

Recent research from the USA indicates that lifetime prevalence rates for those with both substance misuse problems and mental illness are much higher than had been previously thought. There is little research data on dual diagnosis in the UK to complement American studies, but anecdotal evidence suggests that casualty departments, acute psychiatric wards and drug agencies are seeing increasing numbers of clients trying to cope with both problems. Clients can find themselves being seen just by psychiatric services or drug agencies with no bridge for them between the two services.

This Factsheet is simply a basic introduction to some of the issues. It is likely that future issues of *Druglink* will consider different aspects of dual diagnosis in more depth.

What is dual diagnosis?

This refers to co-existing diagnoses of mental illness and substance use. This may be a primary diagnosis of major mental illness with a subsequent diagnosis of substance use which affects mental health adversely such as cannabis use on top of schizophrenia. Conversely, there may be primary diagnosis of drug dependence which leads to mental illness such as is found with chronic use of stimulants like amphetamine or cocaine. In the US it is also acknowledged that there can be two diagnoses co-existing independently or due to the same cause.

The problem of diagnosis

Because in many cases the signs and symptoms of mental illness can be mimicked by the intoxicated or withdrawing state of substance use, the major diagnostic issue is making an accurate diagnosis of the primary problem. The consensus seems to be that a period of three to six weeks of abstinence is needed for a fully accurate diagnosis to be made. Equally important is that a careful and full history of signs and symptoms from the client and significant others will make a crucial difference in sorting out

The following references were used for this sheet. All are available at ISDD together with other references on the subject of dual diagnosis.

For further details contact the Information Officer at ISDD on 0171 928 1211.

Bergman & Harris. "Substance misuse among young adult chronic patients". *Psychosocial Rehab Journal*: 1995, 9(1).

Cohen. "Over diagnosis of schizophrenia: role of alcohol and drug misuse". *Lancet*: 1995, 346, p.1541-42.

Drake et al. "Treatment of substance abuse in severely mentally ill patients". *Journal of Nervous and Mental Disease*: 1993, 181(10) p.606-611.

Galanter et al. "A treatment system for combined psychiatric and addictive illness". *Addiction*: 1994, 89(10) p.1227-1235.

Smith & Hucker. "Schizophrenia and substance abuse." *British Journal of Psychiatry*: 1994, 165, p.13-21.

Solomon et al. "Dual diagnosis: evaluation, treatment, training and program development." New York: Plenum 1993.

what might otherwise be a confused diagnosis. The key issue of correct diagnosis was highlighted in a recent *Lancet* article which claimed that too many people were being rapidly diagnosed as schizophrenic without consideration of the role of drugs and alcohol in the presenting symptoms.

What are the special needs of the client?

1. *Close monitoring* to prevent clients 'slipping through the net'. Maintain intense supervision through frequent contacts between all professionals, carers and agencies.
2. *Assertive outreach* to engage clients in treatment. Offer domiciliary visits or reimbursement of travel costs, practical help and advice on other matters and be flexible in response to their needs.
3. *Education and skills training* to maximise daily functioning ability. Offer various skills such as relapse prevention, anxiety management, symptom recognition and medical management, assertiveness and social skills training.
4. *Access to services* to enable clients to find other areas of support. Liaise with other agencies such as housing, social, therapeutic and legal organisations to facilitate understanding of client needs within these services.
5. *Structured programmes* to decrease the chaos in clients' lives. Structured low key programmes such as low threshold methadone maintenance programmes are of more benefit in reducing chaos than intense therapeutic sessions.
6. *Responsiveness and flexibility* to engage and retain in treatment. Be prepared to work with clients in chaos, be flexible with treatment plans and be responsive to their need in times of crisis.

How can drug and alcohol workers best address the problem?

1. *Raise awareness of the problem locally*. Conduct baseline measures of the extent of dual diagnosis clients and raise it as an issue with managers.
2. *Use the available research* and articles to build up specialist knowledge and increase your understanding of the issues of dual diagnosis.
3. *Adopt an optimistic long-term perspective* as dually diagnosed clients are more likely to relapse in either element of their condition than those with a single diagnosis.
4. *Accept that while abstinence is the ultimate goal it should not be a precondition of treatment*.
5. *Offer training to multi-disciplinary teams* on all aspects of substance misuse treatment including relapse prevention techniques, brief intervention therapy, 12 step philosophy, updated drug and alcohol information, motivational interviewing techniques and so on, to increase knowledge, skills and confidence.
6. *Offer training to clients* in such things as medication management, symptom recognition and control, relapse prevention etc.