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The role of social work in the field of mental health: dual diagnoses as a challenge for social workers

Vloga socialnega dela na področju duševnega zdravlja: Dvojne diagnose izziv za socialno delavce

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This paper provides a discussion about the relevance of medical terminology within the social work context. The authors use the example of dual diagnoses to argue for less stigmatised attitudes toward people who become, in the process of help, labelled as people with dual diagnoses. It sets out that using medical terminology in the field of social work is more often a strategy to exclude people from the system of help than as a moment of providing adequate help. It is concluded that social workers do not need the knowledge about diagnoses – knowing the diagnosis is important only as information that illustrates users' specific experience and perception of reality, the available resources and obstacles that people face in their everyday life. The planning of a social work intervention should be based on an operational definition of everyday life, e.g. how people live through the day, what are the important and valued roles they play in life, what are their wishes and needs.

Keywords: social work; mental health; dual diagnosis; stigma; needs; everyday life

Prispevek problematizira uporabnost medicinske terminologije v okviru socialno delavskega konteksta. Avtorici se zavzemata, da skozi procese pomoči ljudem, ki jim je bila nalepljena dvojna diagnoza, ne bi prispevali k stigmatizaciji. Uporaba medicinske terminologije na področju socialnega dela je pogosteje strategija izključevanja ljudi iz sistema pomoči kot pa trenutek oskrbovanja s primerno obliko pomoči. Avtorici zaključujeta, da socialni delavci ne potrebujejo znanja o diagnozah. Diagnoze so pomembe samo kot informacija, ki ilustria specifične izkušnje uporabnikov in njihovo zaznavanje realnosti, razpolžljivih virov in over, ki jih imajo v vsakdanjem življenju. Načrtovanje intervencij v socialnem delu mora biti utemeljeno na operacionaliziranih definicijah vsakdanjega življenja uporabnikov storitev pomoč, kot npr.: kako preživeti dan, katere so za njih pomembne in cenjene vloge v življenju, kakšne so njihove želje in potrebe.

Ključne besede: socialno delo; duševno zdravje; dvojna diagnoza; stigma; potrebe; vsakdanje življenje

The most devastating combination of diagnoses

In the past few years the term dual diagnosis has become widely used in the professional jargons of various experts, not only psychiatrists but also non-medical

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experts who work in the field of mental health. Social workers are no exception. The presentations of dual diagnoses in everyday language used in social services reflect the invasion of the world by medical explanations. Since social work requires terms that are descriptive enough to bring it closer to social work professional tasks, the term dual diagnosis is, in our opinion, insufficient. Within the social work framework, the understanding of the needs of people labelled with a dual diagnosis must necessarily reach beyond the exclusively reducing designation imposed by the notion of a diagnosis. The above term cannot be expected to reveal more than it says itself, namely that it presents an individual as having at least two diagnoses.

The problem with medicalised jargon is firstly that it gives the impression that people with a dual diagnosis only need to resolve their medical problems, while in reality they face a range of difficulties in their everyday lives and their 'illness as one or several medical problems' is part of their other related needs which can involve a series of social problems like housing, income, employment, social isolation and loneliness. The term dual diagnosis gives the impression that it is possible to look at health conditions without considering the social context. Secondly, a diagnosis permanently labels individuals and thereby prevents them from ever regaining the status they had before they developed their illness.

This article seeks to place the field of dual diagnoses within the social work context. It also intends to develop new attitudes to the everyday needs of people who, within medical and/or psychiatric systems, are recognised as people with dual diagnosis, i.e. attitudes which would be more relevant to social work, and to point out the relevance and role of social services when addressing users with complex needs.

The term dual diagnosis is most frequently used by mental health, addiction and psychiatric experts to describe the co-occurrence of a mental disorder and an addiction to either alcohol or drugs (Pritchard 2006, Golightley 2007). Most experts (Meuser *et al.* 1998, Banerjee *et al.* 2002) link the term dual diagnosis with the coexistence of drug/alcohol use and mental health problems.

People with mental health problems are recognised as patients. The status of a patient relieves them of their responsibility, at the same time as establishing the individual's dependence on health care services. Conrad (1981, p. 119) emphasised that 'medical definitions of deviations shift the responsibility for a certain type of behaviour away from the individual'. On the contrary, the prevailing standpoint in the case of addiction is that a drug user should assume responsibility for their drug use and the consequences of such use (Rabinbach 1992, O'Malley 2002). Ambivalence in the term itself thus results in an everyday situation whereby users get stuck somewhere in-between the two diagnoses (this, in fact, means in-between the different services), receiving contradictory messages. By attributing to people the fact that, as a result of their illness, they are not responsible for their acts, medicine at the same time deprives them of their power, thereby acquiring a legitimacy for external controls (medication, detention, hospitalisation) (Conrad 1981).

In the past, society tried to ensure the general health of people and in order to succeed in this it badly needed medicine, to which the task of caring for health and hygiene was delegated. To summarise Foucault, up until the end of the eighteenth century the practice of medicine turned more to 'health' than to 'normality', implying that account was taken more of the patient's lifestyle than of whether certain norms were being complied with or not (Foucault 1975). The emergence of the paradigm of public health resulted in health being manifested as a moral category, meaning that people are accountable for the quality of their health. The so-called diseases of the

modern lifestyle (weight problems, high blood pressure) are diseases pervaded with moral judgements. Mental illnesses and addictions, however, are polygons where discussions are still going on about what triggers them – illness caused by body/brain dysfunctions or a response to factors from the environment (Wakefield 1997, Hinshaw 2007).

When an individual has been labelled as having a mental illness, it is difficult for them to get rid of that label (Rosenhan 1975). The theory of labelling draws our attention to the fact that categorising people as mentally ill also establishes the ways in which people perceive themselves and limits the understanding of people as capable. Diagnoses thus become lenses through which we judge an individual and understand their actions. These labels are stigmatising since they draw attention to their deficiencies and deviations instead of their competences and strength: 'You understand stigma first hand when a general hospital emergency room doctor brusquely explains, after reading in your chart the diagnosis of "residual schizophrenia", that your fever, nausea, and vomiting are "all in your head"' (Hinshaw 2007, p. 129).

The devastating influence of a psychiatric diagnosis for the social value of an individual is reflected in the individual's loss of credibility within systems of help, whether they are medical or social systems, due to their mental illness (Foucault 1975, Lamovec 1998). People with at least one of their two diagnoses being psychiatric are perceived as dangerous, different or incomprehensible by society. Further, they are perceived as incurable; therefore, not surprisingly, they become permanent travellers through 'the system of help'. As Hawkings and Gilburt (2004) underline, as a consequences of their diverse problems these groups of social welfare and health care service users are treated by various experts (in most cases in a relatively uncoordinated manner), often becoming long-term service users (the 'swinging door' phenomenon) and having many problems in their everyday lives (ranging from poverty and social exclusion to homelessness).

Banton *et al.* (1985) believe that the medical discourse creates a gap between the personal experience of pain/suffering and the broader social context supporting that experience. This is due to the fact that attempts are made to treat the individual instead of dealing with the social circumstances underlying the distress. By reducing the network of social, moral, political and economic factors which cause distress leading to pathology in an individual, the latter becomes appropriate for treatment.

All other non-medical professions involved in the process of providing help to people who have had a psychiatric diagnosis are exposed to the situation where the diagnosis/diagnoses become one of the central points of attention. Within mental health policy, whose nature is essentially medicalised, social work with its practice is often understood as a discipline which in the mental health system serves as a complement or is subordinated to the medical system (Wakefield 1997). Thus the dual diagnosis problem reveals several levels of inconsistency of the medical model.

The specificity of dual diagnoses which includes combinations with morally coloured diagnoses (addiction, hypertension) is that it is preoccupied with the question of what comes first, the sin (socially unwanted behaviour) or illness which is the cause/reason of the sin. Searching for an answer to the question: 'Was it first the addiction and then the mental illness or vice versa?' might lead professionals up a dead-end street where they become engaged in the question of which service is more appropriate for a user of that type, and/or whether someone meets all the criteria to

be eligible for the service, instead of allowing them to provide for the user's needs. If the services work according to moral judgements, considering the individuals guilty of causing their own illness, the experts in these services might not feel bound to help. Unfortunately, such endeavours give rise to a process in which the users are pushed out to the margins, finding themselves somewhere in-between the services designed for help where 'clear pictures' are involved, i.e. designed for those who can turn out to be suitable users/'clear cases'. In the case when a person does not meet the conditions they have to fulfil, none of the services assumes responsibility for helping them.

In certain cases it can also happen that some services refuse to admit people with a dual diagnosis due to the latter being too demanding for them, for instance a service engaged in the mental health field does not admit people who are addicted to drugs or alcohol (Hawkings and Gilburt 2004, pp. 23–24). Therefore, the question is why are social welfare and health care programmes 'often inadequate and unable to address all the problems characteristic of this group of users who are given dual diagnoses' (EMCDDA 2004)? Is it because the 'group is so difficult' or perhaps the professional response is inadequate?

Methodological approach

The aim of the research was to identify attitudes of social work practitioners toward people with dual diagnoses, the characteristics of typical working situations and to identify gaps and needs in the social care system regarding the specific situation of people who live with dual diagnoses.

The research was qualitative and oriented to descriptions of situations. The result of the research is a small, 'grounded' theory which is 'modest, it is not a big theoretical system; it is growing from the empirical basis and is grounded in the course of its formation and bound to the context' (Mesec 1998).

Instruments and variables

For the purpose of the research, an open questionnaire was developed which was used to collect statements by the respondents in the focus groups. The following variables were included in the questionnaire: the dual diagnosis definition, characteristics of dual diagnosis working situations, attitudes to people with a dual diagnosis. Respondents were asked to describe who, in their opinion, is a typical service user, which particular needs do they recognise for this group of service users, and the extent of their competencies to respond to the service users' needs.

Sample

Respondents were selected by non-probabilistic sampling method; we used availability sampling. This kind of sample allows a more intensive portrait of activities and actors but it also limits researchers' ability to generalise and lowers the confidence in the data. In our case this sample gave us a possibility for an intensive investigation of a small population and it was used for the purpose of exploratory study.

The sample design involved the collection of data from key professionals from various institutions who work in the field of social work and mental health in Slovenia, 43 respondents (28 female and 15 male professionals) who joined the

project 'Living with a Dual Diagnosis' on 16 October 2006 at the Faculty of Social Work. The majority of the respondents (27 people) came from non-governmental organisations; 14 respondents were from governmental offices – centres for social work – and there were two participants who work in user organisations.

The respondents were arranged into focus groups where they discussed the research questions. The size of a focus group was from five to six members who had one and a half hours for the discussions. Notes of each discussion were taken by group moderators, who were members of a research team. After the group discussion there was also a panel discussion (one hour) and we include some further comments regarding data collection.

Within qualitative analysis all relevant responses were ranged and classified under basic themes, coded and put into common categories and an indexation value of the statements enabling the identification of key concepts was considered in the data (Mesec 1998).

Results: the perception of the dual diagnosis phenomenon by experts working in social welfare in Slovenia

The majority of participants in the focus groups did not problematise the use of the term dual diagnosis so they were asked to explain who they considered to be people with a dual diagnosis. In the description of users' characteristics which were considered typical of people with dual diagnoses, mainly problems related to the combination of psychological disturbance and problems with drugs and alcohol were mentioned, while some also ascribed behavioural disturbances, learning difficulties and combinations with other health problems (such as deafness, blindness, diabetes), to this group. Most frequently a combination of mental illness and addiction was stated as an example of a dual diagnosis.

A typical description of someone with a dual diagnosis was as follows:

> He is a young man, thin, pale, uncared-for, they use heroin and combine it with alcohol. Usually on medications, often hospitalised, quitting treatment on their own repeatedly, frequently on the street, regular contact with doctors, refuses the arrangement of social matters, insurance.

As is evident, the stereotypical image of a user with a dual diagnosis as viewed by experts is a young person, mostly a man who, apart from psychiatric problems, also has problems due to alcohol or drug use, behaviour and several other problems like homelessness, unemployment, a poor social network. Such descriptions also tell us that the problems of these people are diverse and encountered at various levels: addiction, eating disorders, disability due to homelessness, unemployment, personal conflicts etc., and manifested by varying intensities ranging from necessities to wishes. Experts are usually puzzled by this combination of problems in cases where the institution providing assistance has declared itself as working exclusively either with mental health or with addictions.

What underlies this term is:

> this is the most complicated target group

and

> we cannot guarantee a positive outcome.

However, a group of experts is trying to avoid using this term, applying the following designations instead:

> people with combined needs, more demanding users, people with complex problems, people requiring interinstitutional treatment, people requiring an interdisciplinary approach, etc.

These descriptions, despite being different categorically (ranging from those focusing on the user to those directed at the work procedures involved), are similar in that they expose superlatives: extent, complexity, demanding nature, diversity. They use them to distinguish these users from all other, ordinary users of their services. During the focus group discussion a statement which was typically different from the general opinion was expressed by members of a user organisation who pointed out that it is difficult to give definitions of oneself and name oneself as a type of user. They considered the concept of 'experienced people' which comes from English-speaking countries to be the most attractive. More than seeing their mission in declaring themselves for work with a certain group of people, they preferred to identify themselves with the mission of their organisation, which is to look for answers to questions which at a certain moment are topical and crucial for their members or other interested people.

Similarly, the statements of representatives of an organisation working with the homeless differed from the prevailing standpoints. This group of experts fore-grounded their awareness that many of their users have had psychiatric treatment, and that besides being addicted to alcohol and drugs some others also suffer from other different health problems; for these they try to help them by referring them to an outpatient clinic for homeless people where they can receive basic medical help. They usually do not see their users as people with dual or several diagnoses and do not consider an orientation towards knowledge about diseases as being essential for their work. Thus, they try to help users alleviate their existential distress (with food, clothing) and to manage their everyday lives – they help them survive the day and improve the quality of their life.

> We do not consider the users to be patients and it is therefore difficult for us to think about diagnoses. However, their problems or needs can be very complex.

A common characteristic of most views was that dual diagnoses are difficult cases:

> A tough case, hard to work with, . . . a bigger team is needed, . . . he is a demanding person, we will be unable to cope with the present personnel, . . . they are disturbing for others who only have a mental disorder . . . These people have behavioural disorders . . .

According to the experts' opinion the difficulty of the cases is reflected through several aspects. On the one hand, it is determined by the complexity of difficulties faced when working with this group of users. They listed combinations of these users' problems:

> I work with a man, aged 30. He started to abuse drugs in secondary school. Later in his life there was a mental illness – including forced hospitalisation. He's been unemployed for a long time, he lives only from a social allowance, has no friends, his family wants no contact with him . . . A series of hospitalisations, unemployment, social isolation . . . Unresolved family relations in the background. We are working with his relatives and providing personal consultancy.

A typical example is as follows:

> It was more than helping arrange him financial assistance at the centre for social work. He had a number of troubles: health problems due to his old age; he did not take much care of his diet or hygiene. He had some cases in a law court; he was in constant conflict with his surroundings. His neighbours frequently reported to various addresses that he was disturbing his surroundings. He had a bunch of cats which were undernourished and at one time the neighbours called in the sanitary inspector, and he issued a fine. Everyone agreed it would be best to place him somewhere. Our outreach worker visited him about once a week to bring him food to have during the week. Sometimes he opened the door and sometimes he did not. I think he was quite unsure whether to trust us or not. All our association can offer is visits to a day-care centre, outreach and information about users' rights regarding social assistance; we do not provide other services. We also cannot send anybody anywhere, we can only make proposals.

The above example shows how professionals experience multiple accountabilities: to the law and regulations, to their work colleagues and their employers, to professional ethics and standards, and last but not least to service users and the other people involved like relatives or neighbours. The work process therefore continuously involves seeking a balance between different constraints and interests. Sometimes situations seem to exceed the expert workers' competencies and show that social workers operate in conditions of great uncertainty.

Users' participation and their attitude to the help offered by professionals is seen as a criterion of how demanding and difficult the work is. Users classified as tough cases are noted as being either apathetic, not showing any interest in changing their life or expecting experts to offer them a magic solution. Despite being familiar with the users' specific situations and needs, professionals feel helpless and incompetent when working with them. They feel they have done much for the users who refuse to accept their help:

> We are getting nowhere, no matter what we suggest. We helped arrange monetary social allowance for him, he was offered inclusion in our day-care centre programmes, but he refused. I miss in him some motivation; he is not taking responsibility for his actions.

The above statement also shows that experts often plan their work on the basis of the programmes available or known to them rather than on the basis of the users' needs. The main problem for the experts who encounter individuals with such diverse troubles in this way is that they actually do not know how to work with them or where to refer them. Between the lines a strong paternalistic attitude to people with a dual diagnosis can be felt. They see the solution in designing specialised programmes, involving teams of experts, which are supposed to be interdisciplinary, highly specialised and, as much as possible, provide a 'recipe' for problematic cases. The majority of professionals do not consider themselves to be successful in their work. They often perceive users as people who

> Oppose . . . refuse to accept the assistance offered,

failing to adhere to the instructions/scenarios drawn up for them by the services. In some cases, the blame for such a failure is ascribed to the users,

> being as he is, he cannot control his own life,

while sometimes the reasons are found in

the poor network of services, unsatisfactory co-operation between experts, insufficient protocols for co-operation between various services, inadequate own knowledge ...

The other level of discontent with professional intervention noticed in the research is connected with the service users' behaviour. They often relate problems in their work to the aggressive or insulting behaviour of some users towards the professionals:

> Three years ago I worked with someone who seemed very humble at our first meeting and I thought, ok, this will be nothing special, he had a chance to obtain financial assistance, we registered him at the Employment Office, and then he came back after a few days and he was a different person. He came in, started to yell at me that I have no idea, he pounded on the table, he leaned very close to me as if he was going to hit me, and I really got frightened then. I sat down and said, yes, I have no idea, he was not quite sure if I meant business, I nodded my head and said once again that he was right, we have no idea, and then he stood up and said he did not have time to fuck around there, and left. He did not come back, I do not know what I would do if he showed up again.

Obviously, there is a fear of such users. Above all, the mystification and minimalisation of violence, to which some organisations at the leadership level turn a blind eye, are not considered at the expert team meetings but they leave coping with violence up to individual professionals to deal with as best they can. Thus experts prefer to declare themselves to be against working with people they know behave violently and 'dismiss' them, pushing them on to other professionals. Once labelled as problematic they start to travel around the system:

> A social worker at the centre told me that, when she visited him in prison, there was always a guard present, she said, beware of him.

So in some organisations a certain type of user is defined as unwanted mainly due to their constant making of trouble (disturbing the peace in an otherwise manageable atmosphere created by regular, docile users):

> We did not want to have people who used drugs in our day centre because it occurred that they were dealing with our people to get medical drugs. This occurred when we were still located in the centre of the city and now when we are on the periphery nobody wants to come here. Probably our users still sell to junkies, they have some deals between them, but it no longer happens here.

In order to avoid situations in which conflicts with users could occur, professionals in services establish a dividing line between users on one side who can come and on the other those

> with whom we do not work.

The entry conditions are already established at the level of the institution's mission (we work with people with mental health problems, only people who do not have addiction problems can be accepted in residential units ...), house rules (such as the prohibition of entry to the alcoholised, exclusion from the programme of the violent) and bureaucratic criteria (we only accept people with health insurance, permanent residence in our municipality ...). The classification of users in special categories was also noted as occurring due to professionals' diverse reasons, as we could see, either to be able to cope with their work (have results, show success) or to be able to work in peace.

> When J. gets drunk, he is very loud. He becomes upsetting for other users. The head of our day-care centre does not allow J. to come to the centre when he is drunk. Usually, this happens for about four days after he collects his pension. On other days he is quite ok. Other workers are worried how he is doing when he is not allowed to enter, if he eats anything on those few days. Sometimes our cook gives him something small to take with him, but then he has to leave the centre because we have trouble if the head hears that we let him in.

This kind of strategy, however, can turn out to be a double-edged sword since rules (law, regulations, bureaucratic rules and procedures) which confer powers on practitioners may at the same time restrict their professional autonomy.

The procedure of such a classification is twofold: it goes on at the level of the already mentioned procedural categories as well as at the level of moral categories. Classifications (schizophrenic, has behavioural disturbances, is hyperactive, anti-social) which users were given when treated by other professionals are linked to the assumption that their problems were their fault and caused by what they are 'as a person': good/bad, reliable/irresponsible ... It seems that both classification procedures (categorical and moral) are used with the same intention, namely that professionals in existing associations check whether those looking for help belong to their type of services (within their jurisdiction) or 'deserve' to be helped by them (his misery is not his fault). These are, as Thompson (2001) would say, common traps of assumptions about service users – professionals are treating unique individuals as if they simply fall into social categories without considering their unique lived experience in the context of what we know about these broad categories.

Another problem faced by experts is their feeling of incompetence in resolving such cases,

> as our medical and/or therapeutic knowledge is inadequate, we do not provide programmes for mental illnesses.

What is involved here is an imaginary obstacle or a pretext since the services engaged in the social welfare sphere are not authorised to provide medical treatment, but they could, however, include medical professionals in their teams. The idea of multi-disciplinary teams has, in any case, a long history, more often presenting a pretext for inactivity than reflecting any true commitment. The main obstacles to designing the assistance services reflect the fact that those plans and ideas never involve the role of the users (they are envisaged neither as team members nor as informants). This is in a way logical since the users are, as we have seen,

> patients unable to control their lives, they do not want to settle their social affairs, are antisocial, lack responsibility, are depressed ...

This is also the reason for the situation whereby users, as active participants, are not seen, not heard and not taken into account.

Discussion

In order to understand the nature of social work's tasks concerning dual diagnoses, a thorough investigation of the role of social work within the mental health care system has to be carried out and the relationship between the health care and social welfare systems reflected upon. It is evident from the conclusions of the mentioned research

project that the poor prospects of resolving the dual diagnosis problem are not to be attributed to any specific characteristics of this group of users since they are mainly related to inconsistent expert interventions and social obstacles. Professional social work's principal limitation is professionals' uncritical use of the concept of dual diagnosis as a criterion for an entrance ticket to a programme. Thus an exclusion criterion which is medical is applied by social services. It is psychiatric diagnoses – which although relevant are not of key importance for the work of social services – that appear in combinations with other diagnoses or disturbances which are fatal for the users of services.

Social work experts should stop their 'invisible' role in the field of mental health. They do not need to pretend to have an answer. There is no need in a social work assessment to limit attention to pathology. Quite the opposite, the planning of a social work intervention should be based on an operational definition of everyday life, that is, how a person lives through the day, what is their financial situation, how strong and comprehensive are their personal contacts with other people, what are their housing conditions and job situation, what are the important and valued roles they play in life, what are their wishes, needs and, for them, other important private issues. Diagnoses are important for social work only as far as questions about how the person lives with the diagnosis/es, how the diagnosis/es changes their world, or how the medication influences their everyday life. Therefore, social workers have to thoroughly examine the roles they play as experts. In so doing, we have to take into account the unambiguous proof of the harmful nature of both institutional and superficial work which is solely based on the assumption of a dual diagnosis.

The study showed that services engaged in the social welfare field are only one of the groups of services which people with mental health problems turn to. Which service a user will first turn to is often a matter of pure coincidence rather than a serious possibility of choice. Thus, the first contact depends on the network of services in a certain environment, on the visibility of those services as regards the users, on the prestige ascribed to them, on the service policies as regards target groups, on their orientation to a low or high threshold for user admission, on the working hours, or on accessibility as regards public transport.

It is evident from the research results how individual situations are intertwined and complex, and how important it is to plan work with service users with a sensibility to enable the individual to retain their competencies and strength in the field where the person is capable, and to prevent the individual's existing capital from being destroyed. As a person with a dual diagnosis, people can only move in one direction. As a consequence, such a psychiatric diagnosis can be fatal as you are 'never completely sane'. By means of a psychiatric diagnosis, a person is deprived of their freedom and is assigned a certain destiny. Based on the research, it can be established that procedures of categorisation/classification lead to useless simplifications of the representations of users' everyday life. It was also seen that experts' accounts frequently express narrative modes which 'generalise, summarise' the complexity of situations into single-meaning claims and make them become static as well as lacking in transparency. The effect of such categorical concepts is that their principal value lies in their exchange value for interpersonal communication between experts and the public (Moskovici 1992).

Social workers working in the dual diagnosis field constantly face conflict situations, with an intervention at one level of the person's life achieving positive

results while simultaneously causing damage at other levels of their everyday life (e.g. long-term hospitalisation allowing an individual to take a break from serious distress and alleviating the unbearable symptoms of their illness, but at the same time making the person lose something at the level of their social contacts, employment, career, freedom). It is these risks related to helping interventions that social work should foresee. Szasz claimed that for most people life is a continuous struggle, not for biological survival but for 'a place in the sun' (Szasz 1960). Following this survival philosophy we could say that an intervention plan should include these everyday steps and pursue not only goals which are achievable but also those which are meaningful for the people social workers work with.

The other conclusion which can be drawn is that in crossing social work with medicine (as in the case of dual diagnoses) the process of 'created dependency' can be noted. Welfare institutions have tended to treat people with mental health problems as dependent, and 'this constructed dependency is considered by doctors and social workers as a justification for ever-increasing intervention' (Conrad 1992, Phillips 2000). But at the same time,

> the assumed tenets on which policies creating a dependency culture are founded have undergone radical challenge: working opportunities over the life course have been less predictable, the traditional 'family' is replaced by new formations and structures, welfare provisions of the welfare state have been replaced to a considerable extent by insecurities of the market place, where those with financial resources have greater access to welfare provisions while others are subject to increased isolation and insecurity. (Phillips 2000, pp. 135–136)

These conditions trap professionals in a feeling of great uncertainty and disappointment.

It is essential that the practice of social work regarding dual diagnoses recognises that the users of their services have 'survived treatment systems' (treatment survivors) and mortification processes (Flaker 1998), which means that in most cases they have undergone processes of devaluation, humiliation and exclusion. Thus the way out of the system is linked to recognition of one's own resources and strengths, whereby people who have been 'taught to be powerless' need support. This involves practising to facilitate integration rather than the exclusionary control that serves to perpetuate social division (Davis and Garrett 2004, p. 32).

One of the most notable differences between social work and medicine, between social work and law, and between social work and pedagogy, is the fact that in social work intervention must be left 'open' for negotiations with users – in social work we do not search for the reasons for the actual situation, but rather for ways leading out of that situation. It is in the case of dual diagnoses that this conceptual difference between the disciplines is best observed. Given such a philosophy of social work it is understandable that other, more 'static' disciplines find it difficult to be 'embedded' in the logic of social work. Co-operation with social work is thus preferably seen by them as a specific field ('this is your user, we will not interfere'). Similarly to the difference between the medical and social discourses in the field of mental health, we found that there is a difference between the expert discourse and the service user discourse. By using medical language the problems encountered by people in everyday life are reduced to exclusively physical ones (e.g. the consequences of the irregular functioning of their organs).

Concluding thoughts

We can conclude that social workers have to consider responses to service users' needs in a way which will not harm people further. Experts engaged in social work should avoid using procedural classifications and diagnoses as moral categories. Social work response should not aggravate the distress or place a diagnosis/problem in the forefront as the only point at which an agreement/meeting between the expert and the (service) user is possible. To be able to work, social workers need to understand the everyday lives of people with different situations of distress and to use instruments that will allow them to gain knowledge/information about people's lives. The special knowledge *about* diagnoses is for social workers just one piece of information which is needed to be placed in the wider social context of life. Social workers have to pay attention to how people live with diagnosis/diagnoses, how the medication they use influences their everyday lives, whether they have information relating to social welfare and their health care rights, how they manage to survive, what are their needs and wishes.

Social work experts should start using words which will support the process of normalisation and de-stigmatisation of people with combined needs. It should be oriented toward describing situations which are problematic for service users and not toward classifying the problem. Descriptions of such situations should be translated into needs which are useful for the orientation and planning of social work interventions (implying that we should check whether the user's problem and their desire for help have been understood correctly). It has to be emphasised that the crucial planner in designing such a support network is the user. They should be supported by social workers in providing information about their rights, in properly describing the procedures used, in redesigning possible scenarios, and in explaining professional roles which should not become paternalistic but must be participatory and defending.

In pragmatic terms, social work professionals have to believe in the users and their power of survival. The key instrument for such work is the dialogue created by posing relevant questions, facilitating the obtaining of specific information such as: how do the users live, how do they feel, what would they like to change in their life, what are the main obstacles for them, where do they need help and how do they want to receive it, who do they see as being involved in the network of assistance, who do they want to co-operate with – together with the process of investigating and interpreting everyday situations. The information obtained must be used in a manner enabling the person to find sources of help available in their environment which they require. If these sources are not in place, the mission of social work is to find them together with the user – to co-create them. Only in this way will users be able to get involved in both planning and providing services and will our work be directed towards what an individual really needs.

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