



## DUAL DIAGNOSIS: 15 YEARS OF PROGRESS

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**Editor's Note:** In the following commentary on the article by Dr. Lehman and others on dual diagnosis, reprinted on page 1119 from the October 1989 issue of *Hospital and Community Psychiatry*, Drs. Drake and Wallach discuss the development of clinical understanding of dual diagnosis since the 1980s. Research has shown that among persons with serious mental illness, substance abuse is an underlying factor in violence, incarceration, treatment noncompliance, and HIV risk. Findings support the development of integrated treatment programs that address both types of disorder. Drs. Drake and Wallach describe four perspectives on dual diagnosis—medical, moralistic, psychosocial risk, and phenomenological. They argue that the emphasis on diagnosis and illness may have delayed the development of public policies and programs to address risks for substance abuse inhering in social and environmental settings, such as housing shortages and lack of employment opportunities. (*Psychiatric Services* 51:1126–1129, 2000)

During the era immediately following deinstitutionalization, psychiatry focused on helping patients with long-term institutional histories leave psychiatric hospitals and adjust to living in the community. Awareness of the problems of patients with severe mental illness who had never experienced prolonged hospitalization was slow to emerge. A spate of articles in the early 1980s identified, described, and labeled the “young adult

chronic patient” (1–3). Encounters with the drug culture were described in these and similar articles as the young person’s attempt to cope with mental illness and life in the community. The medical designations of co-occurring disorders and dual diagnosis had not yet been used.

In the late 1980s, as federal health agencies and providers of all kinds began to attend to this new, younger population of individuals with severe mental illness, the concept of co-occurring disorders emerged (4). Affected individuals were often discussed under the rubric of dual diagnosis but were also called mentally ill chemical abusers, substance-abusing mentally ill persons, and a host of other names that emphasized the concept of two co-occurring disorders.

Researchers such as Lehman and colleagues (5) began to address the assessment and treatment of persons with dual diagnoses. At the same time, observers noted the administrative, organizational, financial, and clinical barriers these persons encountered in trying to obtain both mental health and substance abuse services (6). Simultaneously, clinicians, policy makers, and researchers began to tackle the conundrum of how to link mental health and substance abuse services, both conceptually (7) and practically (8).

In many ways dual diagnosis is an unfortunate misnomer. There are other dual diagnosis populations, such as those with mental illness and developmental disabilities. Persons with severe mental illness and substance use disorders can be described in other ways and at other levels: they have multiple interacting disabilities, psychosocial problems, and disadvantages. The population of persons with co-occurring mental illness and substance use disorders is itself quite heterogeneous. It includes individuals with less disabling mental illnesses such as anxiety disorders, those with different severe illnesses such as schizophrenia and bipolar disorder, and those with either substance abuse or substance dependence.

Nevertheless, the term dual diagnosis became standard usage. It began to be included in the subject index of *Hospital and Community Psychiatry* in 1989, and it has survived over the years to refer to adults with severe mental illness and co-occurring substance use disorders. On the positive side, when the complexities were reduced to a simple medical term, attention was drawn to problems related to substance use, which created a mandate for recognition

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and treatment. However, as we discuss below, the medical designation also focused attention on the biological and pharmacologic aspects of treatment, implying that substance use problems inhere in the patient and muting the role of public policy in creating such problems.

### Themes in this journal, 1986–1990

A variety of themes related to dual diagnosis appeared in *Hospital and Community Psychiatry* during the same era. They included the growing numbers of homeless people with mental illness (9,10), public concern about violence perpetrated by persons with mental illness (11,12), incarceration of persons with psychiatric disorders (13,14), high service use by some individuals (15,16), treatment non-compliance (17,18), and the risk of HIV infection in the seriously mentally ill population (19,20). Remarkably, these discussions often neglected the extent of interaction among problems, treating them as discrete events to be listed and inventoried. In particular, the role of substance abuse as an underlying factor was often ignored.

### Dual diagnosis over time

Since 1990 there has been a steady recognition of the links between substance use disorders and other negative outcomes for patients with dual diagnoses (21). Accumulating evidence, including some from prospective studies, suggests that co-occurring substance abuse leads to relapse and rehospitalization, disruptive behavior and violence, familial problems, homelessness, decreased functional status, HIV infection, and medication noncompliance. Current research also indicates that traditional, separate services for persons with dual disorders are ineffective and that integrated treatment programs that combine mental health and substance abuse interventions offer promise (22). Further research is needed on the organization and financing of dual diagnosis services and on specific components of the integrated treatment model, such as family interventions. However, the overall concept of integration appears sound (23).

Newly emerging themes in the dual diagnosis literature include concerns about the use of public funds for acquiring substances of abuse by persons receiving disability payments (24), the role of trauma in the lives of persons with mental illness (25), and the vulnerability of psychiatric patients to serious infectious diseases other than HIV (26). The evidence about entitlements is ambiguous, with some studies suggesting misuse of public funds (27) and others failing to find such a relationship (28). On the other hand, recent studies are consistent in showing the strong role of substance abuse in exposing persons with mental illness to victimization (29) and to serious infectious disease (26).

### Four perspectives on dual diagnosis

As implied by the dual diagnosis label, the psychiatric field has tended to view problems related to substance use from a medical perspective—that is, in terms of illness or disorder. The same problems can, however, be considered from

other perspectives. In this section, we discuss the advantages and disadvantages of four perspectives—medical, moralistic, psychosocial risk, and phenomenological—in relation to empirical research and also to their potential for effective interventions.

#### *Medical perspective*

The medical perspective defines a substance use disorder as a chronic, relapsing illness. The illness model has supplanted the belief that substance abuse is a secondary coping mechanism that would disappear with appropriate treatment of the primary disorder. Research has in fact demonstrated that substance use disorders tend to persist in this population even when patients receive adequate mental health treatment (30) and that concurrent substance abuse treatment is helpful, particularly when it is integrated with mental health treatment (22).

Notwithstanding the obvious contributions of the medical perspective, there are dangers in relying exclusively on a single viewpoint. In research, as elsewhere, a dominant perspective can determine language and modes of thinking. For example, when persons with dual diagnoses leave residential settings and return to substance use, we describe their course as a relapse of illness rather than as a return to the norms of their subculture. The problem is thus situated within the patient. However, research shows that substance use in this population is deeply embedded in particular social subcultures with norms for use and abuse (31) and that patients with dual diagnoses are often stably abstinent while living in protected settings away from their subcultures (32).

More generally, the illness model, if allowed to be a monolithic viewpoint, may overemphasize biological factors and obscure important psychosocial risk factors. For example, the “self-medication” hypothesis, which implies that patients seek specific mind-altering substances to reverse the effects of specific biological deficits related to particular illnesses (33), lacks research support but has nevertheless attained wide currency (34), in part because it fits the dominant medical paradigm. Lehman and associates (5) were prescient in suggesting that an accumulation of known risk factors, such as poverty, residence in disorganized neighborhoods, lack of a job and family responsibilities, and deviant peers might better account for the evidence.

According to such a view, substance abuse is a complex biopsychosocial phenomenon that must be understood from several perspectives. In keeping with the heterogeneity of the population, the medical perspective may have more relevance for dual diagnosis patients who develop the physiologic syndrome of dependence, while social factors may be more relevant for those without physiological dependence (35).

#### *Moralistic perspective*

Our culture has long taken a moralistic view of psychoactive substance use, as reflected in popular themes of bad behavior, bad character, and moral culpability. The moral-

istic view of substance abuse has often dominated public policy and underlies current efforts to “get tough” on drugs by emphasizing control and punishment.

For persons with dual diagnoses, in recent years we have seen increasing public concerns about violence, vagrancy, and misuse of welfare funds, which have led to mandatory restraints and financial controls. Indeed, the criminalization and incarceration of persons with mental illness often result from substance abuse and its related psychosocial instability.

Research should cause us to question these trends. Highly vulnerable individuals were shunted away from hospitals and structured living situations, albeit in the name of humanitarian movements such as deinstitutionalization and supported housing, and into poor living environments replete with physical danger, antisocial gangs, and drugs. Their lives became dominated by victimization at the hands of other inner-city residents. Caught in the web of behavior problems in need of control by the criminal justice system, they ended up in less benign institutions such as jails and prisons.

The reality, of course, is that individuals with mental illness are much more likely to be victims than perpetrators—victims not only of violence but also of misguided public policy. To avoid predation and further victimization, they need safe living settings, adequate incomes, and opportunities to succeed. A moralistic stance toward people whom public policy has shunted into the streets seems unlikely to help. It could be positive only if policies were already in place offering safety, vocational training, and other normal life opportunities so that personal responsibility is a realistic option.

#### *Psychosocial risk perspective*

As noted, the psychosocial risk perspective assumes that persons with severe mental illness are prone to succumbing to risks inhering in the social, cultural, and environmental settings allotted to them by public policy decisions, deinstitutionalization, housing shortages, and inner-city plagues related to drugs, crime, and poverty. In other words, living in poor neighborhoods that are infested with crime and drugs and lacking the protection conferred by jobs, families, social networks, dependents, and other responsibilities renders such persons extremely vulnerable to substances of abuse, especially if these risk factors are considered in relation to the biological and psychological vulnerability of having a brain that is particularly sensitive to mind-altering substances and a life that is short on developmental opportunities. In general, the etiological research supports this perspective (34).

The psychosocial risk perspective provides a useful counterpoint to the prevailing medical and moralistic perspectives because it directs us toward change at the environmental and public policy levels. Rather than prescribing more treatment or more adjudication, we should consider the potential benefits of changes in public policy to match the closing of mental hospitals: better housing in safe neighborhoods; more protection from drugs and alco-

hol; greater social, educational, and vocational opportunities; and the usual responsibilities of citizenship. Just as these factors protect the general population from substance abuse, they may help those with psychiatric illness avoid or minimize use of alcohol and other drugs. Research shows that having more of these positive social factors in place enhances recovery from substance use disorders for those with mental illness (36).

#### *Phenomenological perspective*

People with dual disorders have described their own experiences with alcohol and drugs and their pathways to recovery (37,38). In general, they do not report attempts to treat their own illness by using alcohol and drugs but rather recount confused attempts to survive the stress of mental illness, patienthood, victimization, lack of opportunities, and hopelessness. Patients themselves express goals of education, employment, safe housing, social supports, friendship, and participation in citizenship. They often feel that the mental health system has pushed them toward treatment compliance and passivity rather than helping them to achieve their goals, which often include protected living arrangements (39,40).

According to these same self-reports, mental health providers have also neglected patients' substance abuse or referred them to other, nonintegrated service systems. Meanwhile, patients themselves express the need for a single provider who can be trusted to understand and address mental health and substance abuse problems when both are present (37,38). Contrary to the medical perspective once again, the phenomenologic perspective suggests that clinicians use the acumen and insight of patients' assessments of their own situations at least as much as their own views of patients' deficits and debilities.

#### **Conclusions**

The introduction of the concept of dual diagnosis in the late 1980s was instrumental in focusing attention on problems related to substance use among patients with severe mental illness in the community. It created a mandate for treatment, led to the clarification of service issues, and spawned the development of approaches that integrated substance abuse and mental health treatments. However, the emphasis on diagnosis and illness may have led to an overemphasis on fixing processes or dispositions internal to the patient and may have inhibited the development of policies and programs involving constructive changes of the surrounding social and physical contexts. The recent trend toward moralistic views of dual diagnosis, which has led to criminalization and incarceration of persons with mental illness, creates further victimization and has yet to demonstrate a positive influence.

Attention to the perspectives of psychosocial risk and the phenomenology of the patient may, on the other hand, enhance efforts both to prevent substance abuse and to help dual diagnosis patients to recover. These perspectives suggest that we devote more attention to our policies, not only to provide integrated treatment but also to create safe

and protective environments along with the development of opportunities for educational, social, and vocational success. ♦

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