Defining Dual Diagnosis: a brief literature search

Komala Vencatasawmy
Practice Development Practitioner
Bedfordshire & Luton Mental Health & Social Care Partnership NHS Trust

Literature Search

Introduction
The Good Practice Guide (DH 2002) highlights the lack of a clear operational definition of ‘dual diagnosis’, which should be regarded by services as a fundamental problem. It is therefore the responsibility of services to define the population of people who experience these dual disorders and identify those subgroups.

Defining Dual Diagnosis
The term ‘dual diagnosis’ was first coined in America (Gournay et al 1996) and can be broadly defined as ‘the concurrent existence in an individual of substance misuse and one or more mental disorder’ (Franey & Quirk 1996: 10).

The problem however is more complex than this. The group of people with dual diagnosis is heterogeneous, with complex, changing needs. They may have had previous traumatic experiences such as childhood sexual abuse, bullying at school or a broken and dysfunctional family life (Crome & Myton 2004). Furthermore, Banerjee et al (2002) highlights the importance of being clear that dual diagnosis is not a diagnosis in itself: it simply describes the fact that an individual has both mental health and substance misuse disorders.

Lehman et al (1998) identify four distinct sub-types of dual diagnosis:
1. primary mental illness, with subsequent substance misuse
2. primary substance misuse, with psychiatric consequences:
   o acute symptoms due to intoxication withdrawal
   o mental illness triggered due to pre-existing vulnerability
3. dual primary diagnosis, with both conditions co-existing, though separate from each other
4. A common aetiological factor causing both problems: homelessness.

A dual diagnosis can involve, within these sub-types, all classes of drugs of abuse, including alcohol, poly-substance misuse, and numerous psychiatric disorders (Batki 1990). Banerjee et al (2002) argued that people who are given the label ‘dual diagnosis’ typically have complex needs rather than just two problems. Steel (1997) agreed that dual diagnosis represents a complex collection of behaviours and consequent problems, rather than just a dual presentation, and finds the term to be misleading. However, Rorstad and Checinski (1996) point out that it is nonetheless helpful, as it serves as a marker that draws attention to a very real problem that is not being addressed. The concept is therefore used at its broadest to define an individual with a combination of psychiatric disorder, for example depression, and alcoholism.

Other terms, which have been used to describe this client group, include:
- mentally ill chemical abusers (MIC);
- co-occurring addictive and mental disorders (COAMD);
- chemically addictive mentally ill (CAMI) (Banerjee et al 2002).

The term ‘dual diagnosis’ is very often restricted to specify severe mental illness and problematic substance use (DH 1999). Murphy (2003) questioned what was meant by ‘severe’. He further argues that a diagnosis of schizophrenia sounds severe enough, but the depressive who becomes suicidal is probably as much in need of intervention as the person with the more ‘severe’ disorder. It has also been debated whether or not someone with severe mental illness who has infrequent alcohol abuse would qualify as having a dual disorder (Banerjee et al, 2000).

**In Conclusion**
In view of the above considerations, the good practice guide (DH 2002) clarifies that services should develop their own definition taking into consideration the client group and their immediate problems. It further offers guidelines on identifying various levels of severity on at least two axes: relative severity of the psychiatric disorder; and, relative severity of the substance misuse condition (See Fig. 1). This is likely to be a useful activity in ensuring appropriate referral and in maintaining gate-keeping, as services need to be clear at the outset about which individuals they intend to provide interventions for.
This also implies that care review and treatment planning will need to focus on matching different types of treatment intensity to each type of problem, in ensuring that all of the needs of this client group are met (Murphy 2003). Gafoor and Rassool (1998) point out that this is a crucial point to consider when defining this client group as it will not only help to provide treatment but also to provide the right treatment for dual diagnosis clients. This is acknowledged by the DH (2002): a successful integration of services requires a clear and locally agreed definition of dual diagnosis supported by clear pathways.

Fig. 1: The Co-existence of Psychiatric and Substance Misuse Disorders

<table>
<thead>
<tr>
<th>HIGH: Quadrant 3</th>
<th>HIGH: Quadrant 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Substance Misuse Service</strong></td>
<td><strong>Integrated Specialist Team OR Joint Work Arrangements</strong></td>
</tr>
<tr>
<td>e.g. dependent drinkers who experience increasing anxiety / depression</td>
<td>e.g. an individual with schizophrenia who misuses cannabis on a daily basis to compensate for social isolation</td>
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<table>
<thead>
<tr>
<th>LOW: Quadrant 1</th>
<th>HIGH: Quadrant 2</th>
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<tbody>
<tr>
<td><strong>Primary Care Service</strong></td>
<td><strong>Mental Health Service</strong></td>
</tr>
<tr>
<td>e.g. a recreational misuser of dance drugs who has begun to struggle with low mood after weekend use</td>
<td>e.g. an individual with bipolar disorder whose occasional binge drinking and experimental misuse of other substances de-stabilises their mental health</td>
</tr>
</tbody>
</table>

**Responding to Need**

The intensity and difference in the needs of dual diagnosis clients can be located within specific services, based upon which quadrant they fall into e.g. Quadrant 1 – in the primary care service; Quadrant 2 – in the mental health service; Quadrant 3 – in substance misuse services; Quadrant 4 – in an integrated specialist team OR joint work by both mental health and substance misuse services (Minkoff 2000).
References