Integrated Treatment For Dual Diagnosis: The Journey So Far

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Abstract

Introduction: Integrated treatment model for dual diagnosis patients is a relatively newer approach in the field of addiction psychiatry. It has converged the treatment of substance use and mental illness from its originally dichotomous approach. While no single treatment exists for dual diagnosis, much variation exists within the integrated treatment model.

Objectives: The study provides a narrative overview of the integrated treatment of dual diagnosis disorders.

Conclusions: The current evidence for integrated treatment model is encouraging. However innovative treatment strategies and a change in the socio-cultural environment is the need of the hour.

Keywords: Dual Diagnosis, Integrated Treatment

Introduction

Dual diagnosis is a concept that has come into existence post the era of deinstitutionalization. Up until the early 20th century, most patients with severe mental illness were admitted in long-stay hospitals or asylums with little to none exposure to the wide variety of substances present in the community. With the shift of management of mental disorders from institution based to community based, a large number of patients with severe mental illness in varying stages of remission found themselves living in the community. Exposure and access to substances thus led to a subset of mentally ill patients having both psychiatric disorders and substance use disorders. These patients received labels like dual diagnosis, mentally ill chemical abusers or substance-abusing mentally ill persons to emphasize the concept of two co-occurring disorders [1]. Over the years, the terminology- dual diagnosis has continued to stick on and has become a synonym for mentally ill patients with co-morbid substance use disorders.

Dual diagnosis does not necessarily mean that the psychiatric disorder present should be a severe mental illness. It can also include common conditions like anxiety disorders or depression, and the substance use can be present continuously or during
periods of exacerbation of the psychiatric disorder. Thus irrespective of the duration or severity, an occurrence of these two conditions in varying permutations and combinations warrants a diagnosis of dual diagnosis and a mode of treatment specific to them. It would also be pertinent to note that comorbidity between substance use and severe mental illness is high [2] and therefore a significant number of patients would get diagnosed with dual diagnosis disorders.

For decades, these patients were unable to receive treatment that managed comprehensively their dual diagnosis. A dichotomous approach to treatment was present wherein either the psychiatric disorder or the substance use disorder was treated. This led to shunning of patients from both mental health care and substance use treatment centers. Even if they received treatment, it was incomplete in dealing with either their psychiatric conditions or with substance use. The incomplete management led to frequent relapses and re-hospitalization [3] and patients with dual diagnosis would often get labeled as difficult to treat. The therapeutic nihilism gets compounded by the fact that no single all inclusive treatment exists for dual diagnosis. The relationship between substance use and psychiatric disorders is dynamic and complex. It therefore requires a more time and labor-intensive approach towards management.

The barriers in treating patients with dual diagnosis lie on a continuum ranging from patient and illness related factors to clinician related factors. The poor motivation of psychiatrically ill patients for abstinence from substance use, the frequent relapses of either mental illness or/substance abuse leads these patients to have a poor prognosis along with a range of allied problems like poor social support, homelessness, unstable employment and frequent incarcerations. On the other end, the lack of awareness of in clinician and the dichotomy in treatment providers has resulted in many substance abusers to get inadequate treatment for the mental illness and vice versa. The traditional treatment approaches for dual diagnosis followed the sequential or the parallel model. The sequential model involved treatment of one condition followed by the other condition. This model was inherently flawed, as patients with concurrent substance use would rarely reach remission and recovery before substance use treatment could be initiated. On the other hand, treatment aimed only at abstinence without adequate control of psychiatric symptoms was seldom successful. The parallel approach was the first step towards integration of treatment. However it involved concurrent treatment of both condition by different clinicians. Though the parallel approach allowed a more inclusive treatment but the onus of integration lay in the hands of the patient who could not always achieve it owing to his illness. Also differences in the ideologies of the two clinicians often resulted in patients receiving unclear, mixed or sometimes contradictory advice.

Integrated Mental Health and Substance Abuse Treatment

The next step following the parallel model was the complete integration of treatment of both psychiatric and substance abuse treatment at the level of the clinician. This meant that the same clinician or a multidisciplinary group of mental health professional provided an all inclusive, comprehensive and holistic assessment and care of dual diagnosis patients. The integrated programs recognize that recovery tends to occur over months or years in the
community and therefore is time unlimited approach [4]. It aims to overcome the barriers faced traditionally in managing such patients, as it tends to be comprehensive, assertive, time unlimited, motivation based treatment involving multiple psychotherapeutic and psychopharmacological approach [5]. The comprehensive nature of the treatment acknowledges that patients have problems besides those related to their mental illness. It identifies and attempts to modify other allied issues like dysfunctional interpersonal relationships, vocational instability, housing problems amongst others. Patients with dual diagnosis require not just being asymptomatic but needing to bring about a change in their lifestyles to attain and maintain remission of both mental illness and substance abuse. This requires supported employment, residential facilities, social skill training and family psycho-education to be an integral part of the management. The model also acknowledges that recovery in dual diagnosis is longitudinal and often over a span of months and years and therefore in time unlimited and assertive. It encourages the clinical team to reach out to the patient in the community and not wait for him/her to follow up in the clinic as such patients often have poor motivation with chaotic lifestyles. A close follow up in the community also allows for better therapeutic alliance between the patients and the clinician along with improved adherence. Another difficulty often faced with dual diagnosis patients is the fluctuating levels of motivation. Classically patient have been described to progress from stages of engagement, persuasion, active treatment and relapse prevention [6]. Therefore interventions should be individualized to patient’s motivation stage, which may differ form time to time. Similarly the nature of psychotherapeutic intervention can include a combination of individual psychotherapy (motivational interviewing, cognitive behavioral therapy), group based and family based psychotherapy. It will be the onus of the clinician to identify the intervention best suited to each patient.

Evidence Base for Integrated Treatment for Dual Diagnosis

The past two decades have established that the integrated model is the way ahead for dual diagnosis treatment. However, there is no single empirical integrated program that exists. Owing to the heterogeneity of patients, differing psychological interventions and structure of programs, there lies ambiguity in the interpretation of outcome studies indicating effectiveness of dual diagnosis programs. Despite these caveats, the current evidence indicates that integrated programs have beneficial effects albeit with modest effect size [7,8]. There are certain features of integrated models that have consistently shown to be beneficial across different studies. These include time-unlimited services, motivational interventions and a positive therapeutic alliance between the patient an clinician [8]. While psycho-education, skills training, stage-wise intervention and single or multiple family groups have shown better outcomes for patients [9], no single psychosocial intervention has been found to be superior in a recent meta-analysis [10] and therefore individualization of the interventions is paramount. Long-term treatment including residential treatment spanning from months to years has been consistently found beneficial [11], as recovery in dual diagnosis is a slow and gradual process.

The Road Ahead

The management of dual diagnosis is still an
evolving field requiring much research and innovations. The outcome for this marginalized group of patients would improve with not just newer interventions within the realms of the hospital or clinic, but an overhaul of the environment around these patients. Provision of residential facilities, employment opportunities, low threshold treatment facilities, easy access to medical care, support groups and legal aid will be a step towards a holistic approach to managing patients with dual diagnosis. This would undoubtedly require advocacy, financial and political commitment at the micro and macro level. From clinical research point of view, methodologically sound trials comprising of homogenous groups that have been studied longitudinally over a significant period of time would provide a better outlook regarding the cost effectiveness and usefulness of the integrated treatment approach.

References


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