Real-world challenges
The term “dual diagnosis” describes the clinically challenging comorbidity of a substance use disorder (SUD) along with another major mental illness. Based on data from the Epidemiologic Catchment Area study, the lifetime prevalence of SUDs among patients with mental illness is approximately 30%, and is higher among patients with certain mental disorders, such as schizophrenia (47%), bipolar disorder (61%), and antisocial personality disorder (84%).

These statistics highlight that addiction is often the rule rather than the exception among those with severe mental illness. Not surprisingly, the combined effects of having an SUD along with another mental illness are uniformly negative (Table 1,2-4 page 26).

Based on outcomes research, the core tenets of evidence-based dual-diagnosis treatment include the importance of integrated (rather than parallel) and simultaneous (rather than sequential) care, which means an ideal treatment program includes a unified, multidisciplinary team whose coordinated efforts focus on treating both disorders concurrently.2 Evidence-based psychotherapies for addiction, including motivational interviewing, cognitive-behavioral therapy, relapse prevention, contingency management, skills training, and/or case management, are a necessity,3,5 and must be balanced with rational and appropriate pharmacotherapy targeting both the SUD as well as the other disorder (Table 2,2,3,5,9 page 27).

3 ‘Real-world’ clinical challenges
Ideal vs real-world treatment
Treating patients with co-occurring disorders (CODs) within integrated dual-disorder treatment (IDDT) programs sounds straightforward. However, implementing evidence-based “best practice” treatment is a significant challenge in the real world for several reasons. First, individuals with CODs often struggle with poor insight, low motivation to change, and lack of access to health care. According to the Substance
Dual diagnosis patients

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Abuse and Mental Health Services Administration (SAMHSA), 52% of individuals with CODs in the U.S. received no treatment at all in 2016. For patients with dual disorders who do seek care, most are not given access to specialty SUD treatment and may instead find themselves treated by psychiatrists with limited SUD training who fail to provide evidence-based psychotherapies and underutilize pharmacotherapies for SUDs. In the setting of CODs, the “harm reduction model” can be conflated with therapeutic nihilism, resulting in the neglect of SUD issues, with clinicians expecting patients to seek SUD treatment on their own, through self-help groups such as Alcoholics Anonymous or in other community treatment programs staffed by nonprofessionals that often are not tailored to the unique needs of patients with dual disorders. Psychiatrists working with other mental health professionals who provide psychotherapy for SUDs often do so in parallel rather than in an evidence-based, integrated fashion.

IDDT programs are not widely available. One study found that fewer than 20% of addiction treatment programs and fewer than 10% of mental health programs in the U.S. met criteria for dual diagnosis–capable services. Getting treatment programs to become dual diagnosis–capable is possible, but it is a time-consuming and costly endeavor that, once achieved, requires continuous staff training and programmatic adaptations to interruptions in funding.

With myriad barriers to the establishment and maintenance of IDDTs, many patients with dual disorders are left without access to the most effective and comprehensive care; as few as 4% of individuals with CODs are treated within integrated programs.

Diagnostic dilemmas

Establishing whether or not a patient with an active SUD has another serious mental illness (SMI) is a crucial first step for optimizing treatment, but diagnostic reliability can prove challenging and requires careful clinical assessment. As always in psychiatry, accurate diagnosis is limited to careful clinical assessment and, in the case of possible dual disorders, is complicated by the fact that both SUDs as well as non-SUDs can result in the same psychiatric symptoms (eg, insomnia, anxiety, depression, manic behaviors, and psychosis). Clinicians must therefore distinguish between:

- Symptoms of substance intoxication or withdrawal vs independent symptoms of an underlying psychiatric disorder (that persist beyond a month after cessation of intoxication or withdrawal)
- Subclinical symptoms vs threshold mental illness, keeping in mind that some mood and anxiety states can be normal given social situations and stressors (eg, turmoil in relationships, employment difficulties, homelessness, etc.)
- Any mental illness (AMI) vs SMI. The latter is defined by SAMHSA as AMI that substantially interferes with or limits ≥1 major life activities.

With these distinctions in mind, data from the 2016 National Survey on Drug Use and Health indicate that dual-diagnosis comorbidity was higher when the threshold for mental illness was lower—among the 19 million adults in the U.S. with SUDs, the past-year prevalence was 43% for AMI and 14% for SMI. Looking at substance-induced disorders vs “independent” disorders, the 2001-2002 National Epidemiologic

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<td>More family problems</td>
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Source: References 2-4

Table 1

Both SUDs and other disorders can result in insomnia, anxiety, depression, mania, and psychosis

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Table 2

Combined effects of comorbid substance use disorders with another mental illness

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Source: References 2-4
Survey on Alcohol and Related Conditions found that for individuals with SUDs, the past-year prevalence of an independent mood or anxiety disorder was 35% and 26%, respectively.\textsuperscript{19} Taken together, these findings illustrate the substantial rate of dual-diagnosis comorbidity, the diagnostic heterogeneity and range of severity of CODs,\textsuperscript{20} and the potential for both false negatives (e.g., diagnosing a substance-induced syndrome when in fact a patient has an underlying disorder) and false positives (diagnosing a full-blown mental illness when symptoms are subclinical or substance-induced) when performing diagnostic assessments in the setting of known SUDs.

False positives are more likely when patients seeking treatment for non-SUDs don’t disclose active drug use, even when asked. Both patients and their treating clinicians may also be prone to underestimating the significant potential for morbidity associated with SUDs, such that substance-induced symptoms may be misattributed to a dual disorder. Diagnostic questioning and thorough chart review that includes careful assessment of whether psychiatric symptoms preceded the onset of substance use, and whether they persisted in the setting of extended sobriety, is therefore paramount for minimizing false positives when assessing for dual diagnoses.\textsuperscript{18,21} Likewise, random urine toxicity testing can be invaluable in verifying claims regarding sobriety.

Another factor that can complicate diagnosis is that there are often considerable secondary gains (e.g., disability income, hospitalization, housing, access to prescription medications, and mitigation of the blame and stigma associated with addiction) associated with having a dual disorder as opposed to having “just” a SUD. As a result, for some patients, obtaining a non-SUD diagnosis can be highly incentivized.\textsuperscript{22,23} Clinicians must therefore be savvy about the high potential for malingering, embellishment, and mislabeling of symptoms when conducting diagnostic interviews. For example, in assessing for psychosis, the frequent endorsement of “hearing voices” in patients with SUDs often results in a diagnosis of schizophrenia or unspecified psychotic disorder,\textsuperscript{22} despite the fact that this symptom can occur during substance intoxication and withdrawal, is well documented among people without mental illness as well as those with non-psychotic disorders,\textsuperscript{24} and can resolve without medications or with non-antipsychotic pharmacotherapy.\textsuperscript{25}

When assessing for dual disorders, diagnostic false positives and false negatives can both contribute to inappropriate treatment and unrealistic expectations for recovery, and therefore underscore the importance of careful diagnostic assessment. Even with diligent assessment, however, diagnostic clarity can prove elusive due to inadequate sobriety, inconsistent reporting, and poor memory.\textsuperscript{26} Therefore, for patients with known SUDs but diagnostic uncertainty about a dual disorder, the work-up should include a trial of prospective observation, with completion of appropriate detoxification, throughout a 1-month period of sobriety and in the absence of psychiatric medications, to determine if there are persistent symptoms that would justify a dual diagnosis. In research settings, such observations have revealed that most of depressive symptoms among alcoholics who present for substance abuse treatment resolve after a month of abstinence.\textsuperscript{27} A similar time course for resolution has been noted for

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<th>Table 2</th>
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<tr>
<td>Simultaneous treatment of both disorders</td>
<td>Integrated treatment of both disorders by a multidisciplinary team</td>
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<tr>
<td>Evidence-based psychosocial interventions:</td>
<td>• Case management</td>
</tr>
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<td></td>
<td>• Social skills training</td>
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<tr>
<td></td>
<td>• Motivational interviewing</td>
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<td>• Cognitive-behavioral therapy</td>
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<td>• Assertive community treatment</td>
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<td>• Contingency management</td>
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<td>• Money management/representative payees</td>
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<tr>
<td>Evidence-based pharmacotherapy</td>
<td>Routine/random urine toxicology screening</td>
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Source: References 2,3,5-9

Clinical Point

Because receiving a dual diagnosis often is linked to secondary gains, be savvy about the high potential for malingering
Dual diagnosis patients

Clinical Point
Although the ‘self-medication’ hypothesis is often invoked, this theory has not been well supported in studies

Table 3
Tips for clarifying the presence of dual disorders

| Determine the sequential onset of SUDs and other mental disorders as well as the persistence of symptoms during previous periods of sobriety through: |
| open-ended interviewing    |
| thorough chart review      |
| collateral history         |

Monitor symptoms during prospective trials of sobriety while deferring pharmacotherapy (eg, antidepressants, antipsychotics, mood stabilizers) pending diagnostic clarity and completion of acute withdrawal

SUDs: substance use disorders

Anxiety, distress, fatigue, and depressive symptoms among individuals with cocaine dependence. These findings support the guideline established in DSM-IV that symptoms persisting beyond a month of sobriety “should be considered to be manifestations of an independent, non-substance-induced mental disorder,” while symptoms occurring within that month may well be substance-induced. Unfortunately, in real-world clinical practice, and particularly in outpatient settings, it can be quite difficult to achieve the requisite period of sobriety for reliable diagnosis, and patients are often prematurely prescribed medications (eg, an antidepressant, antipsychotic, or mood stabilizer) that can confound the cause of symptomatic resolution. Such prescriptions are driven by compelling pressures from patients to relieve their acute suffering, as well as the predilection of some clinicians to give patients “the benefit of doubt” in assessing for dual diagnoses. However, whether an inappropriate diagnosis or a prescription for an unnecessary medication represents a benefit is debatable at best.

Pharmacotherapy
A third real-world challenge in managing patients with dual disorders involves optimizing pharmacotherapy. Unfortunately, because patients with SUDs often are excluded from clinical trials, evidence-based guidance for patients with dual disorders is lacking. In addition, medications for both CODs often remain inaccessible to patients with dual disorders for 3 reasons:

- SUDs negatively impact medication adherence among patients with dual disorders, who sometimes point out that “it says right here on the bottle not to take this medication with drugs or alcohol!”
- Some self-help groups still espouse blanket opposition of any “psychotropic” medications, even when clearly indicated for patients with COD. Groups that recognize the importance of pharmacotherapy, such as Dual Diagnosis Anonymous (DDA), have emerged, but are not yet widely available.
- Although there are increasing options for FDA-approved medications for SUDs, they are limited to the treatment of alcohol, opioid, and nicotine use disorders; are often restricted due to hospital and health insurance formularies; and remain underprescribed for patients with dual disorders.

Although underutilization of pharmacotherapy is a pitfall to be avoided in the treatment of patients with dual disorders, medication overutilization can be just as problematic. Patients with dual disorders are sometimes singularly focused on resolving acute anxiety, depression, or psychosis at the expense of working towards sobriety. Although the “self-medication hypothesis” is frequently invoked by patients and clinicians alike to suggest that substance use occurs in the service of “treating” underlying disorders, this theory has not been well supported in studies. Some patients may pledge dedication to abstinence, but still pressure physicians for a pharmacologic solution to their suffering. With expanding legalization of cannabis for both recreational and medical purposes, patients are increasingly seeking doctors’ recommendations for “medical marijuana” for a wide range of complaints, despite the fact that data supporting a therapeutic role for cannabis in the treatment of mental illness is sparse, whereas the potential harm in terms of either causing or worsening psychosis is well established. Clinicians must be knowledgeable about the abuse potential
of prescribed medications, ranging from sleep aids, analgesics, and muscle relaxants to antidepressants and antipsychotics, while also being mindful of the psychological meaningfulness of seeking, prescribing, and not prescribing medications.\(^4\)

Although the simultaneous treatment of patients with dual disorders that includes pharmacotherapy for both SUDs and CODs is vital for optimizing clinical outcomes, clinicians should strive for diagnostic accuracy and use medications judiciously. In addition, although pharmacotherapy often is necessary to deliver evidence-based treatment for patients with dual disorders, it is inadequate as standalone treatment and should be administered along with psychosocial interventions within an integrated, multidisciplinary treatment setting.

**The keys to optimal outcomes**

The treatment of patients with dual disorders can be challenging, to say the least. Ideal, evidence-based therapy in the form of an IDDT program can be difficult for clinicians to implement and for patients to access. Best efforts to perform meticulous clinical assessment to clarify diagnoses, use pharmacotherapy judiciously, work collaboratively in a multidisciplinary setting, and optimize treatment given available resources are keys to clinical success.

**References**


**Bottom Line**

Ideal treatment of patients with dual disorders consists of simultaneous, integrated interventions delivered by a multidisciplinary team. However, in the real world, limited resources, diagnostic challenges, and both over- and underutilization of pharmacotherapy often hamper optimal treatment.