

# Dual Diagnosis: Practice in Context

Edited by

**Dr Peter Phillips**  
(City University London)

**Dr Olive McKeown**  
(St George's University, London)

and

**Tom Sandford**  
(Royal College of Nursing, London)

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# **Dual Diagnosis: Practice in Context**

*Dedicated with love to Caro Stanford (1947–2006) – an insightful teacher, dear friend and champion of harm reduction*  
Peter Phillips

*Dedicated with love to Shaun, Chris, Dan and Jennifer; I appreciate their kindness to me and each other*  
Olive McKeown

*Dedicated to the great nurses I've worked with*  
Tom Sandford

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# Contributors

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Tom Sandford is employed by the Royal College of Nursing (RCN) as the executive director of their services across England. His previous roles in the organisation include five years as a policy adviser and three years as London regional director. Before joining the RCN Tom was general manager of mental health services in the London boroughs of Camden and Islington.

Tom trained as a general and mental health nurse and held a variety of clinical posts in the fields of family therapy and acute and liaison psychiatry. He was Head of Professional Development in Bloomsbury Health Authority and was a member of the ministerial task force coordinating the development of the mental health national service framework. He has served on several public untoward incident inquiries and has taught mental health programmes at universities in Irsee and Frankfurt in Germany, and case management programmes at the University of Barcelona in Spain.

## Contributors

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**Dr Peter Carter** OBE is the Chief Executive & General Secretary of the Royal College of Nursing (RCN), the world's largest professional union of nurses. The RCN has a membership of 400,000 nurses, midwives, health visitors, nursing students, cadets and health care assistants. Before assuming the post of RCN General Secretary in January 2007, Dr Carter spent almost

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**Sharon Dennis**, RMN, BSc (Hons), CMS, RNT, Dip Family Therapy, Dip Performance Coaching (Business), PG Dip Advanced Practice (Nursing), is a regional director at the Royal College of Nursing (RCN). Prior to joining the RCN, Sharon has worked in London NHS mental health services for 20 years, culminating in a role as director of Nursing and Public Involvement and nurse adviser at the National Patient Safety Agency. Her publications include those on professional nursing issues and observation and she has a regular column in the *Nursing Standard* for whom she is the annual guest editor for their *Black History Month* special edition. She has contributed to Department of Health policy documents and National Institute for Clinical Excellence (NICE) guidance. She was an elected steering committee member of the

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**Chris Glover** is currently working as an alcohol liaison nurse at the Whittington Hospital. She has worked in the substance misuse field for over 20 years. Her career includes holding the positions of clinical services manager and lead nurse for substance misuse services, both at Camden and Islington Foundation NHS Trust. She has also held the position of lecturer/practitioner on the dual diagnosis programmes at Middlesex University.

**Kevin Gournay** is a chartered psychologist, chartered scientist and a registered nurse. Originally he trained in psychiatry, learning disabilities and general nursing and then, in the 1970s as one of the first nurse therapists in cognitive behaviour therapy. He worked part time to obtain a qualification as a psychologist, obtaining his PhD in agoraphobia. For the last 30 years, he has combined roles as a clinician treating people with post-traumatic stress and anxiety disorders, depression and psychosis; a researcher; a teacher and a policy advisor to various governments. He has published over 300 papers, chapters and books and made numerous contributions to television and radio. He has worked on a range of dual diagnosis research, education and policy projects over a 15-year period. He is the president and founding patron of No Panic, the United Kingdom's largest anxiety disorders charity. Among various honours he held, he is a Fellow of the Royal College of Psychiatrists, a Fellow of the Academy of Medical Science, a Fellow of the Royal College of Nursing and was elected Nurse of the Year by the American Psychiatric Nursing Association in 2004. He was appointed CBE in the Queen's New Year's Honours 1999. He retired from the Institute of Psychiatry, Kings College, London, in 2006 and in semi-retirement works as a clinician and an expert witness. He retains involvement in a dual diagnosis project at the National Drug and Alcohol Research Centre in Sydney, Australia.

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**Sonia Johnson** studied social and political sciences and medicine at the Universities of Oxford and Cambridge, and also has an MSc in social psychology from the London School of Economics and a DM degree from the University of Oxford. She trained in psychiatry at the Bethlem Royal and Maudsley Hospitals, and was a lecturer in community psychiatry at the Institute of Psychiatry. Since 1997, she has worked at University College London (UCL) and in Camden and Islington Foundation Trust, and she is now a professor of social and community psychiatry at UCL. Dual diagnosis has been one of her major research interests for some years. She managed one of the first UK epidemiological investigations of dual diagnosis, and subsequently the COMO trial of training in management of dual diagnosis for care coordinators. She has supervised students working on ethnic differences and on motivations for use in dual diagnosis, and is currently involved in research on cannabis use in first episode psychosis.

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**Lorna Saunder** graduated from the University of Abertay, Dundee, in 1996 with a BSc (Hons) in Nursing, Mental Health. She left Scotland and returned to England to work in acute psychiatric services. Lorna then briefly worked in a mother and baby unit before eventually deciding that she wanted to pursue a career in helping people with substance use problems. She worked both in residential detoxification and community services. An opportunity then arose for Lorna to combine her clinical skills and a more academic role when she became lecture practitioner in dual diagnosis. Lorna has a PG diploma in academic practice and a PG diploma in drug and alcohol studies.

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**Murat Soncul** trained as a dental surgeon in Turkey, after which he completed a PhD in oral and maxillofacial surgery at University College London. He became interested in drug user oral health issues while working as a research fellow. His interests include health technology that improves access to services and assists diagnosis and treatment outcomes. Murat currently works with South London and Maudsley NHS Trust.

**David Webb** completed the world's first PhD on suicide as someone who has attempted suicide. In his thesis he argued that suicide is best understood as a crisis of the self rather than the prevailing view that it is the consequence

of some pseudoscientific 'mental illness'. Prior to his PhD in 2006 (and the 'four years of madness' that motivated this research), David worked in the computer industry as a software developer and university lecturer. He has been a board member of the World Network of Users and Survivors of Psychiatry (WNUSP) and currently works part time as a research/policy officer with the Australia Federation of Disability Organisations. He regards human rights as the core issue in mental health and that justice will not be possible for users and survivors of psychiatry until the mental health industry moves to the social model of disability that is the basis of the UN Convention on the Rights of Persons with Disability. He has lived in New York, Delhi and London and now lives among the gum trees and kookaburras on the edge of Melbourne as he learns how to be a grandad without having ever been a dad.

**Julie Winnington** has worked in the addiction field for a number of years, both in the community and in in-patient settings. She currently works for the South London and Maudsley NHS Foundation Trust, managing an in-patient unit for drug and alcohol users in crisis. She has a special interest in women with dual diagnosis.

# Foreword

The past decade has seen substantial clinical and research activity relating to the challenges presented by service users with a 'dual diagnosis'. We understand a lot more about the prevalence of substance misuse among the severely mentally ill and the interventions that might be effective in helping people with a dual diagnosis. This emphasis on effective clinical management is critical. As the chief executive of an inner London mental health NHS Trust between 1995 and 2007, I witnessed the rapidly rising incidence of service users with a dual diagnosis in our in-patient units. They have special needs and are often a highly disadvantaged population, impacted by the stigma of mental illness and that associated with drug-related problems. They frequently get a bad press in mental health services, where illicit drug use on in-patient areas has been the source of considerable concern. Drug-related deaths are too frequent and generate much sadness.

The investment that has been made into training and developing the confidence of staff working with people with a dual diagnosis has been welcome. Some good progress has been made around designing specific and appropriate services. However, there is still much more to do in terms of ensuring that this provision is able to respond in sustainable, creative and engaging ways to people with a dual diagnosis.

This book is a welcome step towards that journey. It attempts to understand the dynamics of substance misuse for service users and service providers. It brings together a good cross section of contributors with clinical, academic and policy backgrounds and many different perspectives are expressed. It captures the resourcefulness and energy of some of the great people that we have working in this field, and I hope that it will stimulate the next generation of clinicians and researchers who contribute to developing our knowledge base and skills still further.

Peter Carter OBE, PhD, MBA, MCIPD, RGN, RMN



Part 1

## **Contemporary Context**



## Chapter 1

# Definition, Recognition and Assessment

*Olive McKeown*

### Introduction

Dual diagnosis is arguably one of the most significant problems facing health services. A significant percentage of all patients in general hospitals are thought to be there because of complications related to alcohol consumption, and many people who misuse alcohol and other substances are thought to have at least one mental illness. The relevant literature supports the hypothesis that mental illness and substance misuse occur together more frequently than chance would predict (Lehman *et al.* 2000).

Substance misuse and mental health problems individually constitute a challenging area of work for health care professionals. In combination, these problems place considerable demands on health services and on individual practitioners, often stretching resources and the skills of professionals to their limits. There has been a growing awareness in the United States for some time that there is an increasing pattern of the coexistence or co-occurrence of mental health and substance misuse problems (Regier *et al.* 1990). More recently, in the United Kingdom, awareness about the seriousness of dual diagnosis has been reflected in several Department of Health papers/guidelines. At about the same time, research and publications as well as university-based theory and skills programmes have been established in some parts of the United Kingdom.

The Task Force review was produced in May 1996 by the Department of Health (1996) as part of the government's drug strategy. This was an in-depth review of the effectiveness of treatment for drug misusers in this country. In the report there is recognition of the problem of dual diagnosis, and one of its recommendations is as follows:

*Purchasers and providers should ensure that people working in both drugs and mental illness services are aware of the need to identify and respond to problems of combined psychiatric illness and drug misuse.*

A few years later, The National Service Framework (NSF) for Mental Health (Department of Health 1999), while emphasising the importance of tackling management of dual diagnosis, failed to include standards and service models to address the challenges posed by patients with dual diagnosis, including those with severe mental illness. It was in the context of this gap in policy that the *Dual Diagnosis Good Practice Guide* (Department of Health 2002) was launched. Notably, the NSF also failed to provide standards and to suggest service models for people with substance use disorders, an omission that was addressed by the complementary guidance on models of care produced by the National Treatment Agency (2002) for substance misuse. Since then, recognition and awareness of dual diagnosis in the United Kingdom appears to have grown substantially although dual diagnosis practice guidelines published in 2002 and 2006 have been regarded as being ‘toothless tigers’ because of their respective lack of directives and financial incentives or drivers for service providers. The existing gaps within practice and service delivery are compounded and perhaps caused to some extent by the dearth of curriculum coverage within basic medical and nursing training.

## Definition and terminology

Defining dual diagnosis is a challenge because of its complex and multifaceted nature. A simple definition would be that it is a combination of a mental illness and substance misuse problem co-occurring in one person. Personality disorder may also coexist with mental illness or substance misuse. The term originated from the United States in the 1980s and was adopted in the United Kingdom more recently. The nature of the relationship between the two conditions is complex and is sometimes controversial.

Some authors such as McKeown and Derricott (1996) have argued against the use of the term ‘dual diagnosis’, noting the necessity that health care workers need to pay attention to the language they use in every day practice. They express concern that with the use of the term dual diagnosis and the adoption of a wholly medical philosophy, patients may become disadvantaged, with the understanding of and the potential solutions to problems getting limited. Rostad and Checinski (1996) also debate the usefulness of the term dual diagnosis, suggesting that it is ‘labelling of the worst kind’. They argue so despite bearing in mind that the label in itself serves a very useful purpose in drawing attention to a very real problem, which is not generally well addressed in the United Kingdom.

Abou-Saleh (2004) suggests that ‘comorbidity’ might be a better term, although he does not explain his reasons for this view. The term comorbidity is being widely used internationally in the last few years and is gradually gaining popularity in the United Kingdom. In essence, the shift to using this term simply represents a direct translation from English to a Latin medically

orientated term, with very little advantage apart from the possible medicalisation or perhaps mystification of the term, which arguably is of dubious advantage. It may be that professionals interested in improving the plight of patients with dual diagnosis are replacing one label that is perceived by some as having become unhelpful or counter-productive with one associated more closely with an illness model, perhaps in an attempt to shift blame or responsibility away from individual patients and implicitly suggesting that patients are treatable, thereby endeavouring to promote more optimism about potential treatment outcomes.

## **General considerations in the recognition and assessment of dual diagnosis**

Assessment and diagnosis of patients should be driven by practitioners' intention to make practical and helpful judgements about patients' diagnosis and subsequently to liaise and communicate with each other to work towards effective collaborative management and treatment. Patients may need a variety of approaches to assessment and diagnosis at different stages of presentation and treatment. Initially, it is important to recognise that both problems exist concomitantly and practitioners should avoid coming to premature conclusions about which diagnosis is primary and which is secondary. Longer term management and treatment may necessitate systematic re-evaluation about why a patient has developed both disorders.

A common issue in diagnosing and classifying dual diagnosis patients is that generally there remains a lack of knowledge and awareness about the nature of patients' problems and what strategies and approaches are most helpful. This lack of clarity makes it difficult for practitioners to identify what exactly needs to be prioritised for assessment and subsequent treatment. Understandably, lack of knowledge and awareness on the part of practitioners has major implications for the recognition of dual diagnosis in the first instance. These circumstances further support the need for improving undergraduate training for health professionals about substance misuse and dual diagnosis.

## **How significant is the problem of dual diagnosis?**

The National Institute of Mental Health's Epidemiologic Catchment Area (ECA) study (Regier *et al.* 1990) provided important information on lifetime prevalence of substance misuse and mental health problems within the population generally. In the United Kingdom, it is thought that the number of people with a potential dual diagnosis is high and may be increasing. Community Mental Health Trusts typically report that 8–15% of their patients