Dual Diagnosis Nursing

Edited by

Professor G. Hussein Rassool
MSc, BA, RN, FETC, RCNT, RNT MILT, FRSH
Cert. Ed., Cert. Couns., Cert in Supervision & Consultation

Professor of Addiction & Mental Health, Departamento de Psiquiatria e Ciências Humanas da Escola de Enfermagem de Ribeirão Preto da Universidade de São Paulo, São Paulo, Brazil. Visiting Professor Federal University of Minas Gerais, Brazil. Formerly Senior Lecturer in Addictive Behaviour, Department of Addictive Behaviour & Psychological Medicine, Centre for Addiction Studies, St George's Hospital, University of London, UK.

Blackwell
Publishing

Addiction
Press

Dual Diagnosis Nursing

Dedicated to Safian, Hassim, Yasmin Soraya,
Adam Ali Hussein & Reshad Hassan.

Dual Diagnosis Nursing

Edited by

Professor G. Hussein Rassool
MSc, BA, RN, FETC, RCNT, RNT MILT, FRSH
Cert. Ed., Cert. Couns., Cert in Supervision & Consultation

Professor of Addiction & Mental Health, Departamento de Psiquiatria e Ciências Humanas da Escola de Enfermagem de Ribeirão Preto da Universidade de São Paulo, São Paulo, Brazil. Visiting Professor Federal University of Minas Gerais, Brazil. Formerly Senior Lecturer in Addictive Behaviour, Department of Addictive Behaviour & Psychological Medicine, Centre for Addiction Studies, St George's Hospital, University of London, UK.

Blackwell
Publishing

Addiction
Press

Editorial offices:
Blackwell Publishing Ltd, 9600 Garsington Road, Oxford OX4 2DQ, UK
Tel: +44 (0)1865 776868
Blackwell Publishing Inc., 350 Main Street, Malden, MA 02148-5020, USA
Tel: +1 781 388 8250
Blackwell Publishing Asia Pty Ltd, 550 Swanston Street, Carlton, Victoria 3053, Australia
Tel: +61 (0)3 8359 1011

First published 2006 by Blackwell Publishing Ltd

ISBN-13: 978-14051-1902-3
ISBN-10: 1-4051-1902-0

Library of Congress Cataloging-in-Publication Data
Dual diagnosis nursing / edited by G. Hussein Rassool.
p. ; cm.
Includes bibliographical references and index.
ISBN-13: 978-1-4051-1902-3 (pbk.: alk. paper)
ISBN-10: 1-4051-1902-0 (pbk.: alk. paper)
1. Dual diagnosis. 2. Psychiatric nursing. 3. Substance abuse – Nursing.
I. Rassool, G. Hussein.
[DNLM: 1. Diagnosis, Dual (Psychiatry) 2. Mental Disorders – therapy.
3. Substance-Related Disorders – therapy. WM 270 D8126 2006]
RC564.68.D793 2006
616.89'0231—dc22
2006007828

A catalogue record for this title is available from the British Library

Set in 9.5/11.5pt Palatino
by Graphicraft Limited, Hong Kong
Printed and bound in Singapore
by COS Printers Pte, Ltd

The publisher's policy is to use permanent paper from mills that operate a sustainable forestry policy, and which has been manufactured from pulp processed using acid-free and elementary chlorine-free practices. Furthermore, the publisher ensures that the text paper and cover board used have met acceptable environmental accreditation standards.

For further information on Blackwell Publishing, visit our website:
www.blackwellpublishing.com

Contents

Contributors

M. Abuel-Ealeh. Previously Associate Dean, School of Community Health Studies, Head of Mental and Learning Disability Studies, Anglia Ruskin University, Essex.

R. Barrett. Senior Lecturer in Mental Health, School of Community Health Studies, Mental and Learning Disability Division, Anglia Ruskin University, Essex.

K. Barry. Nurse Consultant, Partnerships in Care Ltd, Llanarth, Wales.

R. Bryant-Jefferies. Sector Manager (Kensington and Chelsea sector), Substance Misuse Service, Central and North West London Mental Health NHS Trust, London.

R. Edwards. Consultant Nurse and Senior Lecturer for Coexisting Mental Health and Substance Misuse Problems (Dual Diagnosis), Joint post between Avon and Wiltshire Mental Health Partnership NHS Trust and the University of the West of England.

M. Epling. Lecturer in Mental Health, Faculty of Medicine and Health Sciences, School of Nursing, the University of Nottingham.

P. Ford. Consultant Psychologist (Substance Misuse), Psychology Department, Kneesworth House Hospital, Bassingbourne, Royston.

J. Gallagher. Senior Lecturer in Mental Health, School of Community Health Studies, Mental and Learning Disability Division, Anglia Ruskin University, Essex.

D. Gallivan. Substance Misuse Worker, Kent and Medway NHS and Social Care Partnership Trust, Dartford, Kent.

A. Hammond. Locality Manager, Kent and Medway NHS and Social Care Partnership Trust, Dartford, Kent.

R. Lawrence. Senior Substance Misuse Worker, Kent and Medway NHS and Social Care Trust, Substance Misuse Service, Medway Towns, Kent.

F. Macrory. MBE. Zion Community Resource Centre, Hulme, Manchester.

D. Manley. Lead Clinician/Team Leader, Nottingham Dual Diagnosis Team (part of NADT), Nottingham.

P.G. Mason. Director Pip Mason Consultancy, Kings Norton, Birmingham.

J. McGregor. Lecturer in Substance Misuse, Nottingham Education Centre, Mapperley, Nottingham.

K. Moore. Manager Dual Diagnosis Service, the Maple Unit, Q1 Block, St Ann's Hospital, Tottenham, London.

P. Phillips. Lecturer in Mental Health & Social Care (Learning Disability), City University, Department of Mental Health & Learning Disability, St Bartholomew's School of Nursing & Midwifery, London.

G.H. Rassool. Professor of Addiction & Mental Health, Departamento de Psiquiatria e Ciências Humanas da Escola de Enfermagem de Ribeirão

Preto da Universidade de São Paulo, São Paulo, Brazil. Visiting Professor Federal University of Minas Gerais, Brazil. Formerly Senior Lecturer in Addictive Behaviour, Department of Addictive Behaviour & Psychological Medicine, Centre for Addiction Studies, St George's Hospital, University of London.

L.M. Rayner. Lecturer in Health, University of Nottingham School of Nursing, Nottingham.

S.J. Scott. Senior Lecturer in Mental Health, School of Community Health Studies, Mental and Learning Disability Division, Anglia Ruskin University, Essex.

A. Simpson. Research Fellow, City University, Department of Mental Health & Learning Disability, St Bartholomew's School of Nursing & Midwifery, London.

J. Winnington. Team Leader, Alex House, Bethlem Royal Hospital, Beckenham, Kent.

P. Woods. Associate Professor, College of Nursing, University of Saskatchewan, Saskatchewan, Canada.

Foreword

It is a pleasure and privilege to be invited to write the Foreword for Hussein Rassool's book on Dual Diagnosis Nursing. I got to know Professor Rassool when we both worked at St George's Hospital Medical School – he ran the postgraduate programme in addiction studies and occasionally I would help by supervising student projects or sitting on the board of examiners.

I always admired the way in which he managed the programme – coordinating the activities of a diverse group of contributors to produce something coherent that is of real practical value. I was not surprised, therefore, to see those same skills applied to this volume. Professor Rassool and the other contributors show a very clear understanding of the needs of their target readership and they present the material without unnecessary embellishment. This volume quite simply contains information that nurses must know if they are to help patients with substance use and psychological problems. The field of addiction, in my opinion, suffers from too many 'manuals' that present waffle and speculation dressed up as fact. This book provides information in the most straightforward terms that will be of practical value to the reader.

The chapters on management of patients with dual diagnosis no doubt presented the greatest challenge because the scientific basis for particular treatment approaches is lacking. We don't know whether approaches such as motivational interviewing give better results than cognitive behavioural approaches or pragmatic, commonsense based approaches – and we may never know because these kinds of issue are extremely difficult to study scientifically. As long as we recognise that the ideas we put forward for managing patients are pragmatic solutions to difficult problems, and do not turn them into articles of faith, no one can ask more of us. Professor Rassool's writing seems to me to fit this ethos very nicely.

Robert West
University College London

Preface

Dual diagnosis, that is the coexistence of substance misuse and mental health problems, is the premise of the book, which is interwoven in all the chapters. The increase in the number of individuals with substance misuse and mental health problems has attracted considerable interest in recent years and will be one of the most important challenges facing both mental health and addiction nurses. It is estimated that 30% of people with mental health problems also have drug and/or alcohol problems, which are highly prevalent across a range of service and treatment settings. Common examples of dual diagnosis include the combination of psychosis with amphetamine use, depression with alcohol dependence, anxiety and alcohol dependence, alcohol and polydrug use with schizophrenia, and borderline personality disorder with episodic polydrug use. Research shows that individuals with a dual diagnosis are at an increased risk of suicide, violent behaviour and non-compliance with treatment. Given the prevalence, and the limited resources available to support individuals with dual diagnosis and their carers, a wide range of professionals from health and social care, including employment, housing and the criminal justice system may be involved in dealing with the complex needs associated with this condition. The prevalence, clinical implications, service provision and the effectiveness of intervention strategies are now becoming more apparent.

This book draws together and synthesises the body of knowledge and clinical nursing practice within the UK framework of working with individuals with dual diagnosis. It focuses on the approaches and intervention strategies that nurses and other health and social care professionals have used to respond to this new challenge in specialist and non-specialist settings. The book does not profess to be a complete dual diagnosis compendium, rather it aims to introduce the reader to the key issues and concerns that surround the coexistence of substance misuse and mental health problems. The book underpins a number of current policy initiatives, as applied to current practice, and covers, practically, most aspects relating to dual diagnosis including an overview of dual diagnosis, the conceptual examination of dual diagnosis and substance misuse and its psychopathology. An added dimension is the coverage of needs of special populations, dual diagnosis in different care and treatment settings, multidimensional assessment, dealing with emergencies, spiritual needs, prescribing and medication management, nursing and psychological interventions, carers' interventions and professional development.

The book is practice oriented and written by

experienced, mostly nursing, academics and clinicians from the field of addiction and mental health nursing. It provides practitioners with awareness, knowledge of addiction and mental health, and skills required to respond effectively to those individuals they encounter in their practice. Whilst the book will address issues related to practitioners in dealing with the coexistence of substance misuse and mental health problems, it will be of interest and act as an excellent resource for other health and social care professionals who are unfamiliar with the 'dual diagnosis' phenomenon. It will be of relevance to students in medicine, nursing, psychology, social work and the criminal justice system, and those attending undergraduate and postgraduate courses in addiction and mental health studies. It will also be beneficial to anyone who has little or no experience in mental health, substance misuse or dual diagnosis.

Dual diagnosis, like substance misuse, is not the sole property of one particular discipline. It is everybody's business (Rassool, 2002)[1].

Structure of the book

This book is presented in five sections. Part 1 introduces the background in providing current literature on dual diagnosis, drug use and misuse, mental health, alcohol and mental health, personality disorders and eating disorders. Part 2 deals with special populations: black and ethnic minority groups, young people and women (parenting and pregnancy). Part 3 covers aspects of a synthesis of role, shared care, dual diagnosis in acute in-patient and forensic settings and models of care. Part 4 focuses on a framework for multidimensional assessment, dealing with overdose, intoxication and withdrawals, prescribing authority and medication management, integrating spiritual needs in holistic care, psychological interventions: cognitive behaviour therapy, motivational interviewing and person centred counselling, and relapse prevention. Part 5 concludes with the role and competencies of staff, educational development and clinical supervision.

[1] Rassool G. Hussein (2002) *Dual Diagnosis: Substance Misuse and Psychiatric Disorders*. Blackwell Publishing, Oxford.

Acknowledgements

I would like to thank all the contributors, and the staff at Blackwell Publishing, Oxford, for their support in the preparation of this book. I also would like to thank Beth Knight at Blackwell Publishing for her support and patience throughout the process of writing and the publication of this book.

I am also particularly grateful to Professor James P. Smith, Professor John Strang, Professor A. Hamid Ghodse and the Florence Nightingale Research Foundation for their guidance in my professional development. Special thanks also goes to Professor Margarita Villar-Luis, Deputy Dean, Escola De Enfermagem de Ribeirão Preto, Universidade de São Paulo, Brazil for our collaboration and development in teaching and research activities in addiction and mental health. Thanks also to colleagues and friends at USP and in Ribeirao Preto, especially to Carlos and Roselyne.

My thanks go to Mariam and Muhsinah for smoothing the path and providing me with the necessary support and help during my sabbatical and subsequent stay in Mauritius. Thanks also goes to all those at Al-Furqan, Les Guibies, for their friendship and support. I would like to acknowledge the contribution of my teachers who enabled me, through my own reflective practices, to follow the path.

My special thanks also to Julie for all the help and support over the years. Finally, I owe my gratitude to my children, Yasmin, Adam and Reshad, who keep me going and active in various endeavours.

Part 1

Background

1 Understanding Dual Diagnosis: an Overview

G.H. Rassool

Introduction

In the past decade, there has been a growing interest in the concept of dual diagnosis or coexisting problems of substance misuse and mental health problems. Dual diagnosis has gained prominence partly due to the closure of long-stay psychiatric institutions, increasing emphasis on care and treatment in the community and the increasing prevalence of substance misuse amongst the general population. Individuals with mental health problems are perhaps becoming more exposed to a wider range of illicit drugs than previously. Furthermore, some individuals with mental health problems who are socially isolated may be drawn into a drug-using culture that appears more attractive and less stigmatised for social interactions.

However, there is still no consensus or common understanding of what is meant by 'dual diagnosis'. The concept 'dual diagnosis' has been applied to a number of individuals with two coexisting disorders or conditions, such as a physical illness and mental health problems, schizophrenia and substance misuse, or learning disability and mental health problems. The concepts of 'dual diagnosis', and 'co-morbidity' are now used commonly and interchangeably. The concept of complex or multiple needs is also associated with those with two existing conditions, which include medical, psychological, social or legal needs or problems. This chapter aims to examine the concept of dual diagnosis and describe its prevalence, treatment models, principles of treatment and issues for service delivery.

Concepts and classifications

There is no operational definition of dual diagnosis. However, dual diagnosis per se does not formally exist as a definitive diagnosis and the concept itself could be interpreted as being misleading and cumbersome (Rostad & Checinski, 1996). Nevertheless the same authors do concede that the 'label' is useful in so far as it draws attention to 'a real problem which is not being addressed'. The diagnostic labels have value in defining a client group and enabling the commissioning and delivery of care but the labels of 'dual diagnosis' should not be perceived as problematic (Rethink & Turning Point, 2004). Health care professionals have used the term dual diagnosis to refer to individuals who were mentally retarded or had a learning disability and who also had a coexisting psychiatric disorder (Evans & Sullivan, 2001). More recently, clinicians have begun to use the term to refer to an individual with a substance use problem and a coexisting psychiatric disorder. The term covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently

Table 1.1 Substance use and psychiatric syndromes.

- Substance use (even single dose) may lead to psychiatric syndromes/symptoms.
- Harmful use may produce psychiatric syndromes.
- Dependence may produce psychological symptoms.
- Intoxication from substances may produce psychological symptoms.
- Withdrawal from substances may produce psychological symptoms.
- Withdrawal from substances may lead to psychiatric syndromes.
- Substance use may exacerbate pre-existing psychiatric disorder.
- Psychological morbidity not amounting to a disorder may precipitate substance use.
- Primary psychiatric disorder may lead to substance use disorder.
- Primary psychiatric disorder may precipitate substance disorder, which may, in turn, lead to psychiatric syndromes.

Source: based on Crome (1999).

(Department of Health, 2002). In the context of this book, the concept of dual diagnosis is defined as the coexistence of substance misuse and mental health problems.

The misuse of psychoactive substances, including alcohol, may result in the individual developing a wide range of mental health problems depending on the drug being used. For example, a cocaine user may experience depressive symptoms and paranoid delusions. It is stated that with dual diagnosis patients, the psychiatric disorders and the substance misuse are separate, chronic disorders, each with an independent course, yet each able to influence the properties of the other (Carey, 1989).

The dual diagnosis individual meets the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for both substance abuse or dependency and a coexisting psychiatric disorder. The DSM-IV (American Psychiatric Association, 1994), defines a mental disorder as 'a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is typically associated with present distress (a painful symptom) or disability (impairment in one or more areas of functioning)'. Substance misuse, according to DSM-IV (APA, 1994), is the maladaptive pattern of use not meeting the criteria for dependence that has persisted for at least one month or has occurred repeatedly over a long period of time. The dual diagnosis patient meets the DSM-IV criteria for both substance abuse or dependency and a coexisting psychiatric disorder.

The nature of the relationship between these two conditions is complex. Dual diagnosis can be categorised into several subgroups and relationships defined by presumed aetiological mechanisms. The relationship between substance misuse and mental health problems can manifest itself in the following ways as shown in Table 1.1 (Crome, 1999).

Individuals with dual diagnosis, like most substance misusers, are a heterogeneous group and any defining features or diagnostic profiles evident may change over time. A more manageable and clinically relevant interrelationship between psychiatric disorder and substance misuse has been described in the *Dual Diagnosis Good Practice Guide* (Department of Health, 2002). The four possible relationships are:

- A primary psychiatric illness precipitating or leading to substance misuse
- Substance misuse worsening or altering the course of a psychiatric illness
- Intoxication and/or substance dependence leading to psychological symptoms
- Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses

Figure 1.1 presents the scope of coexistent psychiatric and substance misuse disorders (Department of Health, 2002). The horizontal axis represents severity of mental illness and the vertical axis the severity of substance misuse. Intervention strategies would need to focus on those whose severity falls within the top right hand and bottom right hand quadrants.

Prevalence

Despite certain methodological difficulties, especially with earlier studies, there is now strong research evidence that the rate of substance misuse

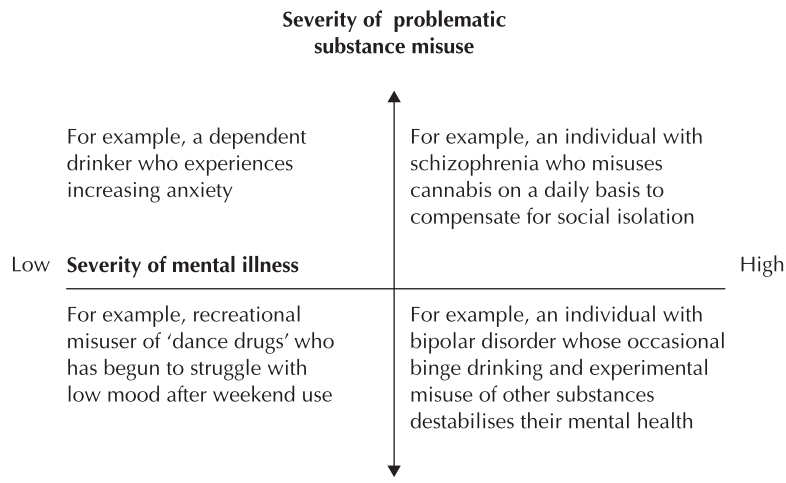

Figure 1.1 The scope of coexistent psychiatric and substance misuse disorders.
Source: Department of Health (2002).

is substantially higher among the mentally ill compared with the general population. The prevalence rate of substance use disorder among individuals with mental health problems ranges from 35% to 60% (Mueser *et al*., 1995; Menezes *et al*., 1996). The Epidemiological Catchment Area (ECA) study (Anthony & Helzer, 1991), a large American population survey, found a lifetime prevalence rate for substance misuse disorder of 16.7% (13.5% alcohol, 6.1% drug) for the general population. Rates for patients with schizophrenia, affective disorders and anxiety disorders were 47%, 32% and 23.7% respectively. For persons with any drug (excluding alcohol) disorder, more than half (53%) had one other mental disorder, most commonly anxiety and affective disorders.

The UK study (Menezes *et al*., 1996) of 171 inner city London patients in contact with psychiatric services found that the one-year prevalence rate amongst subjects with psychotic illness for any substance misuse problem was 36.3% (31.6% alcohol, 15.8% drug). The National Treatment Outcome Research Study (NTORS) (Gossop *et al*., 1998) found evidence of psychiatric disorders amongst individuals with primary substance use disorders. The NTORS found that 10% of substance misuse patients entering treatment had a psychiatric admission (not related to substance dependence) in the previous two years. Suicidal thoughts are commonly reported by drug dependent patients (29%) in treatment, and substance misuse is known to increase by 8–15-fold the risk of suicide (Shaffer *et al*., 1996; Gossop *et al*., 1998; Oyefeso *et al*., 1999). Some of this increased risk may be explained by the presence of co-morbid psychiatric conditions such as depression or personality disorder in substance misusers (Neeleman & Farrell, 1997). The Office of Population Censuses and Surveys household survey estimated the prevalence of alcohol and drug dependence amongst the general population to be 5% and 2% respectively (Farrell *et al*., 1998). Consumption of drugs was particularly high amongst adults with a phobic disorder, panic disorder and depression. Mental health problems are highly prevalent amongst the homeless population, making the chances of dual diagnosis in this population very high. A study of a sample of 124 individuals aged 18–65, who had remained in contact with the mental health team (Wright *et al*., 2000), showed that 33% of patients fulfilled the study criteria for substance misuse. Those individuals (23%) with psychosis had 19 admissions in the two years prior to interview, while 18% of individuals with dual diagnosis had 11 admissions. In a study of 1075 adults, of whom 90% were opiate dependent (Marsden *et al*., 2000), anxiety, depression, paranoia and psychoticism were found, with polydrug use closely linked to psychiatric symptoms. The use of illicit psychoactive substances, including alcohol, by individuals with psychiatric disorders increases the risk for those individuals to have an alcohol or drug-related

problem or dependence. Individuals with schizophrenia for instance, have a three-fold risk of developing alcohol dependence compared with individuals without a mental illness (Crawford, 1996).

A study of the prevalence and management of co-morbidity amongst adult substance misuse and mental health treatment populations (Weaver *et al.*, 2002) showed that some 74.5% of users of drug services and 85.5% of users of alcohol services experienced mental health problems. Most had affective disorders (depression) and anxiety disorders and psychosis. Almost 30% of the drug treatment population and over 50% of those in treatment for alcohol problems experienced 'multiple' morbidity (co-occurrence of a number of psychiatric disorders or substance misuse problems). Some 38.5% of drug users with a psychiatric disorder were receiving no treatment for their mental health problem. Some 44% of mental health service users reported drug use and/or were assessed to have used alcohol at hazardous or harmful levels in the past year.

In summary, UK data from one national survey and from local studies (Department of Health, 2002) generally show that:

- Increased rates of substance misuse are found in individuals with mental health problems
- Alcohol misuse is the most common form of substance misuse
- Where drug misuse occurs it often coexists with alcohol misuse
- Homelessness is frequently associated with substance misuse problems
- Community mental health teams typically report that 8–15% of their clients have dual diagnosis problems, although higher rates may be found in inner cities
- Prisons have a high prevalence of substance misuse and dual diagnosis

Complex problems, complex needs

Individuals with substance misuse and mental health problems are a vulnerable group of people with complex needs. While it is true that each disorder alone may have major implications for how an individual functions, the disorders together may have interactive and overwhelming effects when they coexist. Individuals with this combination of problems often have a lot of additional difficulties that are not purely medical, psychological or psychiatric. They are more likely to have a worse prognosis with high levels of service use, including emergency clinic and in-patient admissions (McCrone *et al.*, 2000). In addition, they have problems relating to social, legal, housing, welfare and 'lifestyle' matters. In summary, the major problems associated with individuals with dual diagnosis are:

- Increase likelihood of self-harm
- Increased risk of HIV infection
- Increased use of institutional services
- Poor compliance with medication/treatment
- Homelessness
- Increased risk of violence
- Increased risk of victimisation/exploitation
- Higher recidivism
- Contact with the criminal justice system
- Family problems
- Poor social outcomes, including impact on carers and family
- Denial of substance misuse
- Negative attitudes of health care professionals
- Social exclusion

In addition, those individuals from black and ethnic minority groups with dual diagnosis face the compounded pressure of stigma, prejudice, institutional racism and ethnocentric intervention strategies. These complex needs cannot be dealt with by a single approach and require a more holistic approach from several different agencies or services in order to meet the medical, psychological, social, spiritual and/or legal needs of the individual.

Aetiological theories: reasons why individuals with mental health problems use psychoactive substances

There are a variety of models and theories that hypothesise why individuals with mental health problems are vulnerable to the misuse of psychoactive substances. These are the self-medication hypothesis, the alleviation of dysphoria model, the multiple risk factor model and the supersensitivity model.

Self-medication hypothesis

Self-medication refers to the motivation of patients to seek a specific drug for relief of a particular set of symptoms. Khantzian (1985; 1997) proposed a model of self-medication and suggested that individuals misuse psychoactive substances adaptively to cope with painful affective states and related psychiatric disorders that may predispose them to addictive behaviours. He stated that potential addicts do not select specific psychoactive substances at random but for their unique effects. Khantzian argues that an opiate user may self-medicate with, or have a preference for, opiates because of their powerful action in dealing with rage, aggression and/or depression. Cocaine has its appeal because of its ability to relieve distress associated with depression, hypomania and hyperactivity.

However, there is available evidence that does not support this hypothesis: no specific substances were found to alleviate specific symptoms of a particular psychiatric disorder (Dixon *et al*., 1990; Noordsy *et al*., 1991). The most common substances used by individuals with mental health problems are alcohol, nicotine, amphetamines, cannabis, and hallucinogens (Schneider & 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 decrease distress or to alleviate such symptoms. However, the self-medication theory may still retain some credence. For example, opiates, cannabis or alcohol may reduce the agitation and anxiety associated with mental illness, whilst stimulants may be used as self-medication for negative symptoms or depression. Psycho-stimulants may help counteract extrapyramidal side effects of antipsychotic medication (Smith & Hucker, 1994) especially akathisia. There is no evidence in support of the self-medication hypothesis as a necessary reinforcer of continued drug use (Castaneda *et al*., 1994).

Alleviation of dsyphoria

This model put forward that severely mentally ill patients are prone to dysphoric experiences (feeling bad) that make them susceptible to use psychoactive substances (Birchwood *et al*., 1993). The rationale for using psychoactive substances initially is for the relief of bad feeling and to feel good (Leshner, 1998) and the literature supports this notion that dysphoria motivates initial alcohol and drug use (Carey & Carey, 1995; Pristach & Smith, 1996; Addington & Duchak, 1997). Most of the studies generally support the alleviation of dysphoria model.

Multiple risk factor model

According to Mueser *et al.* (1995), in addition to the dysphoric experiences, there are other underlying risk factors that may motivate the severely mentally ill patient to use psychoactive substances. The risk factors include social isolation, deficit in interpersonal skills, poor cognitive skills, educational failure, poverty, lack of adult role responsibility, association with drug subcultures and availability of illicit psychoactive substances (Anthony & Helzer, 1991; Berman & Noble, 1993; Jones *et al*., 1994). However, there is no direct evidence for this model, but the rationale for using psychoactive substances is related to the identified factors (Dixon *et al*., 1990; Noordsy *et al*., 1991).

The supersensitivity model

According to this model, 'psychobiological vulnerability, determined by a combination of genetic and environmental events, interacts with environmental stress to either precipitate the onset of a psychiatric disorder or to trigger relapse' (Mueser *et al*., 1995). Mueser *et al.* (1995) argue that the sensitivity to psychoactive substances (increased vulnerability) may cause patients with severe mental illness to be more likely to experience negative consequences from using relatively small amounts of psychoactive substances. There are several studies that provide evidence for this model: lower levels of physical dependence (Drake *et al*., 1990; Corse *et al*., 1995); trigger of clinical symptoms by low dose of amphetamine (Lieberman *et al*., 1987); and negative clinical effects, such as relapse, with small quantities of alcohol or drugs (Drake *et al*., 1989). The supersensitivity model, according to Mueser *et al*. (1995), provides a useful theoretical framework

in the understanding of how low level use of psychoactive substances often results in negative consequences in severely mentally ill patients and also the increased prevalence of drug dependence in this population.

There may be other explanations as to why individuals with mental health problems may use certain psychoactive substances. They may be doing it for the same reasons as the rest of the population. For example, to relax, to relieve boredom, to get high, or because of increased availability or acceptability. Whilst this contention may be true, it fails, however, to explain the observed increased prevalence of substance use compared with the general population. A number of possible explanations can therefore be advanced. The individual with mental health problems may experience downward drift to poor inner city areas (social drift hypothesis) where drug availability is increased. With the advent of deinstitutionalisation, more of the individuals with mental health problems may be finding themselves exposed to an increased availability of drugs in the community (Williams, 2002). Equally, an increased availability of illicit drugs in psychiatric institutions may be a contributory factor (Laurence, 1995; Williams & Cohen, 2000).

Principles of treatment

The accurate assessment and treatment of individuals with dual diagnosis requires time, adequate resources and relevant experience. Drake *et al.* (1993) described nine principles in the treatment of drug misuse in individuals with dual diagnosis. These principles are applicable in most settings and within a shared care framework. A summary of the principles of treatment of substance misuse in individuals with mental health problems is presented in Table 1.2.

Assertive outreach

This group of individuals have a tendency not to engage with treatment agencies or disengage from treatment and they are poor at attending appointments. A more assertive approach will enable supervision and work towards the reinstatement of engagement with the appropriate services. The individuals may require practical assistance with basic needs, such as housing, state benefits or welfare, in which there is some tangible gain for the individual. Contact with the individuals may be

Table 1.2 Principles of treatment of substance misuse in individuals with mental health problems.

Assertiveness	Outreach in the community Practical assistance with basic needs Working with family members
Close monitoring	Intensive supervision Voluntary and at times involuntary
Integration	Integrated treatment programmes in which the same clinician provides mental health and substance misuse treatment in same setting
Comprehensiveness	Addresses living skills, relationships, vocational and interpersonal skills in addition to clinical treatments
Stable living conditions	Access to housing, support and companionship in the community
Flexibility and specialisation	Successful clinicians modify previous beliefs, learn new skills and try new approaches empirically
Stages of treatment	Treatment proceeds in stages: engagement, persuasion, active treatment and relapse prevention
Longitudinal perspective	Recognises that substance misuse and mental illness are chronic relapsing conditions and treatment occurs over years rather than episodically or during crisis
Optimism	Encourages hope and counters demoralisation amongst patients, family and clinicians

Source: based on Drake *et al.* (1993).

made at various locations, for example at the social security department, chemist, family home or probation service. Working with family members is an important aspect for assessment and support of carers.

Close monitoring

There should be intensive supervision at least three times a week, initially, to establish a therapeutic relationship and engage the client for other intervention strategies. Close monitoring, voluntary and at times involuntary, must be made on the mental/psychological state of the individual and on compliance with prescribed medications (methadone, antipsychotics, antidepressants, disulfiram, etc.).

Integration

The treatment programme is based on integrated care pathways in which there is concurrent and coordinated treatment. The use of the care programme approach (CPA) would enhance and facilitate better liaison between mental health and substance misuse services and other appropriate agencies. Virtual teams can be formed across teams and organisations and this has the advantage of flexibility but lacks the cohesion of a single 'physical team' (Checinski, 2002). A strong key worker system would enable the coordination of the network of care and treatment required.

Comprehensiveness

Individuals with dual diagnosis often have complex needs in other areas of their lives. This means addressing living skills, relationships, vocational and interpersonal skills, in addition to routine screening (dental, ophthalmology, cervical smears) and clinical treatments.

Stable living situation

Links with housing services and associations is essential in the provision of accommodation for the individual. Access to appropriate supportive housing may be necessary in the overall support system, as attending hostels or night shelters may expose the individual to alcohol and/or drug environments.

Flexibility with specialisation

Successful practitioners will need to modify previous beliefs, learn new skills and try new approaches. Practitioners need to re-evaluate and modify traditional therapeutic approaches to be effective in engaging individuals with dual diagnosis. Directive 'counselling' and confrontational challenges may be counterproductive and may heighten the risk of disengagement with the treatment services. Overtly self-abusive behaviour, particularly when it involves illicit psychoactive substances, is dealt with in a suppressive and moralistic way by many health care workers, not least of all nurses, probably out of a sense of frustration or inadequacy about their ability to effect any change (Gafoor, 1985). This needs to change.

Stages of treatment

The treatment of individuals with dual diagnosis proceeds in stages: engagement, persuasion, active treatment and relapse prevention. However, in clinical practice treatment rarely proceeds in a linear pathway. Each individual will be different and will typically enter the cycle of change and move through the stages intermittently. Individuals will move back and forward between the stages and specific interventions will be required for particular stages.

Longitudinal perspective

It is important to recognise that substance misuse and mental disorder are chronic relapsing conditions and treatment occurs over years rather than episodically or during crisis.

Optimism

Individuals with dual diagnosis are likely to feel hopeless about the future due to the combined

effects and consequences of both conditions. This may be perceived as having poor or a lack of motivation to engage in treatment. However, practitioners need to view motivation as a dynamic process that can be undermined or enhanced by different therapeutic techniques and approaches. The best treatment outcome may depend upon staff who have therapeutic optimism towards the individual, treatment and recovery.

Models of treatment: whose patient anyway?

Dual diagnosis patients are a heterogeneous population and the demands they make on services pose huge challenges to the models of intervention and the health care delivery system. Models of intervention are based on whether the services are identified as serial, parallel, integrated or shared care. The serial or sequential model is where one treatment follows the other, but they are not offered simultaneously. The parallel model is based on treatment being delivered by both substance misuse teams and the mental health teams concurrently. In both models, expertise is not shared across teams and they have difficulties engaging patients in treatment and reducing non-compliance, which in turn is associated with poor service coordination, and fragmentation of the care delivery process (Edeh, 2002). However, dual diagnosis services with this liaison role have begun to emerge in the UK (Department of Health, 2002).

The integrated treatment model is based on a single treatment system (or dual team) whereby an individual's substance misuse and mental health problems are treated simultaneously by the same practitioner. This model is designed to offer a comprehensive range of interventions, which include pharmacological, psycho-educational, behavioural, case management and self-help approaches. However, this model views dual diagnosis as a static condition where the needs and problems of the individual remain the same constantly. It is regarded as an expensive service provision and isolated from mainstream services. The components of an integrated model are presented in Table 1.3.

The shared care model (joint liaison/collaborative approach) involves the delivery of parallel treatment with close collaboration and communication between teams and the careful timing of interventions. This model is expected to reduce non-compliance, poor service coordination, the fragmentation of the care delivery process and enhance the engagement of dual diagnosis individuals with treatment services. However, the skills and expertise of those in substance misuse and mental health services need to be utilised effectively to provide effective treatment. There is no clear evidence supporting the advantage of any model as a preference over others (Health Advisory Service, 2001; Ley *et al*., 2001). Each local area needs to identify the appropriate model and approach based on health care needs and service configurations. For a comprehensive review of dual or separate services see Edeh (2002).

The National Treatment Agency (2002) guidance on models of care provides a treatment framework for the commissioning of an integrated drug treatment system for adult drug misusers in

Table 1.3 Common components of integrated treatment.

Case management	Multidisciplinary case management with assertive outreach
Close monitoring	Medication supervision (including urine drug screening)
Substance misuse treatment	Motivational interviewing; harm reduction and cognitive behavioural; self-help group (twelve-step programmes) and social skills training
Rehabilitation	Provision of long-term support: day care or residential care, to enable restoration of social and occupational function (supported education and employment)
Housing	Supported and independent
Pharmacotherapy	Provision of antipsychotic medication (particularly clozapine) in those with schizophrenia, and improvement of compliance by providing education and medication supervision

Source: adapted from Drake & Mueser (2000).

England. The models of care framework is intended to support the move towards an integrated care pathway in the development of the essential components of specialist substance misuse services and the importance of links with other health, social care and criminal justice agencies. The integrated care pathways provide a means of agreeing local referral and treatment protocols to define where and when a particular service user needs to be referred.

An optimal model of care for patients with dual diagnosis could be developed in the context of current service models and structures, provided minimum standards for quality are established. This has been suggested by Abou Saleh (2000; 2004). The quality standards for service planning should include:

- Access to relevant services (crisis, support, housing, aftercare, therapeutic and legal services)
- Responsive and flexible approaches (assessment, engagement, retention, managing chaos and crisis, individual responses)
- Continuous care and management (monitoring, liaison, involvement of carers, risk assessment and management)
- Adequately trained staff (access to mental health trained staff)

Intervention strategies

An assessment of substance misuse should form an integral part of standard assessment procedures for mental health problems. For further information on screening and assessment see Chapter 18 on a Framework for Multidimensional Assessment. Osher & Kofoed (1989) provide a useful framework for utilising therapeutic interventions with individuals who have coexisting substance misuse and mental health problems. They identified four stages of intervention:

- Engagement
- Motivation for change (persuasion)
- Active treatment
- Relapse prevention

Within these stages exist various cognitive approaches to the care and treatment of individuals with dual diagnosis, such as harm reduction, motivational interviewing, individual cognitive behavioural counselling, lifestyle change, relapse planning and prevention, and family education.

Engagement

Engagement is concerned with the development and maintenance of a therapeutic alliance between staff and client. Attempts to establish a therapeutic relationship prematurely may exacerbate the potential for clients to disengage from treatment services. The aim at this stage is to understand the client and their view, to respond to their behaviour and language, to recognise their often unspoken needs, and thereby to develop some trust and genuineness (Price, 2002). This can be enhanced by the style of interaction, which should be non-confrontational, empathic and respectful of the client's subjective experiences of substance misuse. The strength of this alliance will depend upon the value a client attributes to the service, the social marketing of the services by the staff and meeting the client's immediate needs. Substance misuse is not addressed directly until the end of the engagement process when a working alliance has developed.

The following guidelines (Rethink & Turning Point, 2004) will help to promote engagement:

- Motivate clients to see the benefits of the treatment process: this requires a clear idea of what they need and value
- Have a non-confrontational, empathic and committed approach
- Offer help with meeting initial needs such as food, shelter, housing, clothing
- Provide assistance with benefit entitlements
- Provide assistance with legal matters
- Involve family or carers wherever possible
- Meet clients in settings where they feel safe: this may be more constructive than expecting them to come to services

Motivation

This stage draws upon the principles of motivational interviewing (see Chapter 25 on Motivational Interviewing) to effect change and is

contingent upon regular contact and a working alliance between staff and client. In this context, its purpose is to empower the client to gain insight into their problems and to strengthen a client's motivation and commitment to change whilst avoiding confrontation and resistance. A variety of simple techniques (Department of Health, 2002) can be used for this purpose including:

- Education about substances and the problems that may be associated with misuse, including the effects on mental health
- Presentation of objective assessment data (for example liver function tests, urinalysis)
- Balance sheets on which the client lists the pros and cons of continued use/abstinence
- Exploration of barriers to the attainment of future goals
- Reframing problems or past events, emphasising the influence of substance misuse
- Reviewing medication and the use of an optimal medication regime

Active treatment

This stage involves the persuasion of the client of the value and benefits of treatment, although it may take a few months before a client is ready to receive active treatment interventions for their substance misuse. It is important at the outset to agree the anticipated goal of treatment and to integrate treatment of mental health problems and substance misuse. This should entail the active involvement of the client in formulating goals and a care plan. If it is unrealistic to aim for abstinence it may be more appropriate to consider intermediate goals that represent reductions in the harm incurred from drug and alcohol misuse, whilst not focusing prematurely on complete cessation (Department of Health, 2002). A number of interventions have been identified for the effective treatment of dual diagnosis, but these lack specificity (Department of Health, 2002). The interventions are:

- Integrated treatment
- Staged interventions
- Assertive outreach
- Motivational interventions
- Individual counselling
- Social support interventions
- Long-term perspective

Cognitive behavioural therapy has been shown to be a potent therapeutic tool for a range of mental health problems (Dattilio & Freeman, 1992). This is no less true in dually diagnosed clients, where the skilful use of analysis, disputing cognitions, combined with realistic homework tasks can enhance the skills that promote abstinence, including increasing self-efficacy in finding, establishing and maintaining appropriate support networks (Price, 2002). Other interventions as part of the holistic approach should be provided in relation to pharmacological management, social support and building self-esteem, social skills, occupational therapy, welfare advice and employment services.

Relapse prevention

Substance misuse and mental health problems are chronic relapsing conditions. Given the relapsing nature of substance misuse it is important, once a client has reduced their misuse, or become abstinent, to offer interventions aimed at the prevention and management of future relapses. It is also crucial that both clients and staff accept relapse and do not perceive it as a weakness or failure. If the substance use is sustained, a return to the motivation for change stage is necessary and attention should be given to the development of new action plans. The principles and strategies of 'relapse prevention' for substance misuse (see Chapter 26) and the management of relapses to psychosis are recommended for this purpose. This approach aims to identify high-risk situations for substance misuse and rehearse coping strategies proactively.

Conclusion

The term dual diagnosis is often used to describe this coexistence and these patients tend to be more problematic to treat and manage in view of higher rates of non-compliance, violence, homelessness and suicide. The relationship between substance misuse and mental health problems is complex. Intoxication and withdrawal from drugs and alcohol can produce psychiatric symptoms, while on the other hand some individuals with psychiatric disorders, such as antisocial personality disorders and schizophrenia are more susceptible to substance

misuse. The mental state of the patient may act as a barrier to recognition as some patients may not be able to understand the nature of the symptoms they experience or adequately describe them in a way that enables clinical staff to make an accurate assessment. This task of diagnosis is further compounded if the patient is a polydrug user and is taking a combination of psychoactive substances at the same time. Even when substance misuse is identified it is often difficult to distinguish between symptoms that are related to substance misuse or a psychiatric disorder. Failure to recognise and treat substance misuse at an early stage will not only lead to ineffective management and treatment outcomes, but may also result in a deterioration of the patient's symptomatology.

The national guidance on good practice in dual diagnosis (Department of Health, 2002) is a step in the right direction. It focuses on the complex needs of patients with coexistence of substance misuse and mental health problems. However, the document fails to address important issues relating to social care, the resource implications of this major service development, and the interface between mainstream mental health services and addiction services, as well as implications for the future and the scope of addiction services (Abou Saleh, 2004). The involvement of service users, families and carers is central in the care planning and treatment process, and must not be tokenistic or superficial. The involvement should take place at all stages: in treatment, in the planning, delivery and development of existing services, and in the planning and commissioning of future services (Rethink & Turning Point, 2004). Attention also needs to be focused on special populations (see Part 2) in relation to dual diagnosis, such as black and ethnic minority groups, homelessness, older people (alcohol and tranquillisers), young people and women (Health Advisory Service, 2001).

There is also the need to address the training and continuing professional development (Chapter 27) of staff to working with coexistence of substance misuse and psychiatric disorders. There is evidence to suggest that mental health service workers lacked the knowledge and skills for assessment and treatment of substance misuse and were insufficiently aware of the available resources and how to access substance misuse services (Maslin *et al*., 2001). Dual diagnosis is often not picked up by substance misuse or mental health services, indicating a need for improvement in staff training and routine assessment and recording (Weaver *et al*., 2002).

The changing patterns and prevalence of the coexistence of substance misuse and psychiatric disorders in the UK necessitate new and innovative responses from health and social care workers and service providers. Dual diagnosis, like substance misuse, is not the sole responsibility of one discipline or specialist. It requires a multidimensional approach and involves inter-agency collaboration in the ownership of common goals in meeting the complex physical/medical, social, psychological and spiritual needs of the individual. There is cause for optimism.

References

Abou Saleh, M.T. (2000) Substance misuse and co-morbid psychiatric disorders. *CPD Bulletin in Psychiatry*, 2, 61–7.

Abou Saleh, M.T. (2004) Dual diagnosis: management within a psychosocial context. *Advances in Psychiatric Treatment*, 10, 352–60.

Addington, J. & Duchak, V. (1997) Reasons for substance use in schizophrenia. *Acta Psychiatrica Scandinavica*, 96, 329–33.

American Psychiatric Association (1994) *DSM-IV: Diagnostic and Statistical Manual of Mental Disorders*, 4th edn, pp. 75–90. American Psychiatric Association, Washington, DC.

Anthony, J.C. & Helzer, J.E. (1991) Syndromes of drug abuse and dependence. In: *Psychiatric Disorders in America: the Epidemiologic Catchment Area Study* (Robins, L.N. & Regier, D.A., eds), pp. 116–54. Free Press, New York.

Berman, S. & Noble, E.P. (1993) Childhood antecedents of substance misuse. *Current Opinion in Psychiatry*, 6, 382–7.

Birchwood, M., Mason, R., MacMillan, F. & Healy, J. (1993) Depression, demoralisation and control over psychotic illness: a comparison of depressed and non-depressed patients with chronic psychosis. *Psychological Medicine*, 23, 387–91.

Carey, K.B. (1989) Emerging treatment guidelines for mentally ill chemical abusers. *Hospital Community Psychiatry*, 40, 341–2.

Carey, K.B. & Carey, M.P. (1995) Reasons for drinking among psychiatric outpatients: relationship to drinking patterns. *Psychology of Addictive Behaviours*, 9, 251–7.

Castaneda, R., Lifshutz, H., Galanter, M. & Franco, H. (1994) Empirical assessment of the self-medication hypothesis among dually diagnosed in-patients. *Comprehensive Psychiatry*, 35 (3), 180–4.

Checinski, K. (2002) Treatment strategies and interventions. In: *Dual Diagnosis: Substance Misuse and Psychiatric Disorders* (Rassool G.H., ed.). Blackwell Publishing, Oxford.

Corse, S.J., Hirschinger, N.B. & Zanis, D. (1995) The use of the Addiction Severity Index with people with severe mental illness. *Psychiatric Rehabilitation Journal*, 19, 9–18.

Crawford, V. (1996) Co-morbidity of substance misuse and psychiatric disorders. *Current Opinion in Psychiatry*, 9, 231–4.

Crome, I.B. (1999) Substance misuse and psychiatric co-morbidity: towards improved service provision. *Drugs: education, prevention and policy*, 6, 151–74.

Dattilio, F.M. & Freeman, A. (1992) Introduction to cognitive therapy. In: *Comprehensive Casebook of Cognitive Therapy* (Freeman, A. & Dattilio, F.M., eds), pp. 3–11. Plenum, New York.

Department of Health (2002) *Mental Health Policy Implementation Guide. Dual Diagnosis Good Practice Guide*. Department of Health, London.

Dixon, L., Haas, G., Weiden, P., Sweeney, J. & Frances, A. (1990) Acute effects of drug abuse in schizophrenic patients: clinical observations and patients' self reports. *Schizophrenia Bulletin*, 16, 69–79.

Drake, R.E. & Mueser, K.T. (2000) Psychosocial approaches to dual diagnosis. *Schizophrenia Bulletin*, 26, 105–117.

Drake, R.E., Banels, S.J., Teague, G.B., Noordsy, D.L. & Clarke, R.E. (1993) Treatment for substance misuse in severely mentally ill patients. *Journal of Nervous and Mental Diseases*, 181, 606–11.

Drake, R.E., Osher, F.C., Noordsy, D.L., Hurlbut, S.C., Teague, G.B. & Beaudett, M.S. (1990) Diagnosis of alcohol use disorders in schizophrenia. *Schizophrenia Bulletin*, 16, 57–67.

Drake, R.E., Osher, F.C. & Wallach, M.A. (1989) Alcohol use and abuse in schizophrenia: a prospective community study. *Journal of Nervous and Mental Disease*, 177, 408–14.

Edeh, J. (2002) Dual or separate services? In: *Dual Diagnosis: Substance Misuse and Psychiatric Disorders* (Rassool G.H., ed.). Blackwell Publishing, Oxford.

Evans, K. & Sullivan, J.M. (2001) *Dual Diagnosis: Counselling the Mentally Ill Substance Abuser*, 2nd edn. Guilford Press, New York.

Farrell, M., Howes, S., Taylor, C. *et al*. (1998) Substance misuse and psychiatric co-morbidity: an overview of the OPCS National Psychiatric Morbidity Study. *Addictive Behaviours*, 23 (6), 909–18.

Gafoor, M. (1985) Nurses' attitudes to the drug abuser. Letter to *Nursing Times*, 30 Oct.

Gossop, M., Mardsen, J. & Steward, D. (1998) *NTORS at One Year: The National Treatment Outcome and Research Study*. Department of Health, London.

Health Advisory Service (2001) Substance misuse and mental health co-morbidity (dual diagnosis). *Standards for Mental Health Services*. Health Advisory Service, London.

Jones, P., Guth, C., Lewis, S. & Murray, R. (1994) Low intelligence and poor education achievement precede early onset of schizophrenic psychosis. In: *Neuropsychology of Schizophrenia* (David, A.S. & Cutting, J.C., eds), pp. 131–44. Erlbaum, East Essex.

Khantzian, E.J. (1985) The self-medication hypothesis of addictive disorders: focus on heroin and cocaine dependence. *American Journal of Psychiatry*, 142 (11), 1259–64.

Khantzian, E.J. (1997) The self-medication hypothesis of addictive disorders: a reconsideration and recent applications. *Harvard Review of Psychiatry*, 4, 231–44.

Laurence, J. (1995) Mental hospitals are 'paradise for drug-pushers.' *The Times*, 14 June, p. 6.

Leshner, A.I. (1998) *Bridging the Disconnect Between Research and Practice*. The National Conference on Drug and Drug Addiction Treatment: From Research to Practice. National Institute on Drug Abuse, Washington, DC.

Ley, A., Jeffery, D., Aclaren, S. & Siegfried, N. (2001) Treatment programmes for people with both severe mental illness and substance misuse. *Cochrane Review, Issue 3*. The Cochrane Library.

Lieberman, J.A., Kane, J.M. & Alvir, J. (1987) Provocative tests with psychostimulant drugs in schizophrenia. *Psychopharmacology*, 91, 415–33.

McCrone, P., Menezes, P.R., Johnson, S. *et al*. (2000) Service use and costs of people with dual diagnosis in South London. *Acta Psychiatrica Scandinavica*, 101, 464–72.

Marsden, J., Gossop, M., Stewart, D. *et al*. (2000) Psychiatric symptoms among clients seeking treatment for drug dependence. Intake data from the National Treatment Outcome Research Study. *British Journal of Psychiatry*, 176, 285–9.

Maslin, J., Graham, H.L., Cawley, M.A.C. *et al*. (2001) Combined severe mental health and substance use problems: what are the training and support needs of staff working with this client group? *Journal of Mental Health*, 10 (2), 131–40.

Menezes, P., Johnson, S., Thornicroft, G. *et al*. (1996) Drug and alcohol problems among individuals with severe mental illnesses in South London. *British Journal of Psychiatry*, 168, 612–19.

Mueser, K., Bennett, M. & Kushner, M. (1995) Epidemiology of substance use disorders among persons with chronic mental illness. In: *Double Jeopardy: Chronic Mental Illness and Substance Use Disorders* (Lehman, A. & Dixon, L., eds). Harwood Academic, Chur, Switzerland.

National Treatment Agency (2002) *Models of Care*. Parts 1 and 2. National Treatment Agency, London.

Neeleman, J. & Farrell, M. (1997) Suicide and substance misuse. *British Journal of Psychiatry*, 175, 303–4.

Noordsy, D.L., Drake, R.E., Teague, G.B. *et al.* (1991) Subjective experiences related to alcohol use among schizophrenics. *The Journal of Nervous and Mental Disease*, 1179, 410–14.

Osher, F.C. & Kofoed, L.L. (1989) Treatment of patients with psychiatric and psychoactive substance abuse disorders. *Hospital Community Psychiatry*, 40, 1025–30.

Oyefeso, A., Ghodse, H., Clancy, C. & Corkey, J. (1999) Suicide among drug addicts in the UK. *British Journal of Psychiatry*, 175, 277–82.

Price, P. (2002) Nursing Interventions in the Care of Dually Diagnosed Clients. In: *Dual Diagnosis: Substance Misuse and Psychiatric Disorders* (Rassool G.H., ed.), Blackwell Publishing, Oxford.

Pristach, C.A. & Smith, C.M. (1996) Self-reported effects of alcohol use on symptoms of schizophrenia. *Psychiatric Services*, 47, 421–3.

Rethink & Turning Point (2004) *Dual Diagnosis Toolkit Mental Health and Substance Misuse. A Practical Guide for Professionals and Practitionery*. Rethink & Turning Point, London.

Rostad, P. & Checinski, K. (1996) *Dual Diagnosis: Facing the Challenge*. Wynne Howard Books, Surrey.

Schneider, F.R. & Siris, S.D. (1987) A review of psychoactive substance use and abuse in schizophrenia: patterns of drug choice. *Journal of Psychiatry*, 165, 13–21.

Shaffer, D., Gould, M.S., Fisher, P. *et al.* (1996) Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry*, 53, 339–48.

Smith, J. & Hucker, S. (1994) Schizophrenia and substance abuse. *British Journal of Psychiatry*, 165, 13–21.

Weaver, T., Charles, V., Madden, P. & Renton, A. (2002) Co-morbidity of substance misuse and mental illness collaborative study (COSMIC). National Treatment Agency, London.

Williams, H. (2002) Dual diagnosis – an overview: fact or fiction? In: *Dual Diagnosis: Substance Misuse and Psychiatric Disorders* (Rassool G.H., ed.). Blackwell Publishing, Oxford.

Williams, R. & Cohen, J. (2000) Substance use and misuse in psychiatric wards: a model task for clinical governance? *Psychiatric Bulletin*, 24, 43–6.

Wright, S., Gournay, K., Glorney, E. & Thornicroft, G. (2000) Dual diagnosis in the suburbs: prevalence, need, and in-patient service use. *Social Psychiatry Psychiatric Epidemiology*, 35, 297–304.

2 Policy Initiatives in Substance Misuse and Mental Health: Implications for Practice

A. Hammond

Introduction

Mental health and substance misuse policy has evolved gradually and separately over time. To understand the action plans set down in policy documents we need to explore the various influences that have impacted on the decision makers who develop these policies. According to Palmer & Short (1989) economic, political, sociological, epidemiological and public health issues of the day are important predictors of policy formation. Also, scientific and medical discoveries, psychological understanding, and philosophical and religious beliefs all underpin policy frameworks. This chapter will explore some of these influences in the context of history, before looking at some of the most recent documents and concerns that have led to the present interest in policy development for those with a dual diagnosis.

Historical context

Before the eighteenth century, policy, if there was such a thing, was underpinned by a belief that God or the gods were responsible for all illness, mental and physical (Escohotado, 1999; Porter, 2002). The ancients knew the link between mental health and drug use; they knew that some drugs used in excess could cause hallucinations and delirium, including alcohol (Escohotado, 1999). During the Dark Ages religion dictated policy. The belief in the supernatural culminated in the witch hunts. This had enormous implications for those with a mental illness and for those who made, took, sold or dispensed drugs that were thought of as diabolic; they were at risk of being drowned or burned at the stake. In his book, *De Praestigiis Daemonum* (1563) (On the Conjuring Tricks of Demons) Johannes Weyer suggested that hallucinations were caused by either dreams or drugs and not witchcraft. He was also branded a sorcerer for his words. With the renaissance the tide turned, and the ideas first put forward by Hippocrates, that mental illness is organic in origin and pharmacology was not inspired by the devil, grew (Porter, 2002), putting the supernatural into the background.

Years of asylum

By the eighteenth century, those whose behaviour was not considered normal were increasingly being cared for in madhouses; these became known as asylums, later mental hospitals and then psychiatric hospitals. Some were concerned about the quality, treatment and civil liberties of those in the institutions as well as the safety of the general public. As a result, several acts of Parliament were passed addressing some of these issues (Rogers &