

# Dual diagnosis: Fact or fiction for the practising clinician?

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*What's in a name? That which we call a rose by any other name would smell as sweet. (Romeo and Juliet; Act II, Scene II)*

The concept of dual diagnosis is not new to psychiatry and has already been the subject of a recent editorial in the Journal.<sup>1</sup> In the present context the term 'dual diagnosis' or 'co-morbidity' refers specifically to co-existence of psychiatric disorders and substance use disorders in the same individual. Increasingly reported in the North American literature, the subject has attracted much less attention on this side of the Atlantic. el-Guebalý<sup>2</sup> suggests the term should include two overlapping but discernible groups of patients. One subgroup has, by DSM-III criteria, both a major substance disorder and a major psychiatric illness. The other subgroup use substances in ways that affect the course and treatment of mental illness. Lehman *et al*<sup>3</sup> describe the following clinical classification: (a) primary mental illness with substance misuse – here the symptoms, sequelae or treatment of the mental illness lead to drug use; (b) Substance misuse with psychiatric sequelae – included here are the acute psychiatric syndromes associated with drug intoxication or withdrawal (eg. psychosis induced by psychostimulants or depression on withdrawal from cocaine); (c) Dual primary diagnosis – where the patient suffers from two initially unrelated disorders that may interact to exacerbate each other and (d) Common aetiology group – where common underlying factors may predispose to both conditions (eg. homelessness as a risk factor for both depression and substance misuse). On the other hand, Rostad and Checinski claim that the term dual diagnosis is misleading and unhelpful.<sup>4</sup> Nevertheless the same authors do concede that, for the moment, the 'label' is useful in so far as it draws attention to "a real problem which is not being addressed".

## Common things occur commonly

Despite certain methodological difficulties, as highlighted by a number of authors,<sup>5,8</sup> there is strong research evidence that the rate of substance misuse is substantially higher among the mentally ill compared with the general population. Similarly there is evidence that among populations of patients with primary substance use disorders, psychiatric conditions are common. Khalsa *et al*<sup>6</sup> found a co-morbidity rate (DSM-III-R criteria for current substance abuse and mental disorder) of 39% among attendees at a psychiatric assessment unit. As patients with co-morbid conditions may be more likely to seek treatment, data from clinical samples may represent an over

estimation.<sup>8</sup> The Epidemiological Catchment Area (ECA) study,<sup>10</sup> a large American population survey, found a life time 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.

In the United Kingdom a study of 171 inner city London patients in contact with psychiatric services<sup>11</sup> found the one year prevalence rate among subjects with psychotic illness for any substance misuse problem was 36.6% (31.6% alcohol, 15.8% drug). The Office of Population Censuses and Surveys in 1994 estimated the prevalence of alcohol and drug dependence among the general population in the UK to be 4.7% and 2.2% respectively.<sup>12</sup>

## Why the mentally ill misuse drugs

Patients with psychiatric illness may use drugs (or choose certain drugs) for the same reasons as the rest of the population do (eg. to get high, to relax, because of increased availability or acceptability etc.). While this contention may be true, it fails however to explain the observed increased prevalence of use compared to the general population. A number of possible explanations can therefore be advanced. The mentally ill may experience downward drift to deprived poor inner city areas where drug availability is increased. Drug use may decrease social isolation by enhancing involvement in a sub-culture or as Mueser<sup>13</sup> frames it "substance misuse...may meet the patients' socio-affiliative need for acceptance and interpersonal contact".

With the advent of deinstitutionalisation, more of the mentally ill (and vulnerable?) may be finding themselves exposed to an increased availability of drugs in the community. Conversely an increased availability of illicit drugs in psychiatric institutions may be a contributory factor.<sup>14</sup>

The self-medication theory of Khantzian,<sup>15</sup> which suggests that substance use decreases distress caused by psychiatric symptoms, still retains credence. For example; opiates, cannabis or alcohol may reduce the agitation and anxiety associated with mental illness while stimulants may be used as self-medication for negative symptoms or depression. Psychostimulants may also help counteract extrapyramidal side-effects of antipsychotic medication.<sup>7</sup> Finally, a common genetic susceptibility predisposing to both conditions, for example via genes regulating dopamine or serotonin function, may even exist.<sup>16</sup>

## Clinical implications of dual diagnosis

For patients with a dual diagnosis, each of the co-morbid disorders can have important implications for the

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course and prognosis of the other disorder. Substance misuse can precipitate psychotic illness in those biologically pre-disposed and is associated with an earlier age onset of illness.<sup>2,13,17</sup> It may modify the clinical presentation of mental illness,<sup>18</sup> exacerbate existing psychotic symptoms<sup>19</sup> and interfere with treatment compliance.<sup>16,20</sup> Substance misuse has been associated with an increased rate of relapse in the chronically mentally ill<sup>21</sup> even in the presence of continued compliance with antipsychotic medication.<sup>22</sup> Mentally ill substance misusers (compared to non-substance misusers) have higher readmission rates and increased use of inpatient services.<sup>11,22</sup> Similarly in the case of drug dependence, concurrent psychiatric conditions, for example depression, have been associated with greater illicit drug use while in treatment and a poorer prognosis.<sup>23</sup>

### **Intoxication masquerading as mental illness?**

In assessing patients with psychiatric symptoms and substance misuse accurate assessment is essential in planning effective treatment. However this can be difficult because of the psychomimetic effects of substance misuse. Substance misuse, both in intoxication and withdrawal, can give rise to a wide range of psychiatric syndromes and transient psychotic states.<sup>21</sup> For example; in a patient with psychotic symptoms and substance misuse, the psychotic symptoms may occur as a direct effect of the substance(s) use, may be related to an independent functional illness or may be related to a combination of both.<sup>24</sup>

Clinicians who attempt to diagnose mental illness without assessing for substance misuse run a grave risk of misdiagnosis and consequently, mistreatment.<sup>13</sup> Indeed it has been claimed that schizophrenia may be over diagnosed in patients for whom the correct diagnosis was psychosis resulting from substance misuse.<sup>25</sup> Equally well there is a risk of missing a diagnosis of mental disorder by too readily attributing symptoms solely to drug misuse.

The timing of diagnosis is important, as many drugs can produce transient short lived syndromes which will settle within days to weeks. Clinicians must establish abstinence criteria, ie. a period of time that the patient must be drug free before a psychiatric disorder, other than a substance disorder can be diagnosed.<sup>6,25</sup> The point is underscored in a recent paper concerning the diagnosis of depression in alcoholics undergoing detoxification.<sup>26</sup> Cohen<sup>25</sup> asserts that the only way to be sure that psychoactive substances cause illness is if the patient recovers when the he stops using them. If the symptoms return when the substance use is resumed the diagnosis is confirmed. Meuser *et al*<sup>13</sup> maintain that if substance misuse has occurred in the past but there is clear evidence of schizophrenic symptomology in the absence of recent misuse (eg. within the last month) a diagnosis of schizophrenia can be reliably made.

In practice the picture is often less clear cut and a period of inpatient assessment may be necessary to clarify the diagnosis and tease out the relevant contributions of mental disorder and substance misuse to the clinical presentation. Assessment will be greatly helped by accessing a wide range of information sources including old clinical notes, general practitioners and relatives. Urine toxicology is essential but samples for analysis need to be taken as soon as possible as certain substances may be undetectable 24-48 hours after ingestion.

### **Whose patient anyway?**

This question must surely strike a chord with many a

general psychiatrist or addiction specialist who has been faced with the challenge of managing patients with dual diagnosis. At best the patient receives either sequential treatment or concurrent parallel treatment by two separate services, both approaches which may be less than perfect.<sup>27</sup> At worst the co-morbid disorders may be ignored.<sup>28</sup>

In a proposal to improve treatment for these patients, Hall and Farrell<sup>28</sup> highlight the need to facilitate staff in both treatment settings to recognise and manage common co-morbid conditions. This they suggest might modestly be achieved by increased awareness, use of screening techniques and by the sharing of skills and support between addiction and mental health services. An ideal or standard approach for the management of dual diagnosis is not yet established and there are limited numbers of studies on treatment outcome.<sup>29</sup> Nevertheless Drake *et al*<sup>27</sup> in a review of the available literature have identified nine emerging treatment principles of dual diagnosis treatment. These structural elements, which the authors claim underlie successful programmes include: assertiveness (including outreach in the community); close monitoring; integration (programmes in which the same clinicians provide mental health and substance abuse treatments in the same setting); comprehensiveness; stable living environment; flexibility and specialisation; stages of treatment (engagement, persuasion, active treatment and relapse prevention); longitudinal perspective and optimism! Models of integrated inpatient treatment programmes have been described.<sup>30</sup> However it seems that with case management and assertive outreach dual diagnosis patients can be successfully engaged by community based services and at a relatively low cost.<sup>31</sup> It is even claimed that the expense involved in initiating such a programme need be little more than educating and supporting clinical staff while they develop the necessary skills for treating this group of patients.

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