsion to take the substance
(2) Withdrawal as evidenced by either of the following the characteristic withdrawal syndrome for the substance or the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms	(2) Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use
(3) The substance is often taken in larger amounts over a longer period of time than was intended	(3) Physiological withdrawal state when substance use has ceased or been reduced, as evidenced by either of the following: the characteristic withdrawal syndrome for the substance or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms
(4) Persistent desire or repeated unsuccessful efforts to cut down or control substance use	(4) Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses
(5) A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects	(5) Progressive neglect of alternative pleasures or interests because of psychoactive substance use and increased amount of time necessary to obtain or take the substance or to recover from its effects
(6) Important social, occupational, or recreational activities given up or reduced because of substance use	(6) Persisting with substance use despite clear evidence of overly harmful consequences (physical or mental)
(7) Continued substance use despite knowledge of having had a persistent or recurrent physical or psychological problem that was likely to have been caused or exacerbated by the substance	

Assessing the interaction between concurrent disorders

One of the main challenges for clinicians when assessing dual diagnosis clients is the overlap in symptomatology between substance use disorders and mental health disorders. Having completed the assessment, and gathered the relevant information on both the mental health and substance use history, formulating a clinical impression should be possible, albeit a differential diagnosis.

Harrison and Abou Saleh (2002) advise that DSM IV, as previously mentioned, places more emphasis on co morbidity than earlier versions and provides three categories:

1. Primary
2. Substance induced, and
3. Expected effects of substance

Where ongoing substance use is present, the guidelines offer criteria for distinguishing co-morbid syndromes. For example, primary major depression is diagnosed if one of the following three criteria is met:

1. Persistence of mood symptoms for more than four weeks after the end of substance intoxication or acute substance withdrawal.
2. The development of mood symptoms that are substantially in excess of what would be expected given the type or amount of substance used or the duration of use, or
3. A history of prior recurrent episodes of Major Depression (American Psychiatric Association, 1994).

Furthermore, if the criteria for primary or substance-induced are not met, the syndrome is diagnosed as substance intoxication or withdrawal.

Independent measures for testing substance use and consequences

Alcohol or drug dependence cannot be diagnosed on the basis of any single laboratory test, but tests do form an essential part of the overall assessment. These tests can be used to confirm current use of a drug or provide evidence of resulting physical damage. They can also be used during treatment to monitor progress.

Testing for current substance use

It is not always possible to smell alcohol on the breath of a person who has been drinking. Inviting them to blow into a breathalyser is an effective way of measuring the blood alcohol concentration. Staff unfamiliar with a breathalyser may feel uncomfortable in its use, but patients will generally accept it once the purpose is explained.

Urine tests are widely employed to assess for illicit drug use. Drug users are rarely required to give the sample under observation when maintenance of dignity is important, but on receipt of the urine bottle a judgement can be made of whether it is close to body temperature. Simple pH dipsticks can confirm its pH is compatible with urine. Although the determined individual can always provide a fake urine specimen, few persistently do so and hence a series of urine tests is often more useful than one sample. However, treatment should never rely on these tests alone, but on the overall assessment.

Table 11: Detection Periods for Urine Drug Screening (Maximum Range)

Cocaine	12 - 72 hours
Amphetamine	2 - 4 days
Heroin	2 - 4 days
Codeine	2 - 4 days
Cannabis (Casual Use)	2 - 7 days
Cannabis (Chronic Use)	30 days
Diazepam	30 days

There are two main methods for testing a sample. Special immunological procedures called *immunoassay tests* are based on detecting antibodies to ingested drugs. These tests are widely available in easy to use kits. *Gas chromatography* is more accurate but this will usually require the urine sample to be sent to a specialist regional laboratory. Hair testing can be used to detect drugs laid down within the growing hair follicle. Using this, one can retrospectively examine drug use over many months, but it is more expensive than urine testing. Serum saliva tests are currently under evaluation. These tests only estimate whether drugs are present or absent and do not measure the amount of drugs in the body (hair tests can give an indication of use over time).

Tests for physical harm

Liver damage which can be caused by alcohol abuse can be assessed indirectly by taking blood for liver function tests. *Liver function tests* will detect enzymes released from damaged liver cells and the products of the liver. *Gamma glutamyl transferase (GGT)* has been reported to be raised in 50 to 70% of heavy drinkers and with further damage other abnormal liver function results will appear. Alcohol can affect the production of red blood cells resulting in their being released before they have shrunk to their mature size. A *Full Blood Count* shows the *Mean Red Blood Cell Volume (MCV)* to be raised in 25 to 50% of heavy drinkers. Platelet levels may be low. Red blood cells are replaced every three months so a raised MCV reflects past drinking. These are summarised in Table 12.

Table 12: Blood Test Results In Alcohol Misuse

Gamma Glutamyl Transferase (GGT)	-	Often elevated before frank liver damage has occurred because of alcohol induced enzyme induction. At higher readings damage more likely.
Alanine Transaminase (AST)	-	When raised it is more suggestive of hepatocellular injury.
Aspartate Transaminase (AST)	-	AST:ALT ratio of more than 2 in the presence of liver disease suggests alcohol related liver damage.
Alkaline Phosphatase	-	Raised in hepatitis with biliary duct obstruction.
Bilirubin	-	The individual may be jaundiced if elevated.
Albumin	-	Low albumin can reflect acute hepatitis or cirrhosis.
Triglycerides	-	Raised in early stage of fatty liver infiltration before hepatitis develops.
Uric Acid	-	Metabolism of alcohol results in acidosis, a build up of urates and possibly gout.
Amylase	-	Raised in pancreatitis.
Mean Cell Volume (MCV)	-	If raised check B12 and folate levels, which may also be deficient due to alcohol misuse.
Platelet Count	-	Low count may reflect bone marrow toxicity.
Haemoglobin	-	Anaemia may be due to poor nutrition, vitamin deficiencies or bleeding from ulcers.
White Blood Count	-	Reduced in bone marrow toxicity and raised in infection, hepatitis and pancreatitis.

Cross infection can occur when intravenous drug abusers share needles, syringes or other paraphernalia. Blood tests for *Hepatitis B* antibodies and antigens may confirm whether the individual is affected. The disease is potentially serious and prevention is desirable. Therefore patients who are negative for Hepatitis B should be immunised. In some cases the first injection can be given before the results of the test, this may be of value since patients may drop out of treatment early. Immunisation usually entails three injections, but even if the course is not completed the patient may have gained some immunity. *Hepatitis C* is estimated to have infected

a third of injecting drug users in this country. A half or more are infected in some drug services. It is a slowly developing illness and those found positive on the blood test should be referred to a liver specialist. Guidance has been produced by the Department of Health (*Hepatitis C - guidance for those working with drug users (2001)*) - available at www.drugs.gov.uk that relates to the management of this issue. HIV infection is found in less than 5% of intravenous drug users. Individuals need to be adequately prepared before testing for HIV or hepatitis C because of the potential implications of the having taken such tests and the results. These tests cannot exclude the possibility of infection in the three months before the test.

Withdrawal signs and symptoms

Signs and symptoms of withdrawal are generally the reverse of the direct pharmacological effect of the drug. For example, alcohol generally reduces anxiety and causes sedation. In large amounts it may induce sleep, coma and death. Withdrawal from alcohol will often produce anxiety, agitation, disorientation, sweating, nausea, vomiting and possibly seizures. The time taken to withdraw from a drug will depend on the particular drug ingested. Withdrawal from drug use is not usually life threatening but is often extremely distressing for the individual and may heighten the risk of suicide. Table 13 details some features of withdrawal that suggest the need for immediate medical attention.

Table 13 - Features of withdrawal that will necessitate immediate medical attention

- Recent drug intake at levels that risk development of toxicity, poisoning or organ damage even if the individual appears asymptomatic
- Ingestion of unknown quantities and substances
- Confusion or delirium
- Tachycardia (if heart rate over 110 bpm)
- History of evidence of physical trauma (particularly head trauma)
- Individual is semi-conscious, can be roused but falls asleep when stimulus is removed
- History of difficult withdrawal
- Severe tremors
- Hallucinations or marked paranoia
- Fever

- Severe agitation
- Poly-substance dependence
- Seizure or history of seizures
- Rapid intake of drugs

Taken from Evans, K. and Sullivan, J.M (2001)

Collateral sources of information

Given the limitation of self-report as an indicator of current substance use, other assessment measures can be used to complete a comprehensive assessment. Family members and friends can be a rich source of information about the individual if they have managed to retain contact. Drake et al (1996) have noted that an individual's 'key worker' or 'case manager' can be adept at monitoring the individual's levels of drug use. They have developed two rating scales to aid this process - the Alcohol Use Scale and the Drug Use Scale - which have been validated for working with individuals with dual diagnosis and have demonstrated reasonable reliability. Both of these tools can be downloaded from the following website: <http://www.dartmouth.edu/dms/psychrc/alcohol.html>

Risk assessment and management

The three main components of risk assessment and risk management are a consideration of: suicidal (or self harming) ideas, plans, intentions and behaviour; ideas thoughts and actions of harm to others; and self neglect.

Clinicians are sometimes wary that asking about 'risky' behaviours might somehow trigger the individual to engage in it. This fear does not appear to be born out clinically and direct enquiry in a calm and non-judgemental manner using plain language will often facilitate the individual to bring such thoughts into the open. It is only when thoughts have been acknowledged that they can be worked with directly, thus minimising risk. If an individual discloses thoughts or actions associated with 'risk' behaviours the following assessment guidelines should be followed.

- Frequency and intensity of the thoughts relating to the 'risk' behaviour
- Whether a specific plan has been formulated to engage in the risk activity
- Whether the individual has the means to carry out the plan

- Any history of the same or similar behaviour
- What has prevented them from acting on similar thoughts in the past?
- Has the person found ways of managing his or her thoughts or behaviours to minimise harm, and can these be harnessed more often?

The individual can be asked to rate the likelihood of acting on the thought (low, medium or high). It is also sometimes useful to try to get the individual to rate their ability to not *act on the thoughts* on a ten-point scale. (Where 0 is no ability to stop putting the thought into action and 10 is full confidence that thought will not be put into action).

Both of these simple techniques give a rough clinical rating of the person's perception of their own ability to take control of or block the thoughts that might lead to high risk behaviour. This can be extended to explore mechanisms that would need to be in place to facilitate their control over the thought or behaviour. It is useful to identify things they have done in the past to prevent themselves acting on risky thoughts. These should be used to identify at least one successful intervention strategy. The factors in Table 14 have been reported to be associated with an increasing likelihood of risk behaviour.

Table 14 - Predictors of risk (adapted from Evans and Sullivan, 2001)

- Previous history of harm to self or others
- A specific plan is in place
- Behaviours in keeping with going ahead with plans to self-harm e.g. giving away treasured possessions, suicide, threats to kill subject paranoid beliefs
- High degree of hopelessness
- Acute agitation or panic
- Command hallucinations
- Social isolation
- Recent losses or set-backs
- Recent psychiatric hospitalisation
- Mental health problem and/or drug use impairs judgement and impulse control

Interventions to minimise or address risk need to be of prime importance for clinicians managing individuals with dual diagnosis. The aim of risk assessment should be to assess the situation systematically as thoroughly as possible and then to use the information acquired to intervene at whatever level is necessary. Consultation and support should be sought through the multidisciplinary team, line managers and clinical supervision. Team discussions of cases and risk are of central importance and can help to ensure that disclosures of risk are acted on in a careful and thoughtful manner that is defensible as good clinical practice. Good quality documentation of risks and the discussions around risk management are essential to communicate the findings of the assessment to others and also as a record of the findings of the assessment and clinical response.

Threats to carry out violent acts to self or others should always be taken seriously and dealt with in a manner appropriate to the nature and level of risk presented. The multidisciplinary team discussion about the risks posed and the management strategies to deal with risk should be thorough and documented as part of the Care Programme Approach or as part of a systematic recording of planning of care with clear accountability and systems for monitoring and review.

Assessment of strengths

Assessment all too often focuses only on the individual's problems and inadequacies. The inclusion of an assessment of strengths can help to redress the balance. A strengths assessment can act as an aid to engagement with people who have become resistant to the assessment process due to the emphasis on deficits. Assessment should include an evaluation of motivations and how these can be positively harnessed. It should focus on strategies that the individual has successfully used in the past to manage both substance use and psychiatric symptoms. It should also focus on general life achievements and how these can be built upon and strengthened.

From assessment, through care-planning to intervention

A thorough assessment should enable the person being assessed and the worker to identify the individual's needs that should be addressed in his or her care plan. This is particularly important for people with dual diagnosis, as they will generally present to services with a multiplicity of needs that may appear overwhelming. The aim of the assessment is to unpack this complexity and produce a statement of explicit need. The care plan should specify which parts of the mental health or drug services take the responsibility to meet specific needs. If only one agency is involved, the care plan is still an essential part of the care process as it defines which goals the individual is

working towards at a given time. It allows the individual and their worker to have something tangible and shared to work on, and to review progress.

In the statutory sector the Care Programme Approach (CPA) seeks to embed care planning at the very root of the individual's care. (see *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach*. This can be found on the Department of Health website: <http://www.doh.gov.uk/nsf/polbook.html>). This document sets out that each individual accessing the mental health services should have an appointed care co-ordinator to ensure that the package of care recommended, post assessment, is delivered within the time frame agreed. Care plans should be regularly reviewed in a collaborative manner between the client, their care co-ordinator, any other workers associated with their care and the wider multi-disciplinary team to monitor progress towards stated treatment goals and to reassess the appropriateness of the plan should problems emerge. In practice the interaction between the processes of assessment, care planning and intervention should be continuous and iterative, reviewing all information at regular intervals.

Child protection

An integral part of any assessment should be an opening out of the initial focus on the individual to their wider social network. Care should be taken to ensure that information is gathered regarding the person's contact with children. For example, is the client a primary carer? What happens to the children when the individual is intoxicated and/or experiencing problems with their mental health? Whilst a person should be approached in a sensitive manner to avoid their disengagement, such questions must be asked to attempt to assess and assure the safety of any children involved. Child protection procedures must be given proper consideration if appropriate. Further information is contained in the following policy documents: Department of Health & Welsh Office, 1999 *Working together to safeguard children* (available by search on: <http://www.doh.gov.uk/>); *Drug Using Parents- Policy Guidelines for Inter-Agency Working* published by Department of Health Social Care Group.

The importance of maintaining contact

If assessment and subsequent care planning and intervention are going to be successful for any individual accessing mental health or drug services engagement with the individual is essential. In the past the importance of engagement has been minimised and the assumption

has been that it is the responsibility of the individual to maintain contact with services rather than vice versa. This assumption may still be supported by some services, particularly drug services, who can believe that individuals accessing their service need to be in 'contemplating change' (i.e. ready to change their drug use or to seek help independently for symptoms of mental ill health) before being eligible for the service. Action will partly be measured by the person's motivation to take responsibility for their problems by keeping appointments with the service.

However people with dual diagnosis are often difficult to engage and may therefore need more assertive modes of engagement than that described above. Some common reasons why people may be reluctant to engage with services include:

- Rejection of the idea that they have problems around substance use
- Rejection of the idea that they have problems associated with mental ill health
- Bewildering experiences of contact with the legal system during mental health crises
- Worries about confidentiality (that disclosure of drug use to the mental health or drug services may be passed on to the police, social services, employers, housing authorities)
- Having a child taken away by social services
- Bad past experiences of being detained in hospital against their will
- Traumatic experiences of hospitalisation
- Experiences of prejudicial treatment, stigma, racism, sexism
- A feeling that experiences and opinions are being taken seriously
- A feeling that services are dehumanising and controlling
- Bad experience of side-effects of medication
- Frustrating contact with governmental agencies, eg housing, police, social services

Assertive outreach teams have the process of engagement as a core objective. They are an increasing part of local mental health services and have been set up to work with people with complex needs who other services have found difficult to engage. It is no coincidence, taking into account the factors above, that a significant proportion of their caseloads is made up of

individuals with dual diagnosis.

Effective engagement with people with a dual diagnosis is essential for the completion of an adequate assessment and the formulation and delivery of an effective care package. Some basic techniques to help maximise engagement are detailed below.

- Remember that engagement is important in itself and its value should not be underestimated. Avoid any tendency to rush in with all but the most essential assessment tools before the relationship has had time to build and consolidate.
- In first meetings try to avoid lengthy tick box assessment schedules and use conversation as a means of ascertaining introductory information.
- It is important to structure the first meeting so that the person attending has a chance to make their own story heard and has time to ask any questions relating to the service you may be providing.
- Make the most of indirect contacts for information. This would include colleagues in mental health or substance use services that have previously managed to engage the person (asking questions such as what worked, what did not). Make the most of written information about the person so that basic information does not have to be repeated but can be checked out with the person if necessary.
- Engage the wider network of those who have worked with the person before, including relatives and friends if appropriate. This will, of course, require the person's consent and should be addressed within the confidentiality policies you are working to.
- Check out why the person has refused or taken up services before, what they liked or did not like about those services.
- Try to avoid early disagreements, as this may be a barrier to future work. Keep confrontational tactics back until a reasonably good therapeutic relationship has developed.
- It may be necessary to help the person with practical issues such as navigating housing, bill payments and budgeting, before any in-depth work can be taken up around substance use or mental health. This can be an effective way to engage individuals by working alongside them towards a pre-determined practical goal where success will be obvious and measurable.

- Have a positive focus on the ability of the person to recover control over both their mental health difficulties and their substance use.
- Try not to push the person towards working on their substance use until they are ready and willing to give it a try as a premature focus on treatment can lead to disengagement.
- Make sure that any objectives set with the person are broken down into small easily operationalised tasks. If the person is clear about the task in hand and it does not feel overwhelming they are more likely to succeed. Successes towards the person's own pre-determined treatment goals will reinforce the engagement process further.

Assessment with diversity in mind

A person's race and culture play a pivotal role in not only how they experience and understand symptoms of mental health problems, but also how the mental health and drug services respond to their needs. Rates of diagnosis of schizophrenia among African-Caribbeans have been reported to be between 2.4 and 18 times higher than in white people (Bhugra et al, 1997). Once the individual has received a diagnosis of schizophrenia, African-Caribbean people also appear to be at greater risk of relapse. The black Caribbean community have a particularly high prevalence of diagnosis of severe mental illness, detention rates under the Mental Health Act, hospital admission and occupation of secure beds (The Sainsbury Centre for Mental Health, 1998). Conversely people from black and other minority ethnic groups have been found to have fewer diagnoses of non-psychotic disorders (Ineichen, 1980).

Within drug services there is also low rates of engagement with individuals from black and minority ethnic groups both in the statutory and non-statutory sectors (Abdulrahmin, 1992). It has been suggested that this may be due to a widely held perception that drug services cater for and are run by white people (Awiah, 1992). That services are at present configured mainly to work with white male opiate users may not be too far from the truth as drug services in the UK have evolved around the provision of services to opiate users (Strang and Gossop, 1994). This suggests that drug services may be unresponsive to other modes of drug use and may not readily fit individuals whose drug of choice is not opiate-based. This is not to say that people from black or minority ethnic groups do not use opiates, but it does reduce

access for users of other drugs. This will exclude many drug users who may attempt to seek help. The issues discussed below will therefore be pertinent when planning or undertaking an assessment with black men or women or individuals from other minority ethnic groups. However, these issues might also be considered as good practice generally for socially excluded groups. For a summary of the evidence about mental health and black and ethnic minorities, good practice and service development guidance see Bhui & Olajide (1999); Bhugra & Bhui (2001) and Wanigaratne et al (2001).

Assessment is not a neutral process. Assessment is a transaction between two or more individuals to ascertain access to a particular service. Both parties come to the assessment process with particular ideas and beliefs about what the range of possible outcomes might be. Generally the worker and the person presenting will approach the assessment process with their own particular biases, their own experiences and world-views. Their aims for outcome of assessment may differ significantly. It is therefore essential that the worker makes explicit any belief system underpinning their recommendations arising from the assessment, both to the individual being assessed and in the wider treatment setting.

The worker should be able to acknowledge the part that racism plays in the lives of people from black and other minority ethnic groups. This includes how this might impact not only on the individuals' presenting difficulties but also on the assessment process.

Pathways of access to a service. Whether access is on a voluntary or involuntary basis will have implications for how people perceive the assessment process and the worker undertaking the assessment with them. It may also directly impact on the individual's engagement with the assessment and any subsequent treatment planning arising from it.

Individuals from black and minority ethnic groups often suffer from being stereotyped. This includes beliefs that they are not 'psychologically minded' and therefore there may be a tendency to recommend chemical rather than psychotherapeutic solutions for the individual's expressed difficulties. Workers should ensure that any recommendations from assessment do not reflect such stereotypical thinking (which can contribute to institutionally racist practices).

Use of interpreters. This can be of great importance when assessing people whose first language is not English. The person and their family should be given the opportunity to express their opinions in their native tongue. The use of an interpreter should be presented as a choice for the individual and their family. One should not assume that the individual might necessarily want to talk to someone from his or her own ethnic group. This may compound feelings of stigma associated with their own beliefs around mental illness and drug use and there may be concerns by the individual regarding confidentiality, particularly if the interpreter comes from the same discrete ethnic community. The individual should be presented with all of the choices on offer locally and given the opportunity to choose whichever option feels right for them.

Account must be taken of the limitations of standardised assessment measures. Rating scales will generally lack normative data for groups different to the standard 'white norm' with little reference to different cultural, linguistic or religious factors. Care should be taken in both the administration and the interpretation of results.

Summary

- A high index of suspicion for dual diagnosis should always be present when assessing individuals with severe and relapsing mental health problems due to the high prevalence of dual diagnosis in this group.
- Accurate histories, whether of substance use or mental health problems, may be difficult to obtain using self-report. Consideration of supporting the assessment using collateral sources is necessary. This will also be important when attempting to chart the progression of the individual's substance use across time.
- Changes in tolerance in individuals with a dual diagnosis may be difficult to track due to binge use or the use of relatively small amounts of the substance.
- Symptoms of intoxication and withdrawal may be masked by or confused with symptoms of mental illness.
- Denial can be a major barrier to assessment. The individual who uses relatively small amounts of drugs may find it difficult to perceive it as a problem. Individuals may also feel that they are successfully using the drug to 'self medicate' against the symptoms

of a mental illness or against the unwanted side effects of prescribed medication.

- Individuals with a dual diagnosis may experience increased negative consequences from the drug at much lower doses. This may have a negative effect on their levels of general functioning.
- Assessment tools can be used to measure progress or deterioration in functioning and symptoms, as well as the outcome from treatments.

SECTION 5 - Interventions

Learning Objectives:

- 1) To understand the range and types of interventions for helping people stop harmful use of drugs and alcohol and to cope with mental illness.
- 2) To understand the 'cycle of change' model and recognise the need to collaborate with the individual in choosing the appropriate treatment.
- 3) To understand the 'long-term' approach and working practices which support staff in carrying out these interventions.
- 4) To understand the role of medication and psychological interventions.

Introduction

There is considerable heterogeneity in the problems that individuals with dual diagnosis develop. The differences that exist between individual cases are considerable and in order to be effective, any intervention must reflect those differences. An accurate assessment is therefore essential not only to identify the problems, but also the individual's readiness to change, their strengths and their vulnerabilities. What is common to all intervention is its collaborative nature. One must work with the person in a mutually agreed framework and not try to impose blanket solutions. This may mean, in some cases, initially having realistic expectations and limited goals and tolerating a slow pace of change.

To meet the needs of those with dual diagnosis a comprehensive approach is required. Whether the different aspects of an individual's care are managed by a single 'one-stop' service or several services will depend on local arrangements. Staff may have to alter their attitudes and practice in recognition of the complex needs of this varied group. Mental health workers may have to tolerate harmful behaviours that do not arise directly out of the mental illness, while substance misuse workers may need to alter their expectations of drug using mental health patients taking greater personal responsibility for engaging in treatment.

It is important for professionals to feel supported within their multi-disciplinary team especially since unrealistic expectations may be present. Key factors include:

- Clear treatment goals
- Good communication
- Adequate support to staff
- Acknowledgement of the long term nature of the work

Skills required to establish rapport with dual diagnosis clients involve being able to foster a non-judgemental, collaborative style, while recognising the long-term nature of the work. Aims should be realistic and may need to be modest. Staff should have an understanding of the range of substances used and their effects on mental health. They must also recognise the range of problems from occasional use to poly-substance binges, through to physical dependency. A non-confrontational stance is more likely to engage someone in a frank discussion of their problems. Most people with dual diagnosis will not be ready to jump straight into action to change their behaviour. It is important to gain trust and explain clearly what the service can offer to meet the person's need. Stages of intervention are summarised in Table 14.

Table 14: Stages of intervention

1. Meeting basic needs.
2. Engagement.
3. Persuasion.
4. Active treatment.
5. Preventing relapse.

Meeting basic needs

Careful assessment will reveal the complex range of needs these individuals have. It is the basic needs, which must be first met before one can go on to address aspects of mental health or drug use.

It is simply unrealistic to expect a person to achieve complicated treatment goals in the midst of the chaos of homelessness or family upheaval. Even the routine task of taking regular medication requires a level of stability in the person's life. Thus finding stable accommodation, ensuring basic safety, regular meals and enabling self care are prerequisites. Many will need help with benefits and personal finances. Those living with families, in relationships or with social networks who are

exposed to actual or threatened violence must be helped to find alternatives. In meeting these basic needs the skills of a wide range of professionals is required. Social Workers, Housing Officers, Probation Officers and Health Workers can all play a role. Interagency collaboration is important to achieve this stability.

Engagement

Elements of the process of engagement have been discussed in the last chapter. Listening to the individual is the first step. There is often a discrepancy between the goals of the worker (ie treatment) and the service user. Listening and responding in a respectful manner are essential to any working relationship. In helping to meet basic needs, one can begin to establish an alliance with the person, which is essential before any intervention can be attempted. Traditional referral routes may need to be re-examined. Routine appointments may fail because letters do not reach people or the client has literacy problems. There may be much to be learnt from the assertive outreach model i.e. reaching out and meeting individuals on their "home turf", rather than expecting individuals to come to service settings.

Inter-agency collaboration also plays a role in engagement. Failure of communication contributes to drop out and individuals may be lost from services. Insensitivity to cultural and ethnic differences may cause barriers to engagement and past experience of racial, sexual or physical abuse can also create suspicion of authority. There must be an awareness of the inevitable imbalance of power in the relationship and the potential for misunderstanding. The instillation of hope is important in the process of engagement even when the problems people face may appear insurmountable in the short term.

Persuasion

Once the therapeutic relationship is established, motivation for change can be assessed. At this point the principles of motivational interviewing can be of use. A person's understanding of their conditions should also be explored. Asking the individual to explain what they think is wrong with them, what diagnosis they have and how it affects them, is an opportunity to clear up misconceptions, particularly if done in a non-judgemental way. Asking why medication is prescribed and what it is meant to do. Enquiring about deficits in the client's daily routine and how they would like this to change are key questions which help in exploring reasons for change. Indeed it may feel disrespectful and high handed to be given advice at odds with one's own view

of one's problems. Thus the aim is to understand the problem from the client's perspective and then work to motivate and engage, and instil hope.

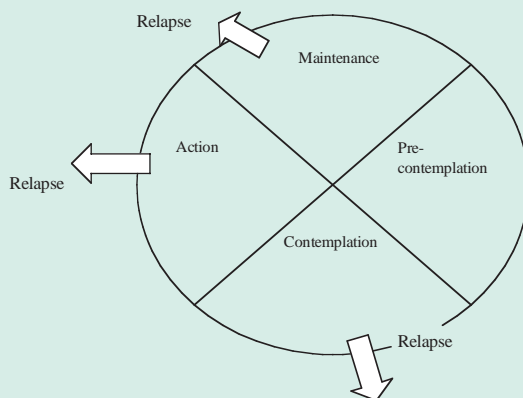
The cycle of change

A widely used model is the Cycle of Change (Prochaska & Diclemente, 1998), see Figure 2. The decision to change self-defeating and damaging habits or drug use is not an all or nothing decision. People who seek help will go through a series of stages before actually committing to changing their behaviour. The value of the model is that the type of treatment offered needs to be appropriate to the stage of readiness for change that the person has reached otherwise resistance will increase and change is less likely. A mismatch between the person's attitudes to treatment and the expectations of them, may also lead to failure and frustration, and damage the strength of the working relationship. The following are the phases of the Cycle of Change model:

- **Pre-contemplation:** people using substances are not aware they have a problem and do not seriously think about change. Others recognise the problem but have decided not to change.
- **Contemplation:** a sense of ambivalence about their behaviour emerges and the person starts to weigh up the pros and cons of their substance use but feels unsure about changing their behaviour. He or she considers there may be a problem and that change may be necessary.
- **Decision:** the person makes a decision to do something about their behaviour or to return to pre-contemplation.
- **Action:** the person chooses a strategy for change and pursues it, taking steps to put their decision into effect. This is traditionally where 'motivation' for treatment is crucial.
- **Maintenance:** during this stage the task is to maintain progress to avoid a return to substance use. Failure to consolidate at this stage may lead to relapse.
- **Relapse:** at the point of relapse the person returns to the behaviours of the pre-contemplative and contemplative stages. Relapse is seen as a normal part of the change process, not a failure of the person but of the plan. Responsibility is shared and blaming is avoided. The experience of relapse can be positively reframed to use as a learning experience, increasing the likelihood of success the next time

round. Most people will experience more than one relapse before their substance use comes to an end. Finally, they can exit the cycle to become free of drugs and alcohol.

Figure 2: Cycle of change model (Prochaska & Diclemente, 1998)



Motivating change over time

Motivational Interviewing is a style of counselling that can be used throughout treatment, but is particularly useful for those in the early stages of change. It is a direct client centred style, which aims to explore and resolve ambivalence as a key to change. The goal is to encourage the person along the Cycle of Change and maintain the gains made.

The key underlying principles are:

- (i) Being empathic, that is displaying a non-judgemental attitude of listening to the person and reflecting back their comments in a modified fashion, but with an attitude of acceptance and respect. Understanding the person's world and their decisions, demonstrating acceptance through reflective listening.
- (ii) Avoiding arguments or head to head confrontations. This provokes defensiveness and resistance to change. Using labels with which the person disagrees can be unhelpful.

- (iii) Developing *discrepancy* in the person's mind, between their current behaviour and their broader goals. The aim is to raise awareness of the consequences of their behaviour but to avoid "lecturing" the person. A number of strategies can be used. Explore the good aspects and then the "less good" aspects of their substance use or behaviour in a non-judgemental manner. Further discussion, recapitulation and feedback strengthen the case for change. Another strategy is to discuss the person's past life, future aspirations and current situation. Using the person's own words in summarising the discussion can tip the balance in favour of change. A third technique, which must be used sensitively, is to explore the person's view of himself or herself as a person versus a substance user. One may ask, "what do your friends say are your good qualities?" or "what do you like about yourself?". After discussion the person is asked how they would describe him or herself as a substance user. Finally one asks how these fit together thus allowing the person to see the discrepancy.
- (iv) Facilitating the resistant individual who becomes argumentative or unwilling to recognise problems by deflecting their confrontational statements rather than openly confronting them. This can be achieved by repeating what the person has said in a modified fashion so as to move the discussion towards change. It is this response to the person's resistance that distinguishes motivational interviewing from other approaches. Comments such as "what do you know, you've never had voices!" may be met by "sounds like you're pretty angry with me". One may reply to "I don't want to stop using drugs" with "you don't think that would work for you?".
- (v) Enabling the person to feel that they can change, but avoid offering your own solutions. The individual is responsible for choosing and carrying out their personal plan. People who are moving towards actively making changes will show less resistance, talk more about how life might be after the change and ask more questions about the change itself. Discuss the available options and spend some time examining the chosen option. It will help to transform a vaguely expressed goal into a practical solution. Awareness of the range of alternative approaches will also give hope and optimism.
- (vi) Working with 'pre-contemplators' who have not started to consider their health problems and substance use, by focusing on providing information. It can correct misconceptions and provoke thinking about change. In asking the person what they know about the risks

associated with their substance use and the effects on their mental illness one can identify errors. Rather than “lecture the person on the facts” one asks if they would like to know more. In a neutral fashion one describes the effects on persons in general and then proceeds to ask how this information is personally relevant. Describe the feature of the relevant mental illness and ask if they recognise these. Doubts are thus raised and the person's own perception of the risks and problems of substance use increased. However, the responsibility for making an informed decision rests with the individual and they may decide to continue using substances for the present. However, the seed may have been sown for the future.

Active treatment

Some individuals may be so ill that they have to be admitted to hospital against their will, under the Mental Health Act to receive treatment for their mental disorder. However treatment is usually a collaborative act after the individual has been persuaded to proceed to treatment. Rather than passively accepting an intervention, treatment should be seen as a sharing of common goals between the professional and that individual. It is invariably multiagency because of the complex needs of the person. Health Workers, Social Workers, Probation Officers, Voluntary Workers and Housing Officers may be just some of the people involved in caring for that individual. Co-ordination and communication is thus essential and one identified worker (or keyworker/co-ordinator of care) should take on that overarching role. Within the Care Programme Approach this is the ‘Care Co-ordinator’. The individual may fail to engage in some aspects of treatment and the co-ordinator can ensure that it is tried again when more appropriate rather than dropped entirely. Psychological interventions are often invaluable in targeting specific symptoms, as well as in helping people make sense of their dilemmas and choices (*Recent Advances in understanding mental illness and psychotic experience* can be found on the British Psychological Society website: <http://www.bps.org.uk>).

Personality disorder

‘Difficult’ patients may be diagnosed as suffering from personality disorder without full consideration given to the accuracy of such a diagnosis. Unpredictable behaviour may be attributed to personality traits when sporadic use of stimulants or other drugs are missed. Drug use from an early age may make it difficult to identify prior more positive behaviours. Conflicting expectations and service constraints can colour the interaction between professionals and substance users and bias the assessment. Psychotic disorders profoundly influence the personality and this may be an

early feature before florid psychosis develops. Some symptoms and signs of addictive behaviour and personality disorder can be the same. One must therefore be careful not to precipitously resort to a diagnosis of personality disorder especially if it may be used to exclude a person from services.

The strengths and weaknesses of an individual's underlying personality usually have a major influence on progress in treatment. In the assessment one should try to gauge these personal resources and explore personality traits. An impulsive person may require more external restraints and the involvement of others to contain and minimise behavioural problems. An inhibited or unassertive individual will need reassurance and encouragement to be more independent. Changing habitual behaviours takes time and patience. This is demonstrated clearly in working with those with borderline personality disorder. They are particularly prone to substance misuse and other impulsive behaviours and often present in changeable and unpredictable ways. People with borderline traits can form intense therapeutic relationships, which oscillate between idealisation of the professional, to denigration, and on occasions, hostility. This can be bewildering for professional staff and can leave them with mixed emotions such as anger, helplessness or anxiety. This is aggravated by the risks these patients take when they harm themselves. It is difficult for staff to resolve these dilemmas when caught up in the midst of the patient's troubles. Supervision is essential to help identify the patient's patterns of behaviour and the emotional "traps" this creates for others. Individuals with personality disorder usually repeat the same maladaptive pattern of behaviour over and over again. Once staff identify these, can find a place to think about them, and reflect on their own responses, and how these might make intervention difficult, staff are usually more confident about working with people with personality problems.

People with personality disorder need the constancy of an on-going relationship with services to help them modify their behaviour. It is essential that all staff "sing from the same song sheet", that they respond consistently and do not contradict one another openly. Staff should agree on which behaviour should have a positive response and what not to give attention to. These patients frequently present in crisis often in a dramatic fashion and staff will need support not to feel overwhelmed and to maintain a consistent approach. Often this requires taking decisions, which are risky, and so decision making should be team based, carefully considered, applied with confidence, and fully recorded. It can be of particular value to agree such approaches between mental health and substance misuse teams (or workers) when both are working with the same person.

However, staff should always have room to re-visit and reflect on decisions, and whether they might need revision. This also should be done on a team basis. Individuals with severe personality disorder may develop depression and other mental disorder and may need emergency psychiatric treatment. In times of stress they may also harm themselves or commit acts of violence. Multiple agencies may become involved at different times and co-ordination is particularly important given the need for a consistent approach. Successful control over the symptoms of transient mental illness and the reduction in harmful drug and alcohol use can alleviate the apparent chaos in those diagnosed with a personality disorder. One may not be able to remove the underlying personality difficulties but services can assist in restoring a degree of stability to their individual lives. Much like substance use problems and severe mental illness, personality problems can be managed, but trying to eradicate them is not realistic. Likewise trying to work only with people with dual diagnosis who do not also have a personality disorder is likely to exclude the significant proportion of those who fall under this umbrella term.

Setting goals

Setting goals lies at the heart of the agreed plan of treatment. Both the client and treatment team should recognise the chosen goal may not work out as planned and treatment may involve some trial and error before a workable plan emerges. The characteristics of these goals are:

- (i) All goals are **negotiated** and reflect both the professional judgement of the treatment team and the individual client's perspective and commitment.
- (ii) Each goal is clearly defined and **measurable**, so that it is easy to identify whether it has been achieved or not.
- (iii) Goals are broken into **short-term targets**, so that the client gains a sense of achievement at each step.
- (iv) The goal should be **realistic** and not so ambitious as to be unobtainable.

Social and family goals

Those with multiple needs often have social and family components to their problems. Goals may include finding more suitable accommodation, reducing isolation or facilitating the client engaging in daytime activities or work. If the client is reluctant to use existing services, such as day centres, rather than abandon the goal, enquire further. Ask why and consider alternatives, which may involve other agencies. Unless the goal is mutually agreed it is unlikely to succeed. Sometimes the goal may have

to be divided into simple steps. For example, a client suffering from social phobia may start with leaving the house for a walk along a busy road and only later try to mix with others in a day centre.

It is useful to identify factors, which aggravate problems. Harmful drug use often peaks after Social Security benefits are received and then declines as the person runs out of money. Simple goals may include buying the week's groceries immediately or asking a relative to 'bank' the money. The client's peer group may also be unhelpful. While similar drug consumption may not cause healthy peers harm, it may aggravate the individual client's mental illness. The goal of finding alternative less exploitative social contact becomes essential.

The family setting may help or hinder. Drugs and alcohol may be used to avoid the tensions of hidden conflicts. Such use may also allow unassertive individuals to express their views when intoxicated. Therefore goals within the family will often have to be shared and agreed upon. As discussed before, the safety and well being of family members, particularly children are important. In negotiating these goals the family may be able to break out of a static situation and begin to change.

Specific goals for alcohol use

There are three possible targets: to stop drinking entirely, to moderate drinking to within defined sensible levels or simply to reduce drinking with hopefully less damaging effects. Within the context of dual diagnosis abstinence is generally the preferred target. Some clients may attribute their symptoms to their associated mental illness, thus a trial period of abstinence may help them realise the true nature of their condition. Those who are unwilling to take this step may agree to controlled or moderate drinking within defined limits. For some this may require even greater effort than stopping. High tolerance means they derive little enjoyment from the reduced quantity and it can be a continuous struggle to keep to the limit. This target may also be a transition towards abstinence. Reduced drinking with ongoing harm should always be seen as a first step with more ambitious targets to come later. One must not unreservedly accept just any goal suggested by the client. It may be necessary to go back to the principles of motivational interviewing and give them more time to reach a decision.

In seeking to reduce drinking to 'safe' levels there must be a precise measurable daily or weekly target. The person must understand the units of alcohol system if this is used. Generally one adopts the recommended levels as this has the added weight of expert opinion behind it. Self-

monitoring is the key to success and helps individuals recognise their pattern of drinking and provides a concrete way to record progress. It involves daily recording of the amount drunk and circumstance surrounding drinking in a diary. This information can help in the early stages to identify those situations that cause problems and so develop coping strategies (e.g. do not drink when angry or upset, stay away from certain drinking companions). It is important to avoid rapid intoxication, as the goal is to remain in control of one's drinking at all times. The individual is encouraged to regularly report the results, which can sustain momentum and encourage progress. Corroboration may be sought through blood tests or feedback from relatives. In maintaining the new drinking pattern the person must learn to refuse drinks, find new rewarding activities and explore alternatives to drinking. Such examination can reveal how much the person's lifestyle was dominated by alcohol, particularly for those who abstain completely. Consideration should be given to alternative activities which can successfully replace the hours spent drinking.

Specific goals for drug misuse

These range from total abstinence to reduction of drug-related harm. Dependent individuals with poor social support and long histories of use are less likely to succeed in stopping abruptly. However, many individuals with dual diagnosis are not necessarily dependent. Their problems arise through their intermittent use of illicit drugs undermining the treatment of their associated mental illness. Even the use of heroin does not automatically imply dependence. Following assessment, giving of information, and use of motivational interviewing, appropriate goals should emerge. Illegal drugs are only available through a restricted source and goals will inevitably include avoidance of other drug users. How to deal with social isolation and find alternate pleasurable and rewarding activities must be considered. In listing the pros and cons of drug use they may say it enhances confidence or enables them to mix socially. These issues must be discussed frankly, but it is only when they identify the disadvantages for themselves that they will consider other approaches.

Those who choose to continue their drug use may be willing to accept goals that reduce the harmful consequences. However, they may be reluctant to record intake in a diary because it gives evidence of illegal use. Targets to reduce the quantity and frequency of use may thus be less precise compared to alcohol misusers. Goals may include shifting to less harmful forms of the drug (e.g. less potent cannabis, not mixing drugs and being reasonably sure they know what they are taking). An avoidance of the substance when psychiatric symptoms emerge or worsen can be an intermediate goal leading to abstinence

Intravenous drug use carries considerable health risks and ideally the drug user should be persuaded to stop. At the very least they should not share needles, syringes and injecting equipment (spoons, filters, water etc). They must be encouraged to use needle exchange schemes or buy fresh needles and syringes from pharmacies. When injecting it should be done safely. Examples of issues covered will include: always inject with the blood flow; rotate injection sites; avoid risky areas such as the neck, groin or infected sites; and dispose of equipment safely.

Specific goals for mental disorder

Goals will centre on taking medication, seeing professionals for psychological support and monitoring, embarking on specific psychological therapies and attending structured activities in day centres or other venues. These may be centred in health or Social Service settings, voluntary agencies, rehabilitation workshops or the person's own home. However before setting any goals one must ensure the person understands their mental illness. It is not always necessary for the individual to have exactly the same view as the professional. Delusions for example are an area where one often effectively agrees to disagree. It is disrespectful to dismiss delusions out of hand, but it is equally unhelpful to pretend to believe them. Rather one takes a pragmatic view, which seeks to minimise the distress caused. For example the therapist can suggest they discuss these beliefs only with carers or professionals rather than strangers who may ridicule them.

Attempts to persuade the individual to agree to treatment are more likely to be successful if there is persistent follow up. Although some might find this intrusive, people are more likely to think of treatment as important if this is reflected by the treatment team.

Complexity of prescribed treatment is associated with poor compliance, therefore drug regimes should be kept as simple as possible. Organising the week's tablets into daily doses can be helpful. Trying to minimise side effects and considering the use of appropriate depot medication can be crucial for some patients. Clear information about medication is essential. People may have concerns that the medicine is unnatural, addictive or a sign of their own weakness, so these issues may need to be carefully explored.

Family members often provide most of the care which people with chronic mental illness receive and can be the people best able to supervise medication and attendance for treatment, always assuming they are persuaded of its value. Education and training can improve relatives

understanding of the illness and they can also be put in touch with self help and support groups.

Different people prefer different environments and the circumstances of follow up should be tailored to the preferences of individuals. Many people with schizophrenia are uncomfortable around others, either as a result of anxiety or their morbid beliefs. Compliance will fail if they have to wait a long time to be seen or have difficulty travelling to inconvenient locations.

Ethnic and cultural factors must always be considered. Poor communication, due to language problems may not achieve the shared understanding needed for adherence to treatment. Dietary restrictions, cultural taboos, racial discrimination and drug interactions with traditional herbal remedies may undermine interventions if they have not been elicited and discussed. There are significant gender issues that should be considered. Women looking after children may not be able to comply with interventions such as group therapy. They may be in vulnerable situations or potentially harmful relationships and past experience of physical or sexual abuse may make them wary of authority.

Preventing relapse

Central to preventing relapse is ongoing contact. Early recognition of symptoms can alert professionals, carers and the individual to the need for intervention. Indeed over time the particular warning signs pertinent to that individual can be identified and incorporated in a plan of action. Relapse with worsening psychotic symptoms will lead to further loss of insight and may necessitate admission to hospital under the Mental Health Act. The impact and disruption to the individual and their family is considerable and subsequent adjustment to normal routine may be slow. Relapse Prevention is a form of cognitive behavioural therapy, which was developed for the treatment of drug and alcohol problems, but increasingly is being used in various mental disorders.

Relapse prevention and drug and alcohol use

A lapse back into using drugs and alcohol is an expected event for many in the process of change. Those who are unaware of this may feel so demoralised that they slip into ongoing relapse with little hope of success. However, these lapses can be used to the person's advantage if they can learn from them. Relapse prevention is an approach which helps individuals to identify and cope with high risk situations and recognise the triggers leading up to them. They may feel overwhelmed by the urge to use in situations such as when feeling anxious or depressed, arguing

with others or under social pressure to use. Relapse prevention helps them avoid the slip becoming an ongoing relapse and in so doing increases their sense of self control and achievement.

One may identify these high-risk situations by discussion or through self-monitoring and ask the person to keep a diary. They may be asked to record the circumstances when they feel cravings as well as the actual lapses. In the early stage they should where possible try to avoid those situations to give themselves time to prepare for them.

This preparation encompasses learning new skills, cognitive therapies and lifestyle changes as listed below:

- Problem solving skills enable the person to identify exactly what the problem is, brainstorm solutions, consider the best option, create a detailed plan and then evaluate the result. This key skill is widely applicable.
- Relaxation training enables the person to cope with anxiety provoking situations.
- Assertiveness training helps people communicate their feelings openly and avoid frustration, anger or distress.
- The person can be trained how to refuse the offer of alcohol or drugs in an appropriate way.
- Marital counselling can help couples regain trust and support each other.
- Cue exposure recognises that cravings will rise in intensity and then fall in the same way that anxiety does. The approach is similar to the treatment of phobias. If one leaves the situation while the craving escalates one reinforces that situation as a trigger for relapse. However, if one rides it out and only leaves after the craving has peaked and falls, one weakens the trigger. This is a technique, which must be used with care, for its ill judged use could set the person back into relapse. In less risky or unavoidable situations such as at work or home, it can be useful.
- Cognitive restructuring involves teaching the person to identify and challenge thoughts or feelings that may lead to a lapse. These thoughts happen so quickly and automatically that they are unaware of them. One helps the person to identify the initial thought that occurs after an adverse event and then analyse the subsequent series of thoughts leading to the unpleasant feeling, which provokes the lapse. For example a person who loses his car keys may automatically assume

he is hopelessly incompetent leading to anger and irritation. The person learns to ask questions as to the evidence for and consider alternative explanations. They learn to interrupt the train of thought, challenge negative thinking and replace them with more reasonable balanced ones.

- The person may be asked to imagine a situation where a slip has occurred and then describe the thoughts that arise and the possible coping skills that could be used. This rehearsal using their imagination helps to consolidate the skills learnt so far and spot weaknesses.
- In changing their lifestyle the person is encouraged to strive for greater balance with less stress and more fulfilling activities such as leisure pursuits, work satisfaction or exercise. People may resort to harmless substitutes when experiencing a craving. Others may throw themselves into a personally rewarding activity that almost amounts to a helpful addiction.

The relapse prevention approach helps people plan ahead and cope with high-risk situations. They learn to spot the warning signs and in time become increasingly skilled in dealing with these.

Preventing relapse in mental health

Many of the interventions used in Relapse Prevention have been applied over many years in the treatment of severe mental illnesses. These include marital counselling, assertiveness, relaxation training and cognitive behavioural therapy for depression and anxiety. Those with schizophrenia have a low tolerance to stress and specific family interventions have been developed to reduce expressed emotion and exposure to tensions within the household. Recently cognitive behavioural treatments have emerged to enable individuals to manage their own psychotic symptoms, such as delusions and hallucinations. Stability and support within the wider social context is essential to continued well being. There is an emphasis on social contact and activities, whether in day centres, self help groups or work settings. To prevent relapse one must ensure that all the needs of an individual are met in a feasible manner.

The role of medication in mental illness

Medication is essential to control severe mental illnesses because of the biological disturbances underlying these conditions. They fall into a number of categories.

Antipsychotic medication

This is used to control the active psychotic symptoms of schizophrenia, mania and depression, such as hallucinations and delusions. They can be given as depot injections at intervals of weeks where compliance is uncertain. However, side effects can occur, one of the most troublesome affecting muscular movements. Newer compounds, the 'atypical' antipsychotics have fewer such side effects.

Antipsychotics are also sometimes used in low doses for short periods to treat anxiety, particularly when one wishes to avoid potentially addictive drugs.

Antidepressant medication

These generally take 3 to 6 weeks for the full effect to develop. The older tricyclic antidepressants tend to have more side effects than the newer types such as the Selective Serotonin Reuptake Inhibitors (SSRIs). The older drugs are also more dangerous in overdose. Antidepressants may be particularly effective in those with clear cut biological symptoms of depression.

Anxiolytic medication

Benzodiazepines are typical of this group. While they are effective in reducing anxiety and helping sleep, tolerance and dependence are problematic. They should generally only be prescribed for short periods of time.

Mood stabilisers

Lithium is used to control mania and to a lesser extent to prevent recurrent depression in bipolar disorders. It is a potentially toxic drug and regular blood tests are performed to ensure the blood levels remain in the therapeutic range. There are potential risks to the thyroid and the kidney in the long term, so it is often confined to those who have relapsed. Drugs used in epilepsy, such as carbamazepine and sodium valproate are also sometimes used as mood stabilisers.

The role of medication in substance misuse

Medication can help individuals achieve their agreed goals. However in isolation prescribed treatments are unlikely to succeed and should always be implemented as part of an overall treatment/care package. Medication plays a role in alleviating withdrawal symptoms (detoxification), substitute prescribing and helping prevent relapse. For further and more detailed information on management of drug misuse and dependence see Drug Misuse and Dependence -

Assisting withdrawal

Careful assessment should identify those who are physically dependent and who may develop withdrawal symptoms on abruptly stopping their drug use. For some, particularly opiate misusers, the fear of the withdrawal symptoms may be a major factor in itself. To some extent this may be addressed in the interventions described above.

Alcohol

Binge drinkers whose bouts last a few days, those with no recent withdrawal symptoms and no recent drinking to prevent withdrawal symptoms will generally not require medication. While many dependent users of alcohol can be safely detoxified at home, hospital admission should be considered for those with a history of withdrawal seizures, delirium tremens (commonly called DTs), deteriorating mental state, serious physical health problems, or risk of suicide. Before starting home detoxification it is best to ensure that they will be seen by a Community Psychiatric Nurse or a responsible person at home to provide support and supervise medication. Explaining what to expect during withdrawal and practical advice on ways of minimising stress can help counter unrealistic fears. During detoxification the person should be seen and their condition checked at regular intervals and they should be encouraged to drink adequate amounts of fluid and resume normal eating as soon as possible.

Treatment with an oral long acting benzodiazepine, such as chlordiazepoxide or diazepam, alleviates the withdrawal symptoms. Chlormethiazole should be avoided because of the risk of respiratory depression in combination with alcohol and the danger of dependence. Benzodiazepines should be discontinued once detoxification has been accomplished or if the person resumes alcohol use. Occasionally prescribing may be extended temporarily to enable the person with dual diagnosis to engage in an aftercare plan as part of a wider package of treatment. Care must be taken not to establish dependence on benzodiazepines. The dose during detoxification of chlordiazepoxide or diazepam will depend on the person's health, symptom severity and level of alcohol use, specialist advice should be sought regarding dosage. The course of medication should be reduced to zero over five to ten days. Metoclopramide orally or intramuscularly may reduce vomiting. Anticonvulsants are only rarely needed and the appearance of seizures indicates a higher dose of the benzodiazepine is required.

People with chronic alcohol dependence are often malnourished and deficient in vitamins, especially thiamine. When undergoing detoxification they should routinely receive oral thiamine together with other B and C vitamins. However, this may be inadequate where there is malabsorption in heavy drinkers so oral vitamins may not prevent the Wernicke-Korsakoff syndrome with its consequent brain damage. Intramuscular or intravenous administration of these vitamins can avoid the problems of malabsorption. This can help to prevent the serious and permanent memory sequelae of the Wernicke-Korsakoff syndrome. Anaphylaxis is a sudden reaction to any medication, which is associated with shortness of breath, a drop in the blood pressure and an allergic reaction. This can be fatal and is a rare complication of giving any drug intramuscularly or intravenously so must be born in mind. However, for this condition the risk is often outweighed by the dangers of brain damage should vitamins not be given. Vitamin preparations should only be given intramuscularly or intravenously where there are facilities for the emergency treatment of anaphylaxis and where staff have the knowledge to instigate such emergency treatment. The intravenous route is less popular because the risk of anaphylaxis is greater.

Opiates

Many dependent opiate users will require medical assistance although some can withdraw without the aid of a prescription, particularly when there is a change in the individual's environment or shift in lifestyle. In preparing for detoxification at home they should be advised to prepare adequately, ensure appropriate support, drink fluids and take hot baths to ease muscle cramps. Withdrawal symptoms will appear sooner for short acting opiates. It is advisable to place greater weight on observable signs rather than subjective symptoms when deciding on dosages for treatment.

Methadone mixture is the most widely used substitute opiate in the treatment of the withdrawal syndrome. Its long action (24 to 48 hours) allows for good control over symptoms and comes as an oral preparation. The initial dose aims to achieve an effective level of comfort while minimising the risk of overdose. Its long action means it accumulates and inappropriate doses can lead to toxicity. In a hospital setting the individual can be reviewed every few hours so that the dose can be titrated. The exact dose will depend on level of opiate dependence and the physical health of the patient. It may take up to five days for a steady blood level to be reached and specialist advice should be sought where there is a question about appropriate dosage.

Doses can be reduced at any pace depending on the results of assessment and the treatment plan. The most rapid regime can be carried out by incremental cuts in dose over one to three weeks, slower regimes may take several months to complete. Slow reductions are favoured when treatment involves complex social or other needs. The greatest reductions are possible at higher dose levels as it represents a smaller percentage of the total. As the dose falls reductions should be more gradual. These reductions can occur at any interval (eg daily, alternate days, weekly). It may be necessary to hold the reduction steady at a given dose over a few days to decrease the person's anxiety and increase their sense of control. This should be done in collaboration with other members of the multidisciplinary team. The goals of treatment must be kept in mind and progress regularly reviewed. Stopping medication is an option and it can be reintroduced later into treatment. Regular re-assessment, urine testing and discussion within the team facilitate monitoring of progress.

An alternative to methadone is buprenorphine, which has recently been licensed for the treatment of opiate dependence, and is taken as a sublingual tablet daily. If this is being considered as part of a treatment plan then specialist advice should be sought. It has both agonist and antagonist actions and can paradoxically aggravate withdrawal symptoms if taken incorrectly, especially if used with longer-acting opiates such as methadone. It needs to be administered at least 24 hours after the last dose of methadone and at least 4 hours after heroin. Buprenorphine may interact antagonistically with high dose opiates and the prescribed dose of methadone may need to be cut before starting. Buprenorphine has a lower risk of overdose and is reported to have less euphoric effects at higher doses compared to methadone.

Dihydrocodeine is a short acting opiate with a high potential for abuse. Poorer control of withdrawal symptoms is likely and it should be avoided where possible.

When dependence is less severe non-opiate drugs are sometimes used and symptoms can be treated individually over 5 - 10 days. Chlorpromazine or benzodiazepines have been prescribed for agitation and insomnia, and loperamide or co-phenotrope for diarrhoea. Metoclopramide can be used for vomiting and non-steroidal anti-inflammatory drugs to alleviate muscle pains.

Lofexidine is an alternative non-opiate that can be used to alleviate most withdrawal symptoms although the person's blood pressure will require monitoring for hypotension, particularly with

evidence of light-headedness. Ideally lofexidine is started two days before the opiates stop, building up to a peak dose on the first or second day of abstinence depending on the opiate. Withdrawal symptoms from methadone will emerge more slowly than heroin. The dose is then reduced to zero within a seven to ten day period. Some practitioners supplement this regime with low dose chlorpromazine or benzodiazepines for a few days to alleviate agitation and insomnia. Clonidine has also been used in hospital settings, but the risk of hypotensive reactions is high.

Benzodiazepines

Sudden cessation of benzodiazepines can lead to a recognised withdrawal state. Many people abuse benzodiazepines as part of polydrug use so there is a need to enquire about their use specifically. Withdrawal substitute prescribing should generally only be initiated where there is clear evidence of benzodiazepine dependence. Management of withdrawal involves gradually tapering the dose down, in the outpatient setting this is usually planned over the course of several weeks. For individuals using short acting benzodiazepines it is usual to change over to an equivalent dose of diazepam as its longer action allows a smoother reduction.

Stimulants

Stimulant drugs such as amphetamines, cocaine and ecstasy do not produce a major physiological withdrawal syndrome and can be stopped abruptly. However, patients who have used regularly may experience insomnia and depressed mood. Antidepressant drugs are sometimes used, but occasional toxic reactions have been described when SSRIs are prescribed and stimulants continue to be taken. In some people with dual diagnosis abrupt cessation of stimulants may trigger a profound transient depression with suicidal thoughts necessitating hospitalisation or close monitoring. Some practitioners have prescribed benzodiazepines or lower dose chlorpromazine for a few days to alleviate insomnia. There may be a limited place for the prescription of dexamphetamine sulphate in the treatment of amphetamine misuse and such treatment is being used in a number of centres in England and Wales. One must exercise great caution in the presence of psychotic illnesses such as schizophrenia or any other co-morbid mental illness.

Cannabis

In general there is no role for medication in dealing with cannabis, although there are reports of symptoms akin to withdrawal in very heavy users. Where agitation or severe insomnia are prominent short term low dose antipsychotics are sometimes considered.

Substitute prescribing

Substitute prescribing plays an important role in helping dependent individuals who are not yet ready to abstain from taking addictive drugs. It helps to achieve the goal of reducing drug related harm and can bring patients with dual diagnosis into long term contact with services and enable a comprehensive treatment package to evolve. The stability afforded through substitute prescribing can foster greater compliance with other components of treatment. In the main, substitute prescribing is limited to opiate dependence. There is no substantial body of evidence supporting the prescription of substitute stimulant drugs and there may be a higher risk of complications such as paranoid psychosis in dual diagnosis. For those individuals who are using 'street' benzodiazepines in a dependent fashion, prescribing of benzodiazepines may be appropriate, but only with the aim of reduction and withdrawal. Those who have been prescribed benzodiazepines for many years may find the prospect of even gradual withdrawal very distressing. In practice carefully monitored prescribing can continue in a minority especially if stability of the mental illness is threatened and a thorough multidisciplinary assessment supports such a plan of care for that person with dual diagnosis.

For opiate dependence, methadone mixture is most commonly used. The individual should be seen regularly with frequent random urine tests for illicit and addictive drugs. One must not lose sight of the goals of treatment, which are to reduce and ultimately stop harmful substance use. Outpatient maintenance methadone programmes, which incorporate psychosocial interventions, can enable individuals to remain stable and can be effective in reducing criminal activity. For those with dual diagnosis goals may include compliance with all aspects of treatment. Injectable prescribing should only be considered in specialist settings for selected patients.

Preventing relapse by prophylactic use of medication

Disulfiram interferes with the breakdown of alcohol in the body to cause a build up of toxic metabolites resulting in unpleasant effects (headaches, flushing, nausea, vomiting, rapid pulse) if even a small amount of alcohol is taken. With larger doses of alcohol the effects may be severe and occasionally life threatening with hypertension, collapse and arrhythmia. In the usual maintenance dose drinking may be significantly reduced, particularly when the medication is initially supervised. In requiring the person at least to wait until the effect of disulfiram wears off, it can deter random impulsive drinking. Rare severe adverse effects include liver damage and psychotic reactions. Liver function tests should be checked intermittently. Disulfiram should be

avoided, or only prescribed with great care, for those who have co-existing psychotic illnesses or impulsive personality traits with a history of self harm.

Acamprosate is believed to work by modifying the effects of transmitters in the brain, thereby diminishing aspects of craving for alcohol after withdrawal. Treatment is usually started soon after detoxification. It should only be used as an adjunct to supportive or other psychosocial therapy. It does not interact with alcohol or benzodiazepines. There is evidence that abstinence is increased in some patients if acamprosate is used alongside other psychosocial interventions.

Naltrexone blocks the action of opiates including the euphoric effects. Thus heroin use is futile while taking naltrexone. However, if the person is still dependent when taking naltrexone it will precipitate an acute withdrawal syndrome. It should be prescribed daily as an adjunct to a programme of relapse prevention. The person should be committed to a goal of abstinence, as simple reliance on naltrexone to deter use is unlikely to succeed. When a patient stops using naltrexone he or she will have lost their previous tolerance to higher doses of opiates. They must be warned of the risk of overdose and death if they are not careful and immediately use the doses of heroin (or other opiates) that they were previously used to.

Tobacco smoking

The level of tobacco smoking among those with mental illnesses and drug and alcohol problems is very high. Increasingly the health consequences of tobacco are recognised and treatments have emerged. Advice, counselling and medication such as nicotine replacement therapy and bupropion are now available. It is important to remember the health benefits of stopping are very substantial at any age and however long or heavily the person has smoked.

Pregnant mothers

Pregnant mothers dependent on opiates require speedy intervention. It is the withdrawal syndrome and the lifestyle associated with drug use, which pose the greatest risk to pregnancy. Methadone mixture is prescribed as outlined above but great care is taken in planning any reductions. Specialist drug treatment services must always be involved in the care of pregnant drug users and support and monitoring by Social Services may be required. It is not advised to stop use suddenly, but with help, the pregnancy can be supported effectively and considered decisions made about optimal treatment and optimal detoxification.

Emergencies

Emergencies are crisis situations that require immediate attention to prevent or minimise harm to self or others as a result of disturbed mental state or physical disorder.

Collapse

This can occur as a result of overdose (alcohol and/or drugs), either accidentally or intentionally.

Psychosis

Frightening or disturbing hallucinations and delusions can accompany relapse of a mental illness and in some withdrawal states. Acute intoxication may also mimic psychotic illness and in difficult to control mental illnesses may aggravate symptoms.

Deliberate self-harm (DSH)

This may occur in response to crisis, stress or worsening mental state and psychiatric symptoms. DSH is a term used to refer to behaviour that results in physical harm to self as a way of coping with distressing feelings, but does not result in death. In many cases DSH is not in itself an attempt to end life. It could be argued that drug use especially long-term alcohol and injecting behaviour constitutes a form of deliberate self harm in itself. In some instances chronic use of harmful drugs is best understood as a way of damaging oneself and finding it difficult to care for oneself. Such an understanding may make sense in the context of a person's life story including traumatic experiences, developmental and educational background, and their personality development.

Alternatively, such behaviours may arise in severe and enduring mental illness as a serious attempt to end one's life, or indeed whilst intoxicated with drugs. Common behaviours include lacerating body parts with sharp objects, inserting objects into body, pulling hair out or hitting one self. Reckless high risk behaviour may also occur, for example walking in front of cars in busy fast traffic, or jumping off a tall building. Those with a history of DSH are more likely to complete suicide. Serious self harm in a state of extreme agitation becomes a psychiatric emergency and staff have a duty of care to prevent harm and reduce distress. Some people report that their use of drugs reduces the desire to self-harm. In a situation of enforced abstinence (custody, psychiatric admission), and its ensuing distress, such behaviour is liable to return. A common assumption is that DSH is a way of seeking attention and manipulation. However, such attributions may be applied to justify decisions (e.g. disengagement from a client) and this should be resisted. DSH

may be used as a coping mechanism and to be told to stop can feel very frightening. This may lead to a build up of tension and distress leading to a more serious outcome such as completed suicide.

Suicide

According to the National Confidential Enquiry of suicides and homicides, drug use is common amongst those who commit suicide (Appleby et al, 1997; Ward & Applin, 1998). Excess risk of suicide among drug addicts is eight times compared to general population (Oyefeso et al 1999), and consumption of antidepressants of more than one class is a high risk for premature death amongst addicts and non-addicts (Oyefeso et al, 2000). Suicidal ideas and impulses can be a result of craving for drugs, disinhibition, or exacerbation of distress as a result of intoxication. Therefore a thorough risk assessment and the formulation of a comprehensive management strategy are essential.

Violence and aggression

Whilst a tolerant and flexible approach is advocated for working with people who have dual diagnosis, violent behaviour is unacceptable. Staff need to consider the safety of themselves and others in the environment. Violence must be dealt with like any other situation. However, it is important to try to prevent hostility escalating into a violent incident. There are well defined techniques to assist in dealing with potential imminent violence such as: reducing stimuli in the environment; lowering noise; talking in a calm tone of voice; and remembering that people who are agitated need to maintain a large personal space around them. Trying to find the reason for aggression is important. The Royal College of Psychiatrists (1998) have produced guidelines for the management of violence developed on the basis of consensus expert opinion. These should be carefully incorporated into local policy and practice, although the precise mechanism for implementation needs to be adapted to local situations.

Research into people with dual diagnosis indicates that they are more likely to have a history of violence when compared to a non-using group of people with mental disorder. The link between violence and substance use is unclear but may be due to disinhibition. People become aggressive if they feel frightened and trapped, or if they feel a 'personal rule' has been violated. People are more likely to misinterpret situations as hostile if they are intoxicated or experiencing the after-effects of drugs. Alcohol and stimulant intoxication are particularly likely to increase aggression, by disinhibition and increased irritability. Craving for substances is also likely to increase agitation.

Adding these effects to a disturbed mental state can lead to increased fear and paranoia. Confrontation regarding drug use and intoxication should be avoided until someone is less aroused and should be done in a way that does not provoke aggression.

Confusional states

These arise as a result of severe alcohol and benzodiazepine withdrawal, or organic damage through drinking causing a confused agitated state such as Wernicke's encephalopathy. Delirium is a synonym for an acute confusional state. Those suffering from such confusional states need psychiatric and medical care due to risks of accidental harm, disturbed behaviour and also the risk of morbidity and mortality from the actual cause of the confusional state. People affected are typically disorientated as to where they are, the day and date. They may act upon visual, tactile and auditory hallucinations as a result of acute intoxication. They may have short term memory problems and be extremely distressed and frightened. Assessment should identify the cause of the delirium and treatment should be focussed on the underlying cause as well as associated behavioural disorder.

Medical emergencies

These constitute situations where physical conditions become life threatening and require emergency medical attention usually via emergency services. For people with dual diagnosis there are a number of possible medical emergencies that may be encountered.

These include:

- Accidents due to intoxication such as head injuries, burns, falls, drowning.
- Accidental or deliberate overdose leading to loss of consciousness, coma and death (sedatives) or cardiac arrest (stimulants).
- Serious medical conditions as a result of drug use itself, such as injecting leading to blood poisoning (septicaemia) or deep vein thrombosis.
- Alcohol and benzodiazepine withdrawal syndrome when severe carries risk of fits and in very extreme cases death.
- Hypothermia as a result of sleeping rough and being intoxicated with alcohol.
- Dehydration.
- Choking and suffocating- choking on vomit whilst heavily sedated, or sniffing aerosols which can freeze the windpipe and stop breathing.

**Table 15 - Summary table examples of
medical emergencies caused by substances**

Physical Signs and Symptoms	Possible causes
Drowsy or unconscious, shallow breathing, pinpoint pupils, cold & clammy, blue hue to skin	Opiate overdose
Breathless, rapid pulse, red faced, headache, highly agitated	Stimulant overdose
High fever, drowsy, red rash over skin	Blood poisoning (septicaemia)
Profuse sweating, shaking and tremor, anxiety, high temperature and blood pressure, confusion, vomiting and nausea	Severe withdrawal from alcohol and benzodiazepines
Runny nose and eyes, dilated pupils, goose bumps, shivering, feeling alternatively hot and cold, diarrhoea, stomach cramps, muscle aches, clammy skin	Opiate withdrawal

Acute intoxication

People who are very intoxicated will be cognitively impaired and will not be able to judge situations as dangerous, therefore they may wander into a busy road or fall off a building. Head injuries are common, and can affect how people tolerate and react to psychiatric medications. Head injuries also increase risk of epileptic seizures so caution needs to be taken when prescribing drugs, which lower seizure threshold. People can lapse into deep sleep and choke on vomit. If someone is acutely intoxicated, they should be placed in the recovery position with the airway clear, and chin extended. Their level of consciousness should be checked regularly (and can be monitored at 15 minute intervals using the Glasgow Coma Scale). Any concerns call for medical attention. Hypothermia is a big risk for homeless drinkers, as alcohol, reduces core body temperature.

People intoxicated with opiates will have diminished pain perception therefore could cause serious damage without knowing (e.g. falling asleep after using heroin next to a radiator causing severe burns). Someone could cause a fire as a result of falling asleep after use of sedative drugs and leaving a cigarette burning or food cooking.

Alcohol withdrawal

Severe alcohol withdrawal can be life threatening, and in some cases require medical treatment. If someone cannot access medical care directly the best advice is to continue to drink alcohol at a minimum level to prevent a withdrawal syndrome. The standard treatment for alcohol withdrawal is a reducing dose regime of benzodiazepines with thiamine. Severity of withdrawal should be monitored and the dose adjusted accordingly. Some people require high doses of benzodiazepines to prevent fits. Anti-psychotic medication will lower threshold for seizures, so an anti-convulsant may be used prophylactically for those at high risk. Vitamin B deficiency can produce irreversible cognitive impairment known as Wernicke-Korsakoff syndrome. This manifests as apathy, confusion and problems with short term memory and intramuscular vitamins may be needed to prevent it. If someone attends services asking for immediate help due to alcohol withdrawal then it is important to also consider them at high risk for suicide. People who drink heavily may go for days or weeks without eating properly. They get calories from alcohol alone and so malnourishment is may also be a problem.

Drug related emergencies

Injecting behaviour is mostly associated with heroin and cocaine use, however, most drugs (even alcohol) can be injected directly into the veins. Intravenous injecting carries a number of risks to health, and often, the user lacks information and skills to inject in a way that minimises those risks. Injecting directly into bloodstream bypasses the body's defence mechanisms for toxins. This means that a toxic dose is easily administered, and takes effect immediately. Instant death is associated with injecting cocaine or crack as well as heroin. Using contaminated equipment introduces bacterial and viral infections into the body. Septicaemia (blood poisoning) can result from an infection and is life threatening. The symptoms include fever, loss of consciousness, and a red rash over body. This usually requires hospitalisation and intravenous antibiotics. People who inject often damage the veins through repeated use. This can lead to blood clots in the deep veins (called a deep vein thrombosis). This effectively limits the blood leaving the limb. The symptoms are pain, and a swollen red or blue limb. Urgent medical treatment must be sought to prevent further damage to the limb, and to prevent a clot dislodging and moving around the body where it can block a blood vessel in the brain or lungs (an embolism). A blockage of blood supply to a limb can also be caused by injection into an artery (eg of crushed tablets). This can lead to gangrene and loss of that limb.

Mixing drugs can lead to accidental overdose. This is usually as a result of mixing sedative drugs such as heroin, benzodiazepines and alcohol. People typically lapse into unconsciousness and coma. Coma is a deep state of unconsciousness where a person shows no response even in response to painful stimuli. A person can stop breathing leading to death. The use of stimulants such as cocaine and amphetamines may lead to a fast heart rate (tachycardia), irregular heart beats (arrhythmias) and the heart might stop beating (cardiac arrest). It is vital for effective medical treatment that the paramedics or Accident and Emergency staff know what drugs have been consumed. Any drugs and bottles, pills and powders found near the victim will help identify what has been used and should therefore be transported with the victim. Some people use drugs when alone therefore it is important to educate people about the risks of. It is often difficult to distinguish between deliberate and accidental overdose, unless the person survives to explain their actions. There is increasing interest in guidance and training for drug users as to such risks; what to do if a user stops breathing and the importance of getting help quickly.

Children at risk

Promoting children's well being and safeguarding them from significant harm depends upon effective information sharing, collaboration and understanding between agencies and professionals. Those working with parents must be aware of their wider responsibility to children and dependents of that adult. Personal information about children and families helped by professionals and agencies is subject to a legal duty of confidence and should not normally be disclosed without the consent of the subject. However, the law permits the disclosure of confidential information necessary to safeguard a child in the public interest. This public interest in child protection may override the public interest in maintaining confidentiality. Staff must be aware of existing protocols and referral routes and follow them when concerns arise.

Deteriorating psychosis

When under reasonable control psychotic symptoms may be kept in check and not dominate the person's thinking and behaviour. They can retain enough insight to recognise that these symptoms are different from normal experiences and so try to ignore them and avoid their intrusion into their daily life. However, if these symptoms worsen this insight may well be lost and the person may put themselves and others at risk by acting upon these symptoms. Voices telling the individual to harm themselves or others may become insistent. Paranoid delusions may come to dominate all thinking leading to isolation from people and services or violence arising out of fear and irritability. A

deteriorating mental state can be an emergency because prompt intervention is required. An individual may require compulsory admission to hospital. It is therefore important that all members of the multidisciplinary team of whatever professional background play an active role in spotting signs of early relapse, communicating their concerns and monitoring for evidence of increasing risks.

SUMMARY

- Successful treatment requires long-term commitment, recognition of which treatments are feasible and adequate support to staff working in multidisciplinary teams.
- The Cycle of Change model describes a way of understanding how individuals reach a decision to change and may offer assistance in choosing the most appropriate treatment.
- Motivational Interviewing is a type of counselling with specific techniques that encourages the person to alter their thinking and behaviour (eg through the Cycle of Change) and so stop harmful use of drugs and alcohol and to accept intervention.
- Treatment is focussed on collaboration in helping the individual set targets for change.
- Relapse Prevention helps individuals who have succeeded in making changes, plan ahead and cope with risky situations.
- Medication has a role alongside other treatments to alleviate withdrawal symptoms, in substitute prescribing, helping prevent relapse and controlling symptoms of mental illness.
- The risk of emergencies arising out of drug and alcohol use in the presence of severe mental illness is high.
- Emergencies range from collapse and confusion to crisis arising out of behaviour and the response therefore ranges from medical to psychosocial interventions.

SECTION 6 - Organisational Issues

Learning Objectives

- To be able to describe common service models and how they support practitioners to work with people with dual diagnosis.
- To be able to identify the essential functions of services for people with dual diagnosis.
- To understand common problems in teams and organisations that lead to conflict and compromise the delivery of a service to people with dual diagnosis.
- To understand clinical governance and how it affects professional practice and service delivery.
- To be familiar with evidence based medicine and its role in individual professional practice.

Introduction

Dual diagnosis could be conceptualised as an organisational challenge as much as a clinical challenge. Currently within the UK there is a general acceptance that substance use and mental health services as they stand fail to meet the complex needs of people with dual diagnosis (Gournay et al 1997). A consequence of this is that some of the most vulnerable service users fall through the net of care. Given the recent Government guidance on 'mainstreaming' dual diagnosis within mental health services, serious consideration and review needs to be given to the organisational framework for providing services for dual diagnosis clients.

Service models

There are a number of service models, however two approaches which seem to currently dominate are the parallel and sequential models of practice. An example of the former is where a client is being treated independently by a mental health and a substance misuse team. Quite often in this situation the onus for communicating or complying with the treatment plan falls on the client, with the result that they 'ping pong' between services. The sequential model demands, as perhaps the term implies, that the perceived 'primary' problem (i.e. drug or mental health) is addressed and resolved before the other 'team' will pick up the case. Neither model bodes well for the dually diagnosed client. There has been research focussed on this problem in the USA (Drake et al 1996a, Drake et al, 1998). The outcome of this work has led to the establishment of 'integrated services'.

This approach consists of equipping mental health services to provide treatment for both mental health and substance use disorders in one setting. An example of such services can be found in New Hampshire, USA, which promotes this Integrated Approach. There is some limited evidence that this approach can have some reduction in bed days, better service user engagement and overall reduction in symptoms, social problems and use of emergency services (Drake et al, 1998).

According to Johnson (1997) in the UK there are three styles of service delivery for people with dual diagnosis, each however with their own difficulties.

Model 1. A specialist service (separate to generic services), like New Hampshire, that can work specifically with this group. The limitations of this approach are:

- It would be very expensive to create a separate service.
- It would not be feasible to include all dual diagnosis clients within the catchment area given that prevalence is so high.
- It does little to raise the skills of the generic workers. This is particularly salient, as it has been documented that mental health workers have poor skills and knowledge in working with substance use problems .
- It would create a third referral route for people who already get passed between services on a regular basis.

Model 2. A second approach suggests specialist skilled workers should be employed to work within generic teams. Individuals with specialist experience and training would predominantly work with dual diagnosis clients but would also be a resource for their colleagues offering advice and training. The limitations of this model are:

- High levels of burnout for the specialist (an expectation that they should deal with all the dual diagnosis issues for the team).
- Limited dissemination of specialist skills and knowledge due to demands of clinical work.
- Lack of time to provide training and consultation to colleagues.
- Specialist workers may be more likely to get promoted and leave.
- In times of absence, the service is on hold.

Model 3. Another idea is to bring everyone's knowledge and skills up to a basic level where people feel equipped to detect, assess and work with substance use problems alongside their routine work. This could be achieved by limited but targeted training for all workers in the team. However, the great advantage of all people from all services having better knowledge of working with people with mental illness and drug use is engagement from whichever service the individual approaches. People with dual diagnosis often mistrust services and may have had past negative experiences. They may also have had traumatic lives in which they find difficulty making and sustaining relationships. Therefore all services are likely to be approached with caution in case this also leads to a repetition of past experiences of being let down. If all professionals, wherever located, have basic skills in working with this group, uptake of treatment will be greatly enhanced. The main limitations of this are:

- Cost of training for all team members.
- The need for ongoing training for new staff as a result of natural turnover.
- Training impact may be less effective for those individuals who lack interest in drug and alcohol issues.

Although these ways of working are listed as three possible approaches in reality one or all of them might be mixed depending on local circumstances. For example, there may be a well resourced addiction service that can support mental health workers in other teams; alternatively in the absence of local addiction specialists it would be more prudent to ensure that all workers had a good working knowledge of addictions and mental health care. Specialist teams are likely to be viable only where the numbers of people with dual diagnosis are sufficient to make it cost effective to have a separate team. The newly established assertive outreach teams spend much of their time working with mentally ill people who use drugs, they will need to have the skills to work with dual diagnosis as well as a range of other skills working with people with complex needs, rather than be specialists in only dual diagnosis. The prevalence of dual diagnosis in mainstream mental health services is so high that it is clear that the development of knowledge and skills (at least to a basic level) is a minimum requirement to begin to meet the needs of patients and professionals in mainstream services.

Function versus structure

The above models describe structures in ways of working, what is more important is the functions that teams fulfil. Often local historical patterns of service provision, the personalities of key stakeholders, and preferred ways of working make innovation difficult to achieve. Practitioners can assess the function of their service using the following functional checklist for service readiness to meet the needs of people with dual diagnosis.

- Team working
- Shared supervision
- Range of professional skills, specialist and generic: mental health, drug services, social care, resettlement
- Reflective practice that engages with conflict constructively
- Flexibility of referral criteria whilst retaining clarity of target group
- Communicating effectively with individuals
- Communicating effectively with organisations that are unfamiliar with working with people with dual diagnosis
- Working with communities so local resources and local problems are understood
- Managing expectations of stakeholders
- A clear theoretical basis to the work to which the team can sign up
- Clarity about the range of interventions offered
- Skills to meet the range of needs that emerge from people with dual diagnosis
- Capacity to respond to crises
- Coherence and seamless delivery of a range of services

Governance and innovation

Although legislation in Scotland and Wales may differ from England in terms of the names given to policies, legislative requirements, and implementation targets; there are common principles for high quality care which are shared by all. *A First Class Service* (1998) described how to achieve improvements through a three layered approach: setting standards, delivering local services and monitoring implementation. *The National Service Framework for Mental Health* (1999) has set core standards, which include the need to engage and retain people with dual diagnosis in treatment.

The principles of the Care Programme Approach, a core part of service provision in England, are central to the co-ordination of care that optimises engagement, anticipates or prevents a crisis, and reduces risk. The emphasis on the lead role of a named care co-ordinator is an attempt to ensure adequate communication between agencies and professionals.

There are four main components of clinical governance:

- Clear lines of responsibility and accountability for the overall quality of care
- A comprehensive programme to improve quality of the service
- Clear policies for managing risk
- Procedures for all professional groups to identify and remedy poor performance

Trusts are in the process of implementing structures and processes to assure good clinical governance and this provides an opportunity to plan specifically for people with dual diagnosis. The remit of multidisciplinary teams can be clarified and training needs recognised. Procedures for professional appraisal and the commitment to lifelong learning can support the need to provide knowledge and fill skill gaps for individual staff members. The processes of clinical governance can provide a mechanism for dealing with organisational obstacles to service provision for people with dual diagnosis. Similar principals apply for non-statutory drug and alcohol providers. This may mean additional training in the harm that drugs and alcohol can cause for community mental health teams, and training in the assessment and management of severe mental illness for those working with drug teams. Both groups need to know how to assess the role of personality in the presentation of those with dual diagnoses, and each group needs to develop more effective ways of working together in their local services.

The following are important elements in any strategy to assure good clinical governance:

- Clinical audit
- Effective management of poorly performing clinical colleagues
- Risk management
- Evidence based clinical practice
- Implementation of clinical effectiveness evidence

- Development of clinical leadership skills
- Continuing education for all clinical staff
- Audit of consumer feedback
- Management of the clinical performance of colleagues, developing guidelines and protocols
- Accreditation of hospitals, community providers and primary care groups
- Continuing professional development for all staff

Service evaluation

By a focussed evaluation of a service one can identify whether the needs of those with dual diagnosis are being met. Direct feedback from patients may be obtained from surveys or reviewing complaints. However this is insufficient on its own. Increasingly services are expected to provide data on their contact with individuals, types of interventions offered and the outcomes of treatment. The Department of Health produced guidelines for purchasers of services for drug users identifying a range of performance indicators. However there is little specific guidance on dual diagnosis, although suggestions have included hospital readmission rates and cross referrals between agencies.

Another form of evaluation is to check whether services have appropriate policies and procedures in place. The Department of Health funded Alcohol Concern and SCODA (now DrugScope) to produce the manual "Quality in Alcohol and Drug Services " (QuADS). This document presents standards covering management, staff and working practices. This has been developed to apply to all drug and alcohol services and is now being used by an increasing number of drug and alcohol services to demonstrate good practice.

Local audit provides a further tool to assess whether standards are being met. Such projects require resources to collect the information required, but they have the flexibility to choose specific local issues to investigate. Gaps in local service provision can be identified by well conducted audits of service structure and practice.

Summary

- Commissioners, managers, and practitioners have an important role to play in identifying gaps in services.
- There are three main service models for people with dual diagnosis (specialist team, specialists within teams, and giving existing mainstream teams the appropriate skills). These may be combined. Each has its advantages and disadvantages. However, there is clear value in all professionals within mainstream services, irrespective of their specific interest, being aware how to assess and manage people with dual diagnosis. This 'mainstream' model is likely to form an important element in provision for people with dual diagnosis given the high prevalence in mainstream services.
- Clinical governance requires that individual clinical practice is underpinned by continuous professional development and lifelong learning, audit and service development.
- Evidence based practice should not constrain innovation but help support it
- Service evaluation should be an ongoing activity used to improve services for the benefit of service users including those with complex needs which are not adequately addressed within existing provision. People with dual diagnoses fall into this group.
- The principles of the Care Programme Approach and the National Service Framework for Mental Health are valuable in any service.

SECTION 7 - Information Sources

Learning Objectives

- To provide information on internet and library sources of further information on the subject of dual diagnosis
- To understand the meaning of common terms used to describe substance use and conditions associated with mental illness and substance use
- To identify 'search terms' that could be used to search for information about the subject of dual diagnosis

Websites

The following is not intended to be an exhaustive list, rather it is hoped that the addresses (both real and web based) presented here and in the text of this book will provide a starting point for those interested in gaining further more detailed information.

For past and ongoing research projects, go to: <http://www.dartmouth.edu/dms/psychrc/project.html> then follow the leads for 'dual diagnosis'. Under 'instruments' it provides useful diagnostic tools.

An Australian site with a range of information is
http://ourworld.compuserve.com/homepages/Rich_as_Midas

Also see <http://drugnet.bizland.com/Specialty/coexist/coexisting.htm> for another useful Australian site.

Further information can be searched for on the World Wide Web using search engines such as 'www.google.com' and 'www.alltheweb.com'. Local training will generally be available to develop these skills.

Libraries

The national drugs library is held by **DrugScope** (see below under 'Organisations and helplines'). It does not keep literature relating to alcohol, but this can be accessed at Alcohol Concern, which is in the same building.

Alcohol Concern is the national agency on alcohol misuse. Its library holds research papers, books, leaflets, and journal articles. The library database is available for searching online and photocopies can either be requested by post for a charge or you can visit in person. Advance booking is necessary. Website: www.alcoholconcern.org.uk. It also has an information unit (Tel 020 7922 8667) which provides an inquiry service contactable by phone, post or email (see website).

DrugScope and Alcohol Concern can be found at: Waterbridge House, 32-36 Loman Street, London, SE1 0EE.

The Institute of Psychiatry's library has an extensive collection of journals and books, but access is restricted. Borrowing is allowed for students and staff at the Institute and some staff at the Maudsley Hospital. If you have a library card for one of the colleges of the University of London, you can use it as a reference library, alternatively it may be possible to arrange to visit or an inter-library loan via a local library. Institute of Psychiatry, De Crespigny Park, London, SE5 8AF. Tel 0207 836 5454 (main switchboard). www.iop.kcl.ac.uk

The King's Fund is an independent health care charity that has a bookshop, public library and information service. The library also takes enquiries in writing, by telephone or by e-mail. It is available for reference only so no material can be taken or borrowed directly. The library database is available on CD-ROM, along with the databases of the libraries at the Department of Health and the Nuffield Institute for Health. The library can be contacted at the address or telephone numbers below: 11-13 Cavendish Square, London W1G 0AN. Tel: 020 7307 2400. Fax: 0 20 7307 2801 e-mail: library@kingsfund.org.uk

The Cochrane Library is an electronic publication designed to supply evidence to inform people providing and receiving health care, and those responsible for research, teaching, funding and administration. It is published quarterly on CD-ROM and the Internet, and is distributed on a subscription basis. However, the abstracts of Cochrane reviews are available without charge, and can be browsed or searched at <http://www.update-software.com/cochrane/cochrane-frame.html>. The main output of The Cochrane Collaboration is systematic reviews of the effects of healthcare interventions. These systematic reviews are published electronically in successive issues of The Cochrane Library.

Evidence Based Mental Health: A useful site and journal is that produced by Evidence Based Mental Health. The website for more information is: <http://www.ebmentalhealth.com>

Searching databases

In addition to the databases available through the libraries and websites listed above, there are a number of databases, listed below, which can be searched freely over the Internet. Others will need a subscription from your institution and require passwords.

The NHS's **National Electronic Library for Health** is in development and has a pilot website at: <http://www.nelh.nhs.uk>. It is working to produce an Electronic Library for Mental Health available on the Internet and is likely to become a valuable resource.

PubMed, a service of the National Library of Medicine, provides access to over 11 million citations from **MEDLINE** and additional life science journals. PubMed also includes links to other sites providing full text articles and other related resources. It can be found at: <http://www.ncbi.nlm.nih.gov/PubMed/>

Tips for searching:

If you are doing a database search for articles on dual diagnosis, simply entering the search term 'dual diagnosis' is unlikely to find all the articles you may need, and may also bring some from other specialties where the term has a different meaning. Better results may follow when you put in the name of a particular mental illness combined with the following drug terms. Again local training and support should be available to help the development of electronic search skills:

Comorbidity, substance, drug, polydrug, alcohol, tranquilliser, chemical, narcotic, opiate, street drug, solvent, inhalant, psychotropic, intoxicant, abuse, use, misuse, using, utilising, dependent, addictive, illegal, illicit, habit, withdraw, behaviour, abstinence, abstain, rehabilitation, non-prescription. Further information on search terms is available through the Cochrane Library (see above).

Organisations and Helplines

You may find these organisations useful for obtaining further information for yourself or they may be able to help clients.

Alcohol Concern is the national voluntary agency on alcohol misuse and can provide information about alcohol and alcohol problems. Waterbridge House, 32-36 Loman St, London SE1 0EE, Tel 0207 928 7377 Fax: 0207 928 4644 Website: www.alcoholconcern.org.uk

Alcoholics Anonymous is a voluntary fellowship of people who help each other achieve and maintain sobriety by sharing experiences and giving mutual support. Regular weekly meetings are held in all parts of Britain. Information is widely available from AA helplines or contact AA at PO Box 1, Stonebow House, General Service Office, Stonebow, York, Y01 2NJ. Tel. 01904 644026 (administration). Helplines: 0207 352 3001/0207 833 0022 (London) 0141 226 2214 (Scotland) 01907 6255574 (Mid-Wales) 01685 875070 (South Wales) 01639 644871 (Swansea). Fax 01904 629091.

DrugScope aims to inform policy development and reduce drug-related risk. It maintains a library of world literature on drugs open to the public by appointment with charges of £5 per visit or £2 for students or the unemployed. DrugScope, 32-36 Loman St, London SE1 0EE. Telephone: 0207 928 1211 Fax: 0207 928 1771 Website: www.drugscope.org.uk .

Narcotics Anonymous is run by and for recovering drug addicts using the '12-step' approach through self-help groups. Information about local meetings and helpline: 0207 730 0090 from 10am to 10pm seven days a week. UK Service Office: 202 City Road, London EC1V 2PH. Tel: 0207 251 4007; Fax: 0207 251 4006. Helpline: 0207 730 0009. Tel 0207 251 4007 (UK Service Officer) for leaflets. Email: ukso@ukna.org and pinews@ukna.org - Public Information Website: www.ukna.org/

Release Legal Emergency and Drug Service works with people who have substance misuse problems and specialises in drug-related legal problems. 388 Old Street, London EC1V 9LT. Fax 0207 729 2599. Advice Line: 0207 729 9904 Monday to Friday 10am-6pm. 24 hour helpline 0207 603 8654

Richmond Fellowship Workschemes teach employment and life skills, usually to people resident with the Richmond Fellowship. It also provides care and rehabilitation to people with mental health needs, substance misuse, eating disorders and other related problems through residential facilities, day centres, advocacy, family units and community outreach projects. 80, Holloway Road, London N7 8JG. Tel 0207 697 3300. Fax 0207 697 3301. Website: www.richmondfellowship.org.uk.

The National Schizophrenia Fellowship offers help to people with severe mental illness (not only schizophrenia) and their carers. 28 Castle Street, Kingston-upon-Thames KT1 1SS. Tel 0208 547 3937. Website: www.nsf.org.uk.

Mental Health Foundation provides a wide range of publications and support services. UK Office, 20/21 Cornwall Terrace, London NW1 4QL, Telephone 0207-535 7400, Fax 0207-535 7474 Scotland Office, 5th Floor, Merchants House, 30 George Square, Glasgow G2 1EG, Tel 0141 572 0125, Fax 0141 572 0246. Email mhf@mentalhealth.org.uk Website: www.mentalhealth.org.uk

MIND (national association for mental health) provides a national information and legal service as well as 230 local groups offering a range of support services in the community. Head Office: Granta House, Broadway, London, E15 4BQ. Administration: Tel. 0208 519 2122. Fax 0208 522 1725. Helpline: (In London) 0208 519 2122 ext. 275 or (Outside London) 0345 660163 (Local rate). Website: <http://www.mind.org.uk>

Royal College of Psychiatrists is a professional and educational organisation for all psychiatrists working in the UK and Republic of Ireland. It provides information for professionals and the general public on mental health problems. 17 Belgrave Square, London, SW1X. Tel 0207 235 2351. Fax 0207 235 6051. Website: www.rcpsych.ac.uk

The National Debtline may be useful for clients with financial difficulties and is open Monday and Thursday from 10am-4pm, Tuesday and Wednesday 10am-7pm and Friday 1am-12 noon.

The Sainsbury Centre for Mental Health (SCMH) is a charity which aims to improve the quality of life for people with severe mental health problems by influencing national policy and practice through research, service development and training. User focussed monitoring of services is a crucial part of service evaluation and has been pioneered at SCMH. It provides information, advice and training to professionals and is located at 134 Borough High Street, London SE1 1LB. Tel: 020 7403 8790; Fax: 020 7403 9482. Website: www.scmh.org.uk

SECTION 8 - GLOSSARY & ABBREVIATIONS

NB These are not formal definitions but descriptions of meaning attributed to these terms as they are used in the text.

Addict: convenient short hand term for someone dependent on one or more drugs; the term has acquired pejorative overtones

Addiction: *see dependence*

Affective disorder: group of psychoses typified by change or recurring changes of mood; depressive or manic (qv).

Alcoholic: convenient short hand term for someone who has become dependent on alcohol; the term has acquired pejorative overtones.

Analogue (of a drug): a modification of the original chemical structure retaining essentially the same pharmacological actions.

Anxiety: a chronic state of tension or exaggerated worry. The symptoms may include an unjustified feeling of fear, palpitations, dryness of mouth, sweating (especially of the palms), tight sensations in the head, chest, abdomen, breathlessness, frequent passing of urine, weakness, tremor and faintness.

Approved Social Worker: The functions given under the Act to approved social workers may only be carried out by officers of local social services authorities approved for this purpose.

Bipolar: of the two extremes as in mood disorder such as bi-polar manic depression.

Borderline personality disorder: a type of mental health problem where a person has an enduring pattern of unstable relationships and moods, has low self-esteem, fears being abandoned, may tend to self-harm and therefore have difficulty with social and occupational functioning.

Communicable disease: disease that is capable of being transmitted from person to person, (in this context mainly by drug users sharing infected needles, syringes or other paraphernalia).

Delirium tremens (DTs): acute confusional state (delirium) with tremors, anxiety, delusions; a dangerous consequence particularly of sudden withdrawal of alcohol or sedative drugs. This is not the same as an alcohol withdrawal syndrome which is not associated with the gross confusion of DTs and is usually much less severe.

Delusion: false belief, held as genuine, in spite of evidence or reason to the contrary.

Dependence: substance use meets the criteria for dependence according to DSM IV and ICD10.

Depression: this is essentially a low mood that is more marked or sustained than an ordinary reaction of sadness to loss or current circumstances. The symptoms of severe depression include a deep sense of misery, worthlessness, guilt, dread, thoughts of death and suicide as well as sleep disturbance, loss of appetite, loss of interest in self and hopelessness.

Designer drug: this term refers to synthetic drugs that are analogues of controlled drugs and the term was originally coined to refer to drugs specifically created with the intention of evading drug control legislation.

Detoxification: the process by which drug withdrawal is managed in a dependent user, usually under medical supervision.

Drug: in both scientific and ordinary usage this word can have a number of meanings. Strictly speaking, most of the medicines prescribed by doctors are drugs. So are many widely used substances like aspirin which are available 'over the counter'. In most instances in the text the term is used in a more restricted sense to refer only to psychoactive substances, both illegal substances such as cannabis and heroin, and legal substances, such as solvents and tranquillisers used in an unsanctioned manner, as well as alcohol and tobacco.

Drug misuse: should be applied to use which is unlawful (illegal or illicit), or which is not socially or medically approved, and which has the potential to cause harm. The term 'hazardous use' is also

applied to potentially harmful use. It should be noted, however, that the terms abuse, misuse, problematic use, hazardous use and harmful use are often used interchangeably.

Drug use: “use” is applied to legal use, which is acceptable socially, medically approved and which is non-hazardous, i.e. without impairment of social, psychological or physical functioning.

Endorphin: a substance produced by the body itself with similar pharmacological effects to opiates.

Hallucination: sensory perception in the absence of sensory stimulation e.g. seeing scorpions on the bedspread that are not really there or hearing voices of someone who is not there.

Hallucinogen: a drug that produces hallucinations (q.v.) or perceptual distortions, such as an altered sense of the passage of time.

Harmful use: this term should follow the ICD10 definition, that ‘there must be clear evidence that the substance use was responsible for or substantially contributed to physical or psychological harm’. The term ‘problematic’ use can be used interchangeably.

Hospital: The definition of hospital in the Act covers all hospitals in the National Health Service (including Special Hospitals) and any accommodation provided by a local authority and used as a hospital under the National Health Services Act 1977.

Hypochondria: exaggerated concern with one’s physical health and preoccupation with the fear of having a serious illness.

Hypomania: a state typified by elation, overactivity, a sense of well-being, grandiosity in plans, possibly with delusions, sleep disturbance, exhaustion and moodswings. Sometimes associated with the liability also to develop depressive episodes as in manic depression (bipolar disorder q.v.).

Hysteria: an emotional state which presents as disordered bodily function without any physical cause (that has been explained as the patient converting emotional conflict into physical symptoms also known as ‘hysterical conversion’). Also used to describe a state of loss of control over one’s emotions.

Mania (adj: manic): see hypomania.

Obsessive compulsive disorder (OCD): an anxiety (qv) disorder in which unwelcome thoughts and ideas intrude and cause the person to perform ritualistic actions eg constant hand washing, in order to remove tension.

Opiate: a drug extracted from the opium poppy (such as morphine or codeine), or derived from one of these (such as heroin). Also commonly used to describe a similar synthetic drug (such as methadone).

Narcotic: a term widely used in the United States to describe opiates or cocaine but sometimes, as in international legislation, it refers to a wider range of illicit drugs.

Negative symptoms: refers to aspects of schizophrenia that make the person withdrawn, lacking in emotional warmth and motivation.

Neurotransmitter: a chemical by which a nerve cell communicates with another nerve cell or with a muscle fibre.

Noradrenaline (known as norepinephrine in some countries): a neurotransmitter (qv) and hormone which increases blood pressure and the heart rate.

Panic attack: acute bout of anxiety or sense of imminent danger or doom, with sudden onset, which makes people feel overwhelmed and out of control. Panic attacks usually last for several minutes and consist of feelings of terror and physical symptoms such as palpitations, dizziness, trembling, shortness of breath, sweating and fear of dying.

Paranoia (adjective: paranoid): irrational and/or extreme and persistent suspiciousness or sense of persecution (current common usage of the term).

Parkinsonism: a state of tremor, muscle stiffness, shuffling, excessive salivation. May be a side-effect of some neuroleptic drugs.

Patient: A patient is a person suffering from or appearing to suffer from mental disorder

Personality disorder: group of disorders involving enduring traits/ways of perceiving the world which are outside normal limits and which cause distress to the person or to others.

Phobia: irrational fear, intense dread or anxiety of an object or situation.

Polydrug use: use of more than one drug by the same individual, either in a drug 'cocktail', or one after the other, or because the user's preferred drug is unavailable. Drugs may be combined to enhance their sought after effects or minimise unwanted ones.

Problem drug use: see harmful use.

Psychoactive drug: any drug which affects mood, thought processes or perception.

Psychosis: a form of mental illness characterised by delusions (irrational beliefs), hallucinations, and bizarre behaviour. Drug-induced psychoses are usually short-lived.

Psychosomatic: disease with physical symptoms but strongly associated with psychological factors, e.g. stress causing or aggravating the physical features.

Recreational drug use: a term describing the hedonistic or experimental use of drugs and implying, not always correctly, that there is no significant associated harm.

Relapse: a return to drug use after a period of abstinence by someone attempting to remain drug free.

Responsible Medical Officer (RMO): The RMO is defined in Section 34(1) of the Mental Health Act (1983) as the registered medical practitioner in charge of a detained patient's treatment.

Schizo-affective disorder: some patients present with features of mood disorder and features seen in schizophrenia without a clear diagnosis of one disorder alone and in some cases it can be appropriate for a specialist to diagnose schizo-affective disorder.

Schizoid: a personality disorder characterised by emotional coldness, absence of tender feelings, and withdrawal.

Schizophrenia: a severe and often long-lasting mental illness characterised by particular psychotic symptoms (cf psychosis).

Stimulant: a drug which elevates mood, increases wakefulness and gives an increased sense of mental and physical energy.

Tolerance: a state in which the same dose of a drug produces a reduced effect or higher doses are needed to maintain the same effect; this occurs as a result of the body's adaptation to the repeated use of the drug.

Toxicity: the harmful medical effects, immediate or slowly progressive, of a drug.

Treatment: defined as including 'nursing.... care, habitation and rehabilitation under medical supervision' i.e. the broad range of activities aimed at alleviating, or preventing a deterioration of, the patient's mental disorder. It includes physical treatment such as ECT and the administration of drugs and psychotherapy.

Volatile substance abuse (VSA): sniffing or inhaling solvents or vapours for their psychoactive effects.

Withdrawal syndrome: the physiological and psychological response to the sudden absence of a drug on which the individual had become dependent. Symptoms are usually the opposite of those produced by the drug itself, and are usually unpleasant.

Slang

Slang terms for drugs vary locally and change quickly. You can use the DrugScope website to search these terms: www.drugscope.org.uk/druginfo/drugsearch/home.asp

By typing in the slang term, it will bring up information on the drug and other names used to describe it.

Adapted from *Drugs, Dilemmas and Choices*, (Gaskell, 2000), with kind permission of Gaskell, Royal College of Psychiatrists and R. Hallmark *The Mind psychiatric legal dictionary*, (Mind, 1997) by permission of Mind (National Association for Mental Health)

Abbreviations

AA Alcoholics Anonymous

ADL Activities of daily living

ASW Approved Social Worker

CA Chronological Age, used in calculating IQ, especially in children

DAAT Drug and Alcohol Action Team

DAT Drug Action Team

DDU drug dependency unit

DRG Drug Reference Group

DSH deliberate self harm

DTs delirium tremens

ECT electroconvulsive therapy

EEG electroencephalogram

FME Forensic Medical Examiner (also known as police surgeon)

FRCPsych Fellow of the Royal College of Psychiatrists

GAF Global Assessment of Functioning, a psychological test or scale of psychological, social and occupational functioning.

LSD lysergic acid diethylamide

LFT liver function test

LOC loss of consciousness

MDMA 3-4 methylenedioxyamphetamine (ecstasy)

MDA methylenedioxyamphetamine

MRCPsych Member of the Royal College of Psychiatrists

MSU medium secure unit

NA Narcotics Anonymous

NFA no fixed abode

NMS Neuroleptic Malignant Syndrome

NOS not otherwise specified (in the classification of mental disorder)

OCD obsessive compulsive disorder

PERLA pupils are equal and react to light and accommodation (ie normal result on test of eyes)
RCPsych Royal College of Psychiatrists
RMN registered mental nurse
SAD seasonal affective disorder
SMI severe mental illness
SUD substance use disorder
SSRIs selective serotonin reuptake inhibitors
VSA volatile substance abuse

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APPENDIX A - Basic Drug & Mental Health Awareness

Psychoactive substances: use and effects

Specific drugs are identified to be “illicit drugs” by social and legal precedent. Thus what constitutes an illicit drug will vary over time and between world cultures and societies. For example, in our society alcohol is a socially acceptable drug. Its use is actively encouraged and socially reinforced. Yet, caffeine and nicotine also have potent psychoactive properties as well as harmful physical effects. The categorisation of these substances as legal or illegal is not only based upon a scientific assessment of their relative toxicity or dependence potential, but also upon historical developments such as which groups of people are associated with using the drug, how popular it had become and which interest groups could control its supply. Once any drug is made illegal there are additional risks to health from an unregulated supply. Involvement in criminal activities also lead to lifestyle and legal issues that make it more difficult to seek help and sustain a recovery and rehabilitation program. The degree of severity of penalties for possession, dealing and trafficking of drugs in the UK is outlined in the 1971 Misuse of Drugs Act. One way of approaching the assessment and management of people who engage in harmful use of drugs is to remind ourselves why we use legal drugs such as caffeine, nicotine and alcohol. This may help us empathise with those who use illicit drugs.

Why do people use drugs?

1. To feel euphoric
2. To feel more confident
3. To feel nothing
4. To avoid unpleasant feelings
5. To enhance a social occasion
6. To celebrate
7. To commiserate
8. To forget troubles/problems
9. To unwind after a stressful day
10. To avoid dealing with practical matters
11. To work longer hours or enhance performance
12. To be part of a social group

13. To kill time/alleviate boredom
 14. To alleviate physical pain and other health problems
 15. Because its become a habit
 16. To satisfy cravings
 17. To avoid withdrawal symptoms
 18. To keep weight down
 19. To experience an altered state of consciousness
 20. Curiosity
- (Please note: this list is not exhaustive)

Reasons for people with severe mental illness to use psychoactive substances?

Certainly all the above reasons may apply to clients with severe mental illness (SMI). However, there are some theories as to why clients with SMI are particularly susceptible to substance use problems.

Self Medication

It was originally proposed that clients with SMI used substances as a form of self-medication to alleviate symptoms of mental illness (Khantzian, 1985). However, this does not fit with the kind of substances clients with SMI typically use. The most common substances used are alcohol, nicotine caffeine and psychoactive drugs (e.g. amphetamines, cannabis, and hallucinogens)(Schneier & Siris, 1987). These have been shown to increase severity of positive symptoms of psychosis (auditory and visual hallucinations, delusional beliefs and other thought disorders) so would not be used to alleviate such symptoms. Another explanation for the choice of substances is that they are being used to counteract unpleasant affective states produced by a co-existing depression, or negative symptoms of psychosis such as apathy, low motivation and inability to feel pleasure or happiness. Clients with SMI could also be using psychoactive drugs to counteract the sedative effects of anti-psychotic medication, or relieve parkinsonian side effects.

Vulnerability

Since the closure of the large asylums and with the advent of Care in the Community, clients with SMI have been living in smaller hostels and private accommodation in areas of social deprivation where substance use is highly prevalent. Lacking a structured and supportive social network that

is tolerant and understands severe mental illness some clients with SMI become associated with other disenfranchised sub-groups such as those engaging in harmful use of drugs. There is also a drift into criminal activity in order to fund a drug habit and this can include small time dealing, selling sex and shoplifting. Despite the risk of aggression and violence associated with harmful use of substances among the severely mentally ill, these clients are frequently victims of violence themselves (especially women).

Supersensitivity

The supersensitivity theory proposes that clients with SMI who use substances have poor outcomes due to them being biochemically intolerant of psychoactive drugs. Alternatively the use of psychoactive drugs by people with mental illness may have a disinhibiting effect on their behaviour. Either way, the actual levels of substance ingested may be relatively low, yet have profound effect on psychological, social and cognitive functioning.

Specific drugs and their effects

Drugs manufactured on the black market, because of their unregulated 'quality' pose additional risks to their users. Adulterants may be added to dilute the drug or to enhance its effects. 'Purity' levels will also vary. These can pose particular risks for injecting drug users, although reports of rat poison and similar additions are rarely substantiated. Occasionally one drug, such as amphetamine, may be sold as another more expensive one such as ecstasy.

As well as differences in the ingredients of the drugs themselves, their effects also vary according to the situation in which they are taken, the individual's expectations, mood and physiology. Therefore the following descriptions of drug effects are common but will not apply in all cases.

Drugs that depress the central nervous system

Benzodiazepines

Form and mode of administration: Benzodiazepines, as prescription only drugs, may be misused by the owner of the prescription or obtained from diverted pharmaceutical supplies, and are usually available in tablet or capsule form to be taken orally. In the 1980s there was a serious problem with injecting the contents of oral temazepam capsules. This was greatly reduced when the formulations were banned from NHS prescription and additional controls were introduced. The

literature concentrates on the psychotic effects of benzodiazepine withdrawal, but there is little known of effects of these drugs on pre-existing mental illnesses.

Sought after effects: relief from tension and anxiety, as well as providing pleasurable feelings. They may be used to enhance the effects of other drugs such as opiates or the ease the 'comedown' from stimulants such as cocaine, amphetamines or ecstasy. They may be prescribed for short term relief of anxiety, promoting sleep, or as muscle relaxants and also in alcohol withdrawal and the treatment of epilepsy.

Adverse effects: when misused, benzodiazepines tend to be taken in much larger doses than in medical use and the effects of this are not fully understood. In the short-term, users may experience tiredness, depression of respiration and sometimes dizziness and unsteady movement. Overdose is rarely fatal unless in combination with other sedating drugs such as alcohol or opiates. Dependence can develop and the withdrawal syndrome can be dangerous if fits occur. The user can also suffer rebound symptoms such as insomnia, anxiety and tension.

Solvents and gases (volatile substance abuse)

Form and mode of administration: many of these substances are found in household products such as types of glue, dry cleaning fluids, petrol, butane gas cigarette lighter refills and aerosols. When butane is inhaled from a cigarette lighter refill, the user takes the plastic nozzle between his teeth and breathes in the gas. Glue is usually put into a plastic bag and the rising vapour is then sniffed.

Sought-after effects: immediate euphoria with confusion, unsteadiness and lack of co-ordination. Distorted perceptions and hallucinations can also occur. These effects are usually short lived with the misuser recovering fairly quickly.

Adverse effects: death can occur from butane slowing or stopping the heart due to the severe cooling and from accidents while intoxicated. Users of solvents and gases can also lose consciousness and die through inhaling vomit. Long term use can damage the brain, liver and kidneys and bone marrow. These substances are mainly used by school-age children.

Alcohol

Form and mode of administration: Alcohol is taken orally as a drink and is our most commonly used

drug. Alcoholic beverages are measured in "units" which equate to one regular-sized glass of wine, 1/2 pint beer, 1 measure/shot of spirits, but these only apply to normal strength drinks. Beer ranges from around 3.5% to over 12% alcohol by volume. Strong lagers such as Tenants Super and Kestral Super have around 5 units of alcohol per can.

Alcohol rapidly enters the blood stream from the stomach and intestines. The time to maximum blood concentration ranges from 30-90 minutes. A number of factors affect this such as concentration of alcohol in drinks, and the presence of carbon dioxide and bicarbonate increase absorption rate. The presence of food delays absorption, as does decreasing body temperature. The liver breaks down alcohol.

Sought-after effects: In low doses, alcohol disinhibits behaviour, may increase confidence and sociability and produces a mild euphoric feeling. 'Safe' drinking levels have been the subject of controversy. It has been shown that regular consumption of small amounts of alcohol can protect against coronary heart disease in men over the age of 40 or women past the menopause. The maximum recommended intake per week for males is 21 units and females 14 units, but spread over the week rather than drunk in one session. Alternative Department of Health guidance suggests sensible limits of no greater than 3-4 units per day for men and 2-3 units per day for women. This is not to suggest that such upper limits are to be encouraged as a daily intake. Bingeing is also discouraged.

Adverse Effects: For a man, 21-50 units per week carries moderate health risks, more than 50 units a week and he risks severely damaging his health, and over 100 is likely to be very dangerous to health. At this level the drinker is likely to be alcohol dependent and need medical attention in order to detoxify (stop consumption). Women cannot tolerate the same quantities of alcohol as men and therefore damage occurs at lower levels. Alcohol tolerance can be reduced by age and concurrent liver damage such as might result from hepatitis viral infection.

While low doses may be beneficial, as the dose increases, CNS depression increases, with slurred speech, ataxia, blurred vision and diminishing consciousness. Toxicity usually results in vomiting thus preventing fatal overdoses. However, inhaling vomit is responsible for a number of deaths every year. Because alcohol affects co-ordination, reaction time and judgement, it makes users particularly prone to accidental injury.

Alcohol seems to stimulate people in small doses, but in fact is a depressant drug. This means that it slows down the nervous system, and causes low mood in high doses. Like all drugs, the effects of alcohol are governed by the situation and prior mood of the person. Alcohol is associated with violent incidents and suicide, with the risk of suicide in heavy drinkers being 60-120 times higher than in general population.

Large amounts of alcohol can lead to hypothermia, inflammation of the stomach lining, ulcers and oesophageal varices. Alcohol has a diuretic effect, causing loss of water in the form of dilute urine. Hangovers are mainly the effects of dehydration and low blood sugar. Fluid and salt/sugar intake can help in the recovery.

A physical dependency can result from alcohol consumption and this can lead to marked physical withdrawals on cessation. These include nausea, vomiting, sweating, high temperature, hypertension, anxiety, restlessness and sometimes fits. In severe cases, people experience a state called delirium tremens, which is characterised by confusion, hallucinations, agitation and sleeplessness and can be mistaken for psychosis. Heavy drinkers may also be at risk for seizures that can occur approximately 7-48 hours after cessation of drinking. Chronic alcohol consumption can also lead to irreversible organic brain damage.

Opiates and opioids

Form and mode of administration: Heroin, the most powerful opiate, morphine and codeine are derived from the opium poppy. Codeine, a milder opiate, is found in some over-the-counter pharmaceuticals in very small quantities due to its properties as a cough suppressant or to control diarrhoea. The synthetic versions, known as 'opioids', include pethidine, methadone, dipipanone and buprenorphine.

Heroin may be snorted as a powder, smoked with tobacco in a cigarette or, when 'chasing the dragon', placed on a piece of aluminium foil, heated with a cigarette lighter, and the vapour inhaled through a tube. It can also be injected intravenously, intramuscularly or subcutaneously. Intravenous injection gives the most rapid effect.

Diverted pharmaceutical opiates and opioids may be formulated for injection, oral use or occasionally as suppositories. Tablets are sometimes crushed and injected.

Sought-after effects: Opiates and opioids provide powerful relief not only of physical pain, for which they are most often used medically, but also of psychological pain. They induce intense feelings of euphoria. Although initially these drugs may be taken for the pleasurable feelings they provide, users may continue to use them just to avoid withdrawal symptoms. Methadone may be prescribed to prevent opiate withdrawal symptoms because its slow elimination from the body means that it can be taken once a day in the form of a drink (compared with injected heroin which needs to be taken up to four or five times a day to prevent withdrawal) thus reducing the risks around injecting.

Adverse effects: Dependence on heroin develops after repeated use over several weeks and while not all users become dependent, it is a notoriously difficult drug to manage recreationally. Sudden withdrawal leads to anxiety, nausea, muscle pains, sweating, diarrhoea and goose flesh. This can last for up to ten days and is relieved immediately by taking more heroin or another opiate/opioid. The severity of withdrawal symptoms will depend on the extent of an individual's dependence.

Tolerance develops quickly so that larger amounts of the same drug are needed to produce the same effect. It also diminishes quickly during a period of abstinence so that a relapsing user can easily overdose by taking their former dose. Overdose occurs as a result of depression of the respiratory centre in the brain, which leads to respiratory and cardiac arrest and death unless immediate medical attention is received.

Methadone is also addictive and can cause overdose within an hour of administration or after two or three days as the drug builds up in the body. The market in diverted methadone poses particular risks to those who have no tolerance to it and have not been prescribed the drug. Tolerance to other opiates such as heroin will provide tolerance to methadone as well, but novice users may overestimate this, particularly in combination with other drugs.

Opiates and opioids have depressant effects on reflex functions such as coughing, breathing and the heart rate; they also dilate blood vessels and depress bowel activity, producing constipation. Fatal overdose is most common when combined with other depressant drugs such as alcohol, benzodiazepines or more than one opiate.

Injecting carries the risks of blood borne viruses such as HIV and hepatitis B and C, from sharing

injecting equipment, as well as septicaemia and infective endocarditis which can damage the heart valves and lead to heart failure.

Drugs that alter perceptual function

LSD (Lysergic Acid Diethylimide)

Form and mode of administration: LSD is taken by mouth in extremely small doses (50-150 micrograms) which are usually on small paper squares. The effects tend to start about half an hour after taking it, and according to the dose, last up to 12 hours or sometimes even longer. Once the effects start, they cannot be stopped and the user has to wait until they wear off.

Sought-after effects: LSD distorts shapes, colours and sense of time, and can produce hallucinations, make the user laugh a lot and feel exhilarated. Hearing and touch can become very sensitive.

Adverse effects: The same effects that can be pleasant in one situation or for a particular user can also be upsetting in another, causing the person to feel agitated or have paranoid ideas. The hallucinations can also feel threatening and hostile and occasionally may cause the user to be aggressive or violent. LSD does not cause dependence, but as with other intoxicants, accidents can happen while under its influence. Psychological effects can be more serious: it can precipitate relapse in those already susceptible to schizophrenia, and 'flashbacks' of a previous hallucinatory experience can occur after use.

Hallucinogenic mushrooms

Form and mode of administration: Psilocybe mushrooms, commonly known as 'magic mushrooms' or 'liberty caps' are small with a thin, white stalk and a pale brownish cap 5-10mm in diameter. They contain psilocybin and psilocin and may be eaten raw or cooked. Sometimes they are frozen, dried or occasionally made into tablets. It usually takes about 30-50 mushrooms to produce a hallucinogenic experience similar to that experienced with LSD.

Sought-after effects: these are similar to LSD but usually milder, and last a similar length of time.

Adverse effects: poisoning from picking the wrong mushrooms is a risk, and can be fatal. Nausea,

vomiting and dizziness can occur during use and flashbacks afterwards. As with LSD, the experience can be pleasant or unpleasant depending on both internal and external circumstances.

Cannabis

Form and mode of administration: 'hashish', made from the cannabis plant's resin can be smoked in a pipe or 'bong', or with tobacco in a 'joint'. It can also be mixed into food or drinks. The dried leaves and buds can be smoked with or without tobacco, and are available in various strengths. 'Skunk' is a stronger breed. Cannabis oil, which is much more potent than the other forms, is less common.

Sought-after effects: cannabis produces an intense, pleasurable feeling of relaxation in some users. If eaten, its effects tend to last longer than when smoked.

Adverse effects: while some users find cannabis produces a pleasurable experience, others can feel depressed, anxious and paranoid. Although fatal overdoses are not a risk, panic attacks can occur. It also slows reactions and because it is eliminated very gradually from the body, these effects can last for a while after use. Heavy use can lead to an acute psychosis which resolves as the active substances leave the body. Memory and learning can be impaired by cannabis use, but it is not known to what extent this is reversed by stopping use.

Because cannabis is usually smoked, it brings similar risks to tobacco, such as lung cancers and cancers of the head and neck. There is some evidence that these may occur at a younger age than in cigarette smokers, but since the two are often smoked together, it is hard to distinguish their effects.

Khat

Form and mode of administration: Khat (local names vary) is an evergreen shrub that grows in parts of East Africa and the Middle East. It is transported to the UK by air and is generally preferred fresh as its potency deteriorates in a few days. The users usually chews about two ounces of leaves or stems for a number of hours, swallowing the juice. Because the juice dries the mouth, large amounts of liquid are also drunk. Effects start about a quarter of an hour into chewing and finish up to two hours after stopping.

Sought-after effects: the main active substances in khat are cathine and cathinone and these are closely related to amphetamine but are of less potency (one is half as potent and the other is more

like caffeine). Khat generally produces talkativeness and mild euphoria. In many countries has social and cultural significance and it is mostly used as a social stimulant on festive occasions.

Adverse effects: Dependence can develop and heavy use can be problematic. People may become aggressive and have hallucinations (sought after and otherwise). Nausea, vomiting, abdominal pain, headache and palpitations can occur. Over the longer term, loss of appetite, migraine and sometimes psychotic behaviour can result. Digestive problems such as constipation and stomach ulcers have been reported frequently to affect regular users. In the UK use is most common among immigrants from East Africa and the Middle East. The research evidence is not strong for its adverse effects but it may be a problem for vulnerable groups.

Methcathinone, a synthetic compound related to cathinone, the main active constituent of khat, has a powerful effect similar to cocaine. It is therefore likely that effects on mental illness will resemble those of amphetamine (see below), and cocaine, with which it also shares similarities. However, the social setting and expectations with which khat is experienced will influence these effects.

Central Nervous System Stimulants

Amphetamines

Form and mode of administration: Amphetamines are a large group of chemicals among which are amphetamine sulphate, dexamphetamine and methamphetamine (which is more common in the US). After cannabis, amphetamines are the second most commonly used illicit drugs in the UK and are taken in the same ways as cocaine powder and also orally in tablet form. Users may crush the tablets to inject them.

Sought-after effects: amphetamines elevate mood, boost self-confidence, energy levels and wakefulness and also suppress appetite.

Adverse effects: The initial 'rush' may be pleasurable, but after a while this may produce unpleasant anxious feelings. The extra time awake and active on amphetamines results in exhaustion and depression after it has worn off. With increasing toxicity, irritability anxiety and paranoia can feature as well as teeth grinding, confusion, and disorganised patterns of behaviour. In heavy amphetamine users "behavioural stereotypy" may occur - repetitious thought or behaviour

possibly due to inhibition of the re-uptake of dopamine neurotransmitter. Heavy users may experience severe weight loss and psychosis. As with most drugs, tolerance develops and the user finds they need more of the substance to achieve the same effect or graduating to more cost effective modes of use i.e. from snorting to injecting. There are the usual health risks associated with injecting, and also heavy prolonged use of amphetamines can lead to sores, liver damage, hypertensive disorders, stroke (cerebrovascular accidents) and kidney damage. However, it is uncertain to what extent these effects are directly attributable to the effect of the drug or to the lifestyle of an amphetamine user.

Caffeine

Form and mode of administration: caffeine naturally occurs in tea and coffee (a related drug, theobromine, is found in cocoa). It is also added to soft drinks and over-the-counter medicines.

Sought-after effects: Caffeine is a minor stimulant that increases alertness and reduces fatigue.

Adverse effects: There is potential tolerance and a moderate psychological and physical dependence, which can produce irritability and headaches on withdrawal.

Cocaine

Form and mode of administration: Cocaine powder is derived from coca leaves and can be snorted, injected or rubbed on the gums. In the 1980s crack, a processed form of cocaine, came onto the black market and has since increased in availability in UK. It gives a more powerful "high" but is short lived (few minutes only) leaving the user wanting more. Crack crystals or 'rocks' are heated up and vapours inhaled.

Sought-after effects: Cocaine is both a powerful stimulant and an effective anaesthetic. When taken, it gives a brief, intense high, and makes the user feel more confident and talkative. It can also act as an aphrodisiac. As a local anaesthetic it is used in ear, nose and throat surgery.

Adverse effects: Because it constricts blood vessels cocaine causes a very sudden rise in blood pressure, and it also depresses the heart rate. As the pleasurable effects wear off, the user may become anxious and exhausted. An overdose can cause sudden cardiac arrest. As tolerance builds and doses get higher, the margin between a dose that is fatal and one that producing euphoria

narrows. It is highly addictive, but not associated with the degrees of physical dependence problems found with heroin. Regular snorting of cocaine can damage the nasal passages and lead to nosebleeds and perforation of the septum. Cocaine also has adverse effects on the coronary arteries increasing the risk of premature heart attacks within a few years of regular use. Smoking crack can additionally damage the lungs.

Like amphetamines, heavy users experience perceptual disturbances such as hallucinations and delusions, usually of a paranoid nature. They may become aggressive or even violent towards others.

Alkyl nitrites

Form and mode of administration: amyl and butyl nitrite ('poppers') are sold in sex and other specialist shops as well as clubs. Fumes from the liquid are sniffed and the effects are short-lived (a few minutes). They are subject to legislation controlling medicines but not the Misuse of Drugs Act.

Sought-after effects: because they relax the anal muscles and can enhance anal sex, they are used by some gay men. Poppers are also taken for the initial rush they produce and giggly, light-headed feelings that follow.

Adverse effects: poppers cause a fall in blood pressure and rise in heart rate which can lead to fainting and loss of balance, headache and nausea. Swallowing the liquid can be fatal but is rare. Although tolerance can develop after two to three weeks of continuous use, they do not seem to be addictive.

Ecstasy and related drugs

Form and mode of administration: Ecstasy (3,4-methylenedioxymethamphetamine or MDMA) and its variants MDEA (3,4-methylenedioxyethylamphetamine) and MDA (3,4-methylenedioxyamphetamine) have similar effects and are classed as hallucinogenic amphetamines, although hallucinations only occur in high doses. They are usually taken by mouth in tablet form or sometimes sniffed as powder. Injecting has been known but is extremely unusual.

Sought-after effects: About 20 minutes to an hour after taking a tablet the user experiences euphoric feelings which then plateau for 2-3 hours before wearing off. Combining the stimulant effects of amphetamines with a feeling of empathy, meaningfulness and relaxation,

they have become popular at all night parties and raves, but are also taken to enhance other social situations.

Adverse effects: some sudden deaths have occurred as a result of overheating in people dancing for several hours without replacing lost fluid or resting. Unfortunately health education advice warning of this danger led to others suffering water toxicity from drinking too much fluid while not exerting themselves. Because ecstasy increases the levels of anti-diuretic hormone in the blood, the excess water is not excreted, causing the brain to swell with dangerous consequences. A few people have also experienced liver damage and strokes after taking the drug. The extent and prevalence of adverse psychological effects is unknown, but panic attacks, paranoid psychosis and depression have been reported. In regular weekend users there is a mid-week depressive effect or mild "come-down". Dependence is possible if taken frequently enough, but because this is very unusual, it is not currently thought to be a problem. A particular concern thought to pose a danger over the longer term is the toxicity of MDMA to the serotonin terminals in the brain, although the effects of this have not yet become clear. Although tablets sold as ecstasy may contain other drugs or substances, there is no evidence that the adverse effects result from such contaminants.

Nicotine

Form and mode of administration: nicotine occurs naturally in tobacco, the leaves of which are smoked either in a pipe, rolled in a cigar or as a cigarette. They can also be chewed or snorted in the form of snuff. Nicotine replacement therapy in the form of chewing gum, skin patches or 'inhalators' provides a reducing dose of the drug without the health risks associated with smoking, help smokers give up in a controlled fashion.

Sought-after effects: Tobacco is a mild stimulant which improves concentration and suppresses appetite. It is often used to relieve stress, although this effect may result simply from the relief of the craving for nicotine.

Adverse effects: there are few adverse short term effects from tobacco and fatal overdose is unknown. However, long term smoking causes a number of diseases of the heart and lungs including heart disease, lung and other cancers and stroke. It also increases the risk of many other diseases and is the single greatest cause of preventable illness and premature death in the UK.

Nicotine is highly addictive and the withdrawal syndrome includes increased appetite, weight gain and irritability.

Drugs which affect the endocrine system

Anabolic Steroids

Form and mode of administration: Anabolic steroids are synthetic drugs similar to natural hormones such as testosterone that promote protein build-up and therefore muscle gain in the body. They are taken in cycles with an average of about eight weeks using and eight weeks not using but there is considerable variation and multiple use of different steroids for different effects and side effects. They may be injected or swallowed as tablets. Although they may look like diverted pharmaceuticals, they are often illegally manufactured counterfeits.

Sought-after effects: most users of anabolic steroids do so to build up their muscle size and body strength. They may be prescribed for the treatment of anaemia.

Adverse effects: if injected, the usual risks apply. In addition, psychiatric conditions have been attributed to anabolic steroid use including hypomania, mania and anger and depression on discontinuation. They may also cause aggression and an increased sex drive. Men can suffer breast development and shrinking of testicles. Other physical problems linked to steroid use such as acne, coronary heart disease, raised blood pressure and possible liver and kidney damage.

Mental disorders

The following section gives a brief introduction to specific disorders, and aims to act as an aide memoir, rather than a text book. Readers are referred to the Oxford Textbook of Psychiatry (Published by Oxford University Press) or Pocket Psychiatry (Bhui et al, 1998). The following excerpts are summarised from the latter text).

Delirium:

Acute organic brain dysfunction, characterized by disturbance of consciousness and attention, perception, thinking, memory, psychomotor activity and emotion that is transient and of fluctuating intensity.

- Impairment of consciousness and attention. Disorientation for time, place and sometimes for person. Inability to attend to one stimulus for a prolonged period
- Illusions, hallucinations, and delusional beliefs. Usually transient, fragmented and poorly systematized. Hallucinations may be visual as well as auditory
- Restlessness, overactivity and agitation. May however show signs of hypo-activity and psychomotor retardation. Speech may be increased or decreased
- Impairment of registration: very poor short-term memory
- Emotional disturbance: depression, anxiety, and fearfulness are common. Mood may appear quite labile. Perplexity and suspiciousness are also seen
- Disturbance of sleep-wake cycle: manifests as insomnia, reversal of diurnal cycle, daytime drowsiness and worsening of symptoms at night
- Other signs of cerebral dysfunction including dysphasia, apraxia, and dysgraphia

Schizophrenia

The most common psychotic disorder, schizophrenia is characterized by abnormalities in perception, beliefs, thought processing and expression, volition, and reality testing. The phenomenology of schizophrenia can be divided into acute and chronic features.

Acute illness

Auditory hallucinations: though both second- and third-person auditory hallucinations occur, it is the latter which are of diagnostic importance. Third-person auditory hallucinations are characteristically described as two or more people discussing the patient, often in a derogatory manner; also experience third-person commentary in which the patient hears someone describing their actions as they are carried out, and echo de la pensée in which the patient can hear their own thoughts aloud. Somatic (bodily) hallucinations or somatic passivity: though diagnostically significant, these are less common than auditory hallucinations. Delusional beliefs are very common, particularly those with persecutory content. The most important diagnostically, and also the rarest, are primary delusions, in which a fully formed belief suddenly occurs 'out of the blue' not secondary to an abnormal mood state or other delusion. Ideas of reference are also very common in schizophrenia, in which unrelated notices, signs or remarks are believed to be messages with specific meaning for the patient. Ideas of reference are often found in the media, and usually involve a tangential connection with the subject. These can be of delusional intensity.

Thought insertion and withdrawal occur when the patient believes some external agent has placed thoughts in, or removed thoughts from, their mind. In thought broadcast they believe their thoughts are available to others because these can be heard aloud (*akin to echo de la pensée*) or are transmitted through radio or television. It is possible that both delusional beliefs and auditory hallucinations are involved in such experiences.

Passivity experiences occur in which the patient feels that their bodily functions, emotions or thoughts are under external control. Thought block, in which a train of thought comes to a sudden halt, accompanied by the experience of having the thought removed from the patient's mind may represent thought withdrawal as discussed in the previous paragraph. This may cause the patient to abruptly stop speaking. Formal thought disorder is where an individual has difficulty constructing and expressing their own thoughts. In mild thought disorder an individual has trouble maintaining a train of thought (loosening of association), and may appear to 'go off at a tangent', or talk past the point (*vorbercheiden*). When more severe this results in disjunctures in thought, or 'knight's move' thinking (or derailment). When very severe words become jumbled up in a 'word salad' (*verbigeration*), which may contain examples of words invented by the individual (neologisms). Individuals with acute schizophrenia may be highly suspicious, aroused and irritable, or grandiose.

Chronic symptoms

Also referred to as 'negative symptoms', the symptoms of chronic schizophrenia include affective blunting, apathy, poverty of thought and speech, social withdrawal, and self-neglect. Although the acute symptoms are extremely distressing, and may lead to potentially life-threatening behaviour, it is the chronic symptoms that are responsible for most impairment and handicap.

Affective Disorders

Two types of mood disorder are recognized by categorical systems of classification - mania and depression - though in reality these probably exist as extremes on a continuum.

Clinical features of mania

Lability of mood and features of both 'classical' mania and depression. Manic episodes generally develop over 1 or 2 days, culminating in disinhibition, overactivity and increasingly uncontrollable behaviour. Patients with acute mania may do themselves great harm through overspending

and sexual disinhibition, and are prone to physical exhaustion. Mania is by definition a psychotic condition.

Clinical features of depression

In contrast to mania, depression is only rarely associated with psychotic symptoms. The signs and symptoms of depression are often considered under the following headings.

Physical

- Poor sleep (insomnia): this may take the form of initial insomnia, broken sleep and/or early morning waking. The latter is the most significant diagnostically. Occasionally depressed subjects (especially those with 'atypical' depression and/or seasonal affective disorder, SAD) report hypersomnia. Even when they do sleep, depressed patients characteristically complain of not feeling rested or refreshed on waking
- Fatigue/anergia
- Poor appetite and weight loss. Like sleep, some depressed patients (e.g. SAD) report increased appetite (especially for carbohydrate-rich food) and weight gain
- Diurnal variation of mood: depressed patients typically report feeling worse first thing in the morning
- Psychomotor retardation or agitation: the latter is a very dangerous sign, since agitated patients are at high risk of self-harm, which they may attempt out of desperation
- Dehydration and/or constipation especially in the elderly
- Loss of libido

Psychological

- Low mood
- Anhedonia (inability to experience pleasure)
- Self-blame and guilt
- Feelings of hopelessness and pessimism about the future

- Irritability
- Suicidal ideation

Cognitive

- Poor concentration and increased distractibility
- Memory impairment
- Memory appears selective for 'unhappy' events
- Negative self-appraisal/self-criticism

Neurosis

Anxiety

- Ideational: fear and apprehension
- Somatic symptoms of autonomic arousal, including sweating, dry mouth, palpitations, hyperventilation, tremor, headache, backache, flushing, nausea, diarrhoea, urinary frequency. These symptoms may mimic cardiovascular disease, particularly if accompanied by chest pain. Also sensation of muscular tension. These symptoms may be exacerbated by hyperventilation/ overbreathing, which may also result in dizziness, peri-oral and limb paraesthesiae, and muscular spasm
- Psychological: hypervigilance, exaggerated startle response, irritability, sensitivity to noise, and rumination
- Behavioural: avoidance of anxiety-provoking stimuli, leading to social isolation

Phobias

The three most common phobias are agoraphobia, social phobia and simple phobia, though the boundaries between these are somewhat blurred. Note that although phobias may lead to panic attacks, a diagnosis of panic disorder excludes a diagnosis of phobia, since panic disorder is judged to be a more serious condition.

Agoraphobia refers to excessive worry and anxiety about being away from home, and is usually worse in situations that do not permit immediate escape such as crowded shopping areas, lifts, or public transport.

Social phobia describes an intense fear of being scrutinized by other people, which usually manifests itself in a fear of performing even the most mundane of activities in front of others. Those with social phobia are most often afraid of eating in front of other people.

Simple phobias are fears of very specific situations. Common stimuli are animals, insects, blood, dirt or contamination, heights and specific forms of travel (e.g. air travel). The latter may be difficult to distinguish from agoraphobia, though this distinction is probably of little importance.

Panic disorder

Discrete periods of intense fear or apprehension in which several of the symptoms of anxiety (see above) develop suddenly and increase in intensity over about 10 minutes. Patients characteristically believe they are in imminent danger of 'losing control'; common fears are of collapsing, having a heart attack, 'going crazy', or being incontinent. Panic attacks tend to subside within 30 minutes, and subjects may or may not experience anxiety between panic attacks. For diagnosis, the patient must have at least four panic attacks in 4 weeks, and at least four somatic symptoms must be present during each attack.

Obsessive-compulsive disorder

Obsessions are repetitive, intrusive ideas, images and thoughts. Though unpleasant and unwanted, the subject feels that these are ego-dystonic and that resistance is impossible. The occurrence of obsessional thoughts is characteristically associated with an increase in anxiety, leading to rumination, rituals and compulsions, all of which may be viewed as means of reducing anxiety. Three-quarters of those with obsessional thoughts manifest compulsions, which frequently involve washing, cleaning and counting.

Disorders of personality

The concept of personality disorder as a diagnostic entity has arisen out of attempts to classify a variety of dysfunctional behaviours that are often poorly understood, and which have been largely unresponsive to treatment. While psychologists have preferred to conceptualize personality in terms of a variety of continuously distributed traits, psychiatrists have traditionally opted instead for categorical models. Personality disorders therefore represent persistent and characteristic patterns of behaviour and ways of relating to the self and others. Central to the definition of personality disorder is the notion that these behaviours are harmful to the individual or others. Not

all the personality disorders are described. We have identified those with most relevance to dual diagnosis work. Paranoid personalities, Schizoid personalities, Impulsive personalities, Antisocial or dyssocial personalities. These descriptions should not be assumed to be perfect diagnostic categories nor the primary problems, but people with dual diagnosis are likely to have one or more of the patterns described in some combination.

Definition: Enduring maladaptive patterns of behaviour, modes of thinking and relating to oneself, the environment and others which cause either impairment in social functioning or considerable distress to the individual or others. These personality features should be recognizable by adolescence, and should persist throughout adult life. Personality disorders are primary and not secondary to other psychiatric or physical disorders. When substance misuse begins young it is not always easy to disentangle primary and secondary features.

Paranoid personality disorder: excessive sensitivity to setbacks, a tendency to bear grudges and harbour resentments, suspiciousness, unwillingness to trust others, litigiousness and a preoccupation with 'conspiracy theories'. Individuals with paranoid personality disorder often suspect their spouse or partner of being unfaithful, and have a tendency towards self-importance. Such individuals are extremely 'brittle' and, contrary to their protestations, have an extremely fragile self-esteem, which they are required to bolster continuously by means of projection.

Schizoid personality disorder: Cold and aloof, these individuals do not appear to take pleasure from any activities and seem incapable of expressing strong positive or negative emotions. Affect cold, detached or flat. Little capacity for, or interest in, intimate relationships (including sexual relationships). Thus, individuals with schizoid personality disorder have few friends and appear to prefer solitary pursuits. Social awkwardness may be very prominent. A further defining characteristic is an apparent insensitivity to praise or criticism.

Dyssocial personality disorder: perhaps the most dangerous of all the personality disorders, characterized by antisocial behaviour and callous disregard for the feelings, safety and well-being of others. Dissocial personality disorder incorporates the earlier categories of sociopathic and psychopathic personality disorders. Those with dyssocial personality disorder are irresponsible, show no concern for rules or social norms, and are often in conflict with authority. There is a characteristic inability to tolerate frustration, resulting in aggressive and violent behaviour.

Individuals with dissocial personality disorder appear incapable of experiencing remorse and tend to blame others (including their victims) for their own shortcomings and misdeeds. There is some empirical evidence that such individuals are impaired in their ability to learn from punishment or rewards, which may reflect underlying brain dysfunction.

Emotionally unstable personality disorder: Two types of emotionally unstable personality: impulsive type and borderline type. Both are characterised by emotional instability, poor self-control and impulsive behaviour. Emotions are experienced with unbearable intensity, leading to explosive outbursts and attempts at self-harm. In the impulsive form of this personality disorder individuals respond to criticism with violent or threatening outbursts. Individuals with borderline personality disorder are said to have a 'chronic sense of emptiness', and may become involved in intense and unstable personal relationships. Emotional crises are common, often arising out of a fear of abandonment. Such individuals may experience transient psychotic episodes, such as the intensity of their emotions. Some individuals with borderline personality disorder cope with their unbearable internal feelings by indulging in 'self-mutilating behaviours' such as cutting or burning their arms or legs, while others may take overdoses or make more serious attempts at suicide. The cardinal feature of such 'self-mutilating behaviour' is that the patient reports an immediate release of anxiety on inflicting the wound.

Other personality disorders: Histrionic personality disorder, Anankastic personality disorder, Anxious (avoidant) personality disorder, Dependent personality disorder.

APPENDIX B: TRAINING MATERIALS

The training materials provided are designed to be used flexibly to supplement the information manual. Trainers can pick and choose what material they wish to use within a session. It is anticipated that trainers will also have their own materials. It is recognised that trainers should have a degree of knowledge and clinical skill in the field of dual diagnosis but their proficiency in training may vary.

The following training materials are offered

- Training tips
- Two example of vignettes (A & B) and discussion guides
- Examples of overheads (Camera Ready) which draw on material contained within the manual.
- Example of an evaluation/feedback sheet

Training tips

- It may not be necessary for the trainer to have extensive experience in the provision of teaching and training.

A lot of the skills needed are an adaptation of basic engagement skills. However, it is vital that the trainer feels knowledgeable about the subject area they are presenting and feels confident that they can both facilitate the audience to explore the issues in some depth and use the group to answer questions. A Trainer must have confidence in their ability to think on their feet and answer questions clearly. Managing questions and the group is also an important skill. The trainer should therefore be confident that they can cover all of the areas in the manual at a reasonable level and that they have also kept up to date with any practice and policy developments in the dual diagnosis field.

- Remember a confident presentation goes a long way.

Do not be afraid to disclose that you do not know the answer to someone's question if this is the case. In this sort of situation it is useful to open up the question for members of the group to answer. If no answer is forthcoming inform the participant that you will strive to research the answer and get the information to them or direct the participant to the appropriate literature or resource. Or use this as an opportunity to rehearse how information can be gathered, and from where (section 8 of the information manual)

- Know the material you are presenting in sufficient depth so that you can use the information flexibly.

Over-reliance on acetate overhead presentation can lead to boredom in the audience and a deadening of enthusiasm and creative thinking in the group (and the presenter). Where it is necessary to give overhead presentations to provide basic information to the group try to keep it short. Intersperse overhead presentations with small and large group exercises to keep participants energised.

- Always make sure you prepare for a session adequately.

Ensure you have a structured plan for the day that you can refer to if you start to become 'lost' in the material. Bring copies of any overhead presentations as handouts so that participants can focus on the material as you present it and don't feel the need to make notes. Also try to provide further reading material for the participants as this can help to cut down on the time to be spent on overhead presentations. Provision of a reading list with relevant publications and resources such as web-site addresses will lead interested individuals to access relevant materials themselves.

- Tell them what you going to say, say it and tell them what you've said it.

Setting out from the outset the plan of the training (hour, half day, day, week) is essential. This should be presented alongside the learning objectives of each training day. Refer back to the session plan to orientate people, and to use time effectively. If a subject is to be covered later, then don't spend too long discussing it in another slot. Allow some flexibility in the programme and some open time for questions, or for talking about a

subject the trainees have raised as an issue. Group work can also take a long time.

- **Know your training resources.**

This is important as it means you can shift flexibly between subjects and materials should the need arise. It also means that you can target any presentation to the needs of the participants. Take additional materials in case everyone is a star, and works through the exercises quickly. Prepare exercises for different levels of ability, and raise the level of debate and thinking by asking for the group to follow a different exercise to the one they have completed (using the same or different material).

- **The use of clinical vignettes and case studies are popular with participants.**

They bring to life more theoretical aspects of training. Again it is important to know any case material you use well. The most powerful use of case material generally refers to cases that the trainer has worked with directly. This adds a further depth to the exercise. Participants in the group are generally very keen to know the outcome of any work with a client in the real world. It also means that you can share experiences of both success and failure in your work with the group that can help ground the training in reality.

- **Try to adopt a behavioural problem-solving model.**

This model is useful for getting participants to think differently about problems that on the surface can appear very entrenched. It works well with groups and is a way of using the group process to help participants to think creatively and 'outside of their box'. It involves the entire group defining a shared problem and then generating a set of solutions around it. No solution is seen as too bizarre. The group then rank and select solutions that can be carried forward. It should then be suggested that they try to implement those solutions in their day to day work and monitor whether the solution has been successful. This can, if appropriate be fed back in subsequent workshops or practice development sessions. Let the group struggle and don't feel you have to have the answers or make it too easy for them. If they have to think about the material, then the training will be remembered, and is more likely to influence their practice.

- A good working knowledge of resources for people with a dual diagnosis in the area you are training in is useful.

This helps to ground the training in the service context. Using local examples of practice makes the exercises feel more 'real'.

- If training on the practical and skill specific areas such as assessment or motivational interviewing, the provision of follow up sessions is important.

This will allow participants to return for top-up training and also provides participants with a forum for the discussion of any difficulties that became apparent while trying to put the skills into practice in their service environment. It ensures that the participants continue to feel supported. It also ensures that training does not get lost once the training day has finished.

- Development of training to incorporate some 'practice development sessions' can lead the group to become a supervision resource for its members.

Peer supervision is important given the dearth of 'expert supervision in the dual diagnosis field.

- Structure the session to allow plenty of breaks.

The sessions should be structured to ensure that periods of time such as directly after lunch comprise of group exercises or other 'energising' activities, as this is the time that people feel tired and demotivated as concentration can wander.

- Do general housekeeping at the start of the session.

Ensure participants are aware when the breaks for coffee and lunch and the end are so they can plan their day. Make sure you that you stick rigorously to those times. Any changes in time should be negotiated with the group otherwise you will have a seriously disgruntled group whose attention may wander.

- Set ground rules at the beginning of the session.

Write them on a white board so that all participants can see them. These should be negotiated with the group but should also include standards around respect for other group participants, confidentiality within the group and switching off mobile phones and beepers.

- Start the sessions promptly and finish on time.

Do not wait for late comers before starting. This will upset members of the group who have arrived on time. Any change to the start of a session should be negotiated with those participants already in attendance.

- Each session should have specific learning objectives that are presented at the beginning of the session.

This allows the participants to track their own learning and become aware of the important objectives for the session. The learning objectives should incorporate the main topics and ideas you want participants to leave the session with.

- Always evaluate your sessions.

This evaluation should be linked to the learning objectives and ensures that the objectives have been met for each participant. If objectives are met you will need to ask yourself or the participants why this is and revise the session structure in subsequent training sessions to take this on board.

- Always try to ensure the training room is comfortable.

Correct temperature and adequate ventilation. If you are conducting small group exercises try to ensure that other 'break-away' rooms are available to work in, as small group-work in one training room can be noisy and disruptive.

- Providing training in pairs can help boost confidence and ability and ensures that the trainer does not feel 'put on the spot' to answer all questions all of the time.

This also helps the development of ideas and more refined ways of working. It is also useful to have a trusted partner to off-load to at the end of the day, as training can be emotionally strenuous.

- Always leave plenty of time for the group to reflect feedback and discuss any issues raised during the training session.

CASE SUMMARY -Vignette A

Mr. R is a 27-year-old man who from the age of 19 has been smoking cannabis regularly and using ecstasy intermittently. His parents, originally from travelling families, separated during his mid teens. He still lives with his mother but has a poor relationship with her.

In his early twenties he had sporadic contact with mental health services but was diagnosed as having an immature personality with difficulties in sustaining inter personal relationships. Periods of paranoid thinking were attributed to his drug use.

Over the past three years he has not been able to hold down a job for more than a few weeks and increasingly he dismissed his friends as "stupid". Eighteen months ago he was admitted to hospital following an overdose of aspirin and he expressed the belief that he was responsible for a nationally publicised murder. Since then he has never completely abandoned this belief and from time to time has heard voices rebuking him.

Sometimes he appears cold and mistrustful. He has never accepted the diagnosis of schizophrenia. Consequently he will not take the prescribed medication. However his symptoms do worsen after using ecstasy and he will then agree to take medication at least for a month or two.

Recently he has moved into a one bedroom flat and is visited regularly by support staff. They help him with his benefits, shopping and aspects of self care. However he will not agree to attend the mental health day centre because he says he will not mix with "mad people".

Instructions for group work on Vignette A

Distribute copies of the above case summary and after each participant has read it discuss the following issues with the group.

- 1) How unusual were the problems of his early twenties and why was the diagnosis of schizophrenia not made at the time?
- 2) What is the relevance of the parental discord and family ancestry to any potential intervention?
- 3) What are the risks events that may take place during any intervention? Do a risk assessment.
- 4) How would you choose to engage him and what interventions would you hope to guide him into accepting?
- 5) Should he relapse and require admission to hospital under the Mental Health Act how should his desire and attempt to use cannabis be managed?

CASE SUMMARY Vignette B

Mrs. ZK is a 53 year old married woman with three children, the oldest of whom has cerebral palsy. Her husband is a wine merchant and the marital relationship is frequently tense.

ZK has been prescribed antidepressants for many years and has had lengthy hospital admissions for depression. Her management has been complicated by episodes of heavy binge drinking and she has only accepted the goal of abstinence from alcohol for short periods.

Generally she appears long suffering but when drunk she is hostile, argumentative and often attempts self harm. Recently her husband has been receiving treatment for cancer and ZK has been drinking more and her depression has deepened.

Instructions for group work on Case Summary B

Distribute copies of the above case history and after the participants have read it discuss the following issues with the group.

- 1) What are the medical, psychological and social needs arising out of assessment and why?
- 2) Do a risk assessment.....firstly within your professional groups, and then share your respective professional risk assessment to develop a single risk assessment and management plan.

- 3) The husband angrily tells you that his often hits their oldest child when drunk but ZK accuses him of vindictiveness and lying. What should you do?
- 4) Regarding interventions, what are the roles of each member of the multidisciplinary team and of the different agencies involved?
- 5) Should ZK recover during admission to hospital how can she avoid relapse on return home?

Example: Evaluation/Feedback Sheet

Title of Session:		Name of Trainer:		
Date:		Target Group:		
Relevance of Session				
Very Poor	Poor	Satisfactory	Good	Excellent
Clarity/Presentation Skills				
Very Poor	Poor	Satisfactory	Good	Excellent
Level of detail				
Very Poor	Poor	Satisfactory	Good	Excellent
Overall Rating				
Very Poor	Poor	Satisfactory	Good	Excellent

What did you find most helpful from this training?

What did you find least helpful from this training?

General Comments

THANK YOU

APPENDIX C - Key Expert Informants Residential Consultation Weekend

Name	Designation	Organisation
Sally Bailey	General Practitioner	Royal College of General Practitioners
Sue Baker		Alcohol Concern
Dennis Barnes	Chairperson	Association of Nurses in Substance Abuse (ANSA)
Kam Bhui	Consultant Psychiatrist	Queen Mary College University of London, South East Thames Regional Health Authority
Elizabeth Brewin	Senior Nurse	Institute of Psychiatry
Carmel Clancy	CRU Project Manager and Senior Lecturer	School of Health and Social Sciences, Middlesex University
Vanessa Crawford	Consultant Psychiatrist	
Ilana Crome	Professor of Addiction Psychiatry & Chair, Faculty of Substance Misuse, Royal College of Psychiatrists	Keele University & Royal College of Psychiatrists
Chris Daly	Consultant Psychiatrist	Salford NHS Trust
Tony Garelick	Psychotherapist	Psychotherapy Faculty, Royal College of Psychiatrists
Tim Garvey	Consultant Psychiatrist	Salford NHS Trust
Rex Hewitt		HealthWorks
Mark Holland	Community Psychiatric Nurse	Beechmont Resource Centre, Manchester
Chris Holley	Clinical Nurse Specialist	Royal College of Nursing
Don Lavoie		Substance Misuse Advisory Service
Susan Ledwith	Clinical Psychologist	British Psychological Society
Mervyn London	Consultant Psychiatrist	Cambridge Drug and Alcohol Service
Tara O'Neill	Clinical Psychologist	Sainsbury Centre for Mental Health
Mark Prunty	Consultant Psychiatrist	Department of Health, Drugs Misuse Team
Sena Quaye	CRU Project Administrator	College Research Unit, Royal College of Psychiatrists
Daphne Statham	Director	National Institute for Social Work
Richard Williams	Professor of Mental Health Strategy & Consultant Child and Adolescent Psychiatrist	Glamorgan University & St. Cadoc's Hospital Wales

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