Discussion Document on Dual Diagnosis-Declan Byrne (Presented to the Dublin North East Drugs Task Force (DNEDTF) 28th September 2006)

1.1 Introduction

In April 2006 the **Dublin North East Drugs Task Force** through the Treatment and Rehabilitation Sub-Committee initiated a process of developing a position paper on dual diagnosis. It is hoped that this will form the basis of a document that could be adopted by the **Task Force** and then sent to the **National Drugs Strategy Team** for their consideration. This draft paper uses the working definition developed by the National Advisory Committee on Drugs in 2004, which defined it as "the co-existence of both mental health and substance misuse problems for an individual".

It is important that we recognise the complexities of the issues involved in dual diagnosis and that we accept the enormous challenges it presents to service providers and programme designers. The issues involved have depressed some people because they feel that the clients involved dwarf our skills. Others have taken the view that the debate on dual diagnosis might become the engine that will drive those who are providing a service to problem drug mis-users to deliver more individually focused treatment options.

The paper will be divided into three sections (1) Reviewing the Debate in an Irish Context (2) Looking at the Theoretical Complexities (3) Making Practical Suggestions that could help people living in the Dublin North East area.

1.2 Reviewing the Debate in an Irish Context.

Prior to 2000 the debate was mainly confined to specialists working in the field. Certain articles were published such as "Depressive symptoms in opiate addicts on methadone maintenance" by Williams et al 1990 and "Co-abuse of opiates and benzodiazepines" by Rooney et al 1999. However the problem was not widely recognised nor the need to take appropriate action accepted. The first watershed occurred in June 2000 when the Catholic Bishops' Conference called a conference in conjunction with the Irish Times to discuss the issue and invited Dr. Jane Wilson as the keynote speaker. The proceedings of the seminar were published in book form, entitled "Beyond Maintenance" In her address Dr. Jane Wilson from the Scottish Drugs Training Project dealt with the complex issues, the challenges to service providers and suggested possible structures to meet client needs.

Two further reports since then have dealt with the issue of co-morbidity

- Drug Misuse Research Division (2004). Report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) by the Reitox National Focal Point: Ireland, drug situation 2002. Health Research Board, Dublin. (*Relevant section 16 Co-morbidity: psychiatric illness and problem drug use*).
- Drug Misuse Research Division (2004). Report to the EMCDDA by the Reitox National Focal Point: Ireland; new developments, trends and in-depth information on selected issues. Health Research Board, Dublin. (*Relevant section 6.4 Psychiatric co-morbidity*).

In 2004 the National Advisory Committee on Drugs commissioned MacGabhann et al from Dublin City University to bring out a groundbreaking report entitled "Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland". The report highlights 'the inadequacy of services for dual diagnosis' the 'exclusion' from the services for people with dual diagnosis and the current 'gaps' that exist. The report concludes 'Clinically effective service models and treatment approaches need to be developed that fit the context of people in Ireland with dual diagnosis-at (both) regional and local level.'

1.3 Looking at the Theoretical Complexities.

The debate on dual diagnosis has taken place in other countries most notably the United States. In 'Essential Papers on Addiction' (Yalisove 1997) four chapters are devoted to looking at the relationship between psychiatric illness and addiction.

"Psychiatric Severity" as a Predictor of Outcome from Substance Abuse Treatments
- A. Thomas McLellan.

McLellan introduces the addiction Severity Index ASI. It could be described as a 'problem severity profile'. McLellan states, "My colleagues and my experience has suggested that these problems combine in a variety of complex ways to create particular treatment needs in each patient. Furthermore, we feel that if these problems are not addressed along with the chemical dependence in a substance abuse treatment. They can leave the patient susceptible to relapse, re-addiction, and return to treatment". Based on a seven-year research programme he concluded "that low-severity patients have the best treatment prognosis generally, and that they appear to improve significantly in any of the treatment programs to which they are assigned". Turning to the 'high-severity patients' and by combining the research findings with his clinical experience he felt that "none of the programs currently available within our treatment network were effective with these individuals". Attempting to design a programme that would help high-severity patients he looked at "the potential benefits of adding professional psychotherapy to existing drug counselling services". The results of this study offered convincing evidence that traditional drug abuse counselling was able to provide significant benefit to the low-severity patients" and that the supplemental therapy (psychotherapy) did provide significant benefit to the high severity patients.

The Self-Medication Hypothesis of Addictive Disorders: Focus on Heroin and Cocaine Dependence
- Edward J. Khantzian.

Khantzian introduces the 'modern psychodynamic perspective'-"these analysts succeeded in better identifying the nature of the psychological vulnerabilities, disturbances, and pain that predispose certain individuals to drug dependence. This perspective…emphasizes that heavy reliance on and continuous use of illicit drugs are associated with severe and significant psychopathology." Khantzian focused on these

studies in order to examine the clinical and treatment implications. Khantzian deals with his clinical observations with narcotic and cocaine dependent individuals. He adopts a certain position- " I have been impressed that the anti-aggression and anti-rage action of opiates is one of the most compelling reasons for its appeal." While observing over 200 addicts who had lifelong problems with rage and violent behaviour he points out "these patients repeatedly described how opiates helped them to feel normal, calm, mellow, soothed, and relaxed." Commenting specifically on cocaine addiction, "For, some the energizing properties of these drugs are compelling because they help to overcome fatigue and depletion states associated with depression." By drawing together, developments in psychoanalysis, other relevant studies, and his clinical observations he concludes "Rather than simply seeking escape, euphoria, or self-destruction, addicts are attempting to medicate themselves for a range of psychiatric problems and painful emotional states. Although most such efforts at self-treatment are eventually doomed… addicts discovered that the short-term effects of their drugs of choice help them to cope with distressful subjective states and an external reality otherwise experienced as unmanageable or overwhelming."

Substance Abuse as an Attempt at Self-Medication
- Roger D. Weiss and Steven M. Mirin.

This chapter again explores the relationship between substance abuse and psychopathology. Weiss and Mirin begin by reviewing the work of others in this area. They introduce the reader to 'deficiency theories', which provide the basis for more recent self-medication theories. The authors have some methodological concerns about the theories on self-medication. They point out-"One limitation of this theory is the fact that the mere presence of two disorders in the same individual does not imply causality." They examine depression and drug abuse-"the depression seen at the beginning of treatment is related in part to the effects of chronic intoxication. Unfortunately depression levels are most often measured precisely at this time when psychosocial stresses are likely to be highest, and when drug effects are greatest. Results from a study by Rounsaville and associates showing that depressive symptoms in opiate addicts generally improve over time without specific anti-depressant treatment, lend even further weight to the conclusion that the mere presence of depressive symptoms in a newly admitted opiate addict is insufficient evidence to warrant a diagnosis of an affective disorder."

One of their conclusions, which has clinical implications is that:
"It is clear that substance abusers are a heterogeneous group; treating them otherwise does these patients a great disservice. Careful evaluation, followed by individualized flexible treatment planning is necessary in order to successfully treat this very difficult patient population."

Parallels and Paradigms
-H. J. Richards.

In the opening section of this article – Confronting The Problem – Richards introduces us to Suzanne "she had already become a treatment failure in three

systems, the mental health system, the formal substance abuse treatment system, and the self-help alcoholism recovery community. " The purpose is to provide the reader with an experiential grasp of the effects of mental illnesses, and addictions as processes acting upon the total life of the individual, but especially upon the individual's experience of self. Richards states that Suzanne suffers from an 'emergent psychiatric syndrome', by an emergent syndrome he means that " They are becoming more frequently encountered in clinical settings due to improved clinical sensitivity and because larger numbers of patients are developing the syndromes." He discusses the 'dismantling' of the mental health system and the 'relegation' of substance abuse to 'low status professionals, paraprofessionals, or self-help groups'. This has resulted in a system with 'more cracks to fall through' and the individual involved being 'referred out' of these 'speciality delivery systems'.
He then goes on to define dual diagnosis populations and to introduce the reader to the 'key dimensions of dual diagnosis work'. "Often, the dual diagnosis patient reaches the health care system in acute distress from both a severe psychiatric problem as well as sever substance abuse problems". He talks about the 'stuckness', which "connotes the sense of being caught mired down-as if in mud or quicksand" and he points out that "The goal of both substance abuse treatment and treatment for psychopathology is to help individuals to move toward high levels of the experience of freedom". "The different levels reflect differences in ego strength, adequacy of coping skills. In the section 'parallels in experience and needs motivation' we enter a discussion on the schematic concepts of the "depleted self, the inflated self, and the detached self. In the depleted self "the drug use results in a chemical bolstering of the self." In the inflated self "the self has become inflated and overextended, and balance is totally lost." In the detached self "the ground or basis for the self to grow and manage the life space has been undermined to the point of collapse." He then relates this to a 'developmental view' and asserts, "The roots of these experiences… are in infancy before the development of speech." He then suggests 'dialectical thinking' as a means to understanding the challenge presented by dual diagnosis. "In early dual diagnosis programs patients in this population were treated in logical sequences… Patients first were detoxed chemically in a controlled environment, with the expectation that they would turn into normal mental patients. Then they were treated chemically for psychopathology or given psychotherapy. This consecutive or sequential strategy did not work after the acute phase of treatment, because of the interactive-emergent nature of the dual diagnosis problem." He then makes the point that 'reciprocity' is a key dimension in dual diagnosis work and he sets out the aim of treatment strategies "to create a synergistic relationship between the pathological processes." -"both disorders are in constant flux, both make up one river, yet both are separate."

1.4 Making Practical Suggestions

- The NACD Report (2004) recognises the need to quantify the extent of the problem of dual diagnosis in the client group availing of our various services. In certain States in America this issue has been addressed by the drug services, psychiatric services and the community/voluntary drug services all using the same admission/assessment questionnaire. (Action 1-DNEDTF to initiate the debate on standardised assessment tools within all three sectors.)

- The NACD Report (2004) recommends a greater degree of interaction among all sectors working in this area in order to develop regional and local services. (Action 2-DNEDTF to establish if there are any structured links between the Health Services Executive (HSE) psychiatric services and the HSE drugs treatment services in the area and if there is not to push for the establishment of same. Action 3-DNEDTF to develop a structure between the voluntary/community, the HSE psychiatric and HSE drug treatment services).

- A tiny part of the DNEDTF area (Clontarf) falls within the remit of St. Vincent's Psychiatric Hospital (Richmond Road) the rest falls within St. Ita's Psychiatric Hospital (Portrane). People with dual diagnosis problems from the north inner city area (including Clontarf) find it difficult to receive treatment from St. Vincent's. However people living in the St.Ita's catchment area suffering with dual diagnosis problems find it near impossible to access St. Ita's because the hospital operates a protocol that refuses admission to those on methadone. In certain extreme cases exceptions are made but overall this is a major blockage for those seeking treatment (Action 4-DNEDTF to write to St. Ita's to look for an explanation of the protocol and to explore the possibility of having it removed).

- St. James Hospital (Southside) has psychiatric nurse cover attached to the Accident and Emergency Department, twenty-four hours a day, seven days a week. Beaumont Hospital (Northside) has psychiatric nurse cover, nine to five, Monday to Friday. (Action 5-DNEDTF to campaign for extended psychiatric nurse cover for Beaumont Hospital).

- Those working in the field of addiction treatment have called for clinical nurse specialists in addiction to be attached to general hospitals. (Action 6-DNEDTF to campaign for the appointment of a clinical nurse specialist in addiction to be appointed to Beaumont Hospital).

- There are those that argue that all treatment centres should have psychotherapist available to the clients. While experience in England show improved treatment outcomes where programmes employ psychiatric nurse specialists in addiction. (Action 7-DNEDTF to encourage programmes within its catchment area to consider running pilot programmes to see if outcomes can be improved by the use of (1) psychotherapists and/or (2) psychiatric nurse (with specialisation in addiction).