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Profile of Patients with Dual Diagnosis: Experience from an Integrated Dual Diagnosis Clinic in North India

Basu D* and Ghosh A

Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Drug De-addiction and Treatment Centre, Chandigarh 160012, India

Abstract

Dual diagnosis is the co-occurrence of substance use disorder and other psychiatric disorder. Till date the existence of integrated dual diagnosis clinic (DDC) in India is not known. The Drug De-addiction and treatment centre of our hospital has initiated one of the first such clinics in India in October, 2009. In a retrospective chart-based review of consecutive patients over 28 months from August 2011 till December 2013, 287 case files of clinically confirmed dual diagnosis cases (representing 15% of all substance use disorder cases registered in our drug treatment centre) were analyzed. Mood disorders were the commonest psychiatric diagnosis (141, 49.1%), followed by psychotic disorders (65, 22.6%), anxiety and stress related disorders (58, 20.2%), organic disorders (6, 2%) and other mental disorders (22, 7.7%). Alcohol, opioid and cannabis were the common substances used. These preliminary data provide an overview of the profile of patients with dual diagnosis in a substance use treatment centre in north India. This should help in planning and delivering adequate and optimal services for this group of patients.

Broadly speaking, dual diagnosis is the co-occurrence of substance use disorder and other psychiatric disorder when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from [a single] disorder [1]. The concept of dual diagnosis has its origin in 1970's during the time of deinstitutionalization of psychiatry, when a substantial proportion of severely mentally ill persons were discharged from the long term care to the community. With a suboptimal effort towards social reintegration, and rehabilitation, these patients were exposed to chronic daily life stress and a drug using subculture. This created a contingent of people with severe mental illness who were also using various psycho-active drugs to deal with their life difficulties. Unfortunately, in spite of their sizeable number and seemingly insurmountable difficulty, there was no locus of responsibility for the treatment of this group of people. They were simply denied access to treatment in both psychiatric and substance use treatment facility [2]. Recognizing the need and suffering, in mid 1980's integrated services for dual diagnosis patients started in the US [2]. In an integrated treatment centre both the disorders were treated simultaneously by the same or the same group of professionals. In 1996, Virginia Green published a vivid narrative personal account of obtaining treatment for her manic-depressive disorder and alcohol and drug problem from separate and an integrated treatment facility. She unequivocally spoke about the superiority of integrated treatment over a disparate treatment service [3]. Today, the effectiveness and acceptability of integrated treatment for dual diagnosis is well recognized [4].

Till date the existence of integrated dual diagnosis clinic (DDC) in India is not known. The Drug De-addiction and treatment center of our hospital has initiated one of the first such clinics in India in October, 2009. This clinic was started after an 11 year retrospective data from our centre which showed that the prevalence of dual diagnosis is 13.2% and there has been a very high attrition rate and favorable outcome in those who were retained in the treatment [5]. Realizing the number and the need for intensive and comprehensive treatment for this unique group of individuals, the DDC has been established. In our integrated clinic, concurrent treatment of psychiatric and substance use disorder is carried out by the same group of mental health professionals consisting of a Consultant psychiatrist, Senior Resident, Psychiatric social worker and Psychiatric nurse. Dual diagnosis counseling and active surveillance by the psychiatric social workers are the forms psycho-social interventions considered in the clinic.

The aim was to study the profile of patients with dual diagnosis from an integrated Dual Diagnosis clinic (DDC). It is a retrospective chart-based review of consecutive patients. The records were retrieved from DD clinic register data. Data were obtained for substance use disorders, psychiatric diagnosis, and short term outcome. Records of 28 months (August 2011 to December 2013) have been collected for the purpose of the study. In our clinic provisional diagnosis has been made by qualified psychiatrist (Senior Resident) through a clinical interview. Finally definitive diagnosis has been made by Consultant psychiatrist following a thorough examination and critical discussion during the detailed work-up or after a longitudinal follow up. Once the diagnosis has been confirmed, the patient is registered in the DDC. Hence from DDC register which is the source of our study, we are expected to have definitive dual diagnosis cases.

Out of 1929 patients registered over a span of 28 months, 1907 (98.8%) records were traceable. Amongst these, 287 (15%) had a comorbid non-substance psychiatric disorder. As demonstrated in a previous study, this is concordant with the prevalence figure of dual diagnosis (13.2%) from our de-addiction centre [5]. However, the figure was much less than those found in other studies from India (50-75%) and the US (50-60%) [6-8]. Reason for this discrepancy could be many folds. We have used individual level definition for the diagnosis of co-occurring disorder instead of service level definition which is more broad and inclusive [1]. Moreover, as this is a clinic based data, figure depends on the nature of treatment seeking. Hence, it is likely that a substantial majority of the dual diagnosis patients

***Corresponding author:** Debasish Basu, Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Drug De-addiction and Treatment Centre, Chandigarh 160012, India, Tel: 09433-161-840; Fax: +91-172-2744401; E-mail: db_sm2002@yahoo.com

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were seeking treatment from the adjacent psychiatry outpatient clinic which is running since last many years. This indirectly indicates that sensitization of and liaison with psychiatry services is also imperative for an integrated dual diagnosis clinic.

When the pattern of psychiatric disorders in the clinically confirmed dual diagnosis cases was analyzed, mood disorders were the commonest (141, 49.1%) amongst all dual diagnoses. Psychotic disorders (65, 22.6%) were the second most prevalent diagnosis followed by anxiety and stress related disorders (58, 20.2%), organic disorders (6, 2%) and other mental disorders (22, 7.7%). This trend is comparable with the existing literature from our centre, other studies in India and the US [5-8]. Alcohol was the primary substance of use in both psychotic (30.8%) and non-psychotic (47.3%) co-occurring disorder. This perhaps reflects the treatment seeking pattern in the de-addiction centres of India [9]. However, cannabis use is relatively more prevalent (23%) in the psychosis group. This finding is also in line with the literature across the world [10-12]. Opioid (non-psychotic-26% and psychotic-28%). and nicotine (non-psychotic-16% and psychotic-15.6%) use was equally prevalent in both the groups. Mean duration of outpatient follow up was 2.6 months. There has been a high attrition rate (24%) following detailed evaluation (after the first 2 visits). Those who remained in the treatment net, significant proportion (45.7%) of patients were improved. High dropout rate has also been observed in the studies from the US and the rate of dropout after first contact is as high as 42% [13]. Half of the subjects were failed to be engaged in the treatment because of their short follow up duration [13].

This was a chart based retrospective review which is always marred with the problem of limited amount of data, and lack of corroboration. Hence, longitudinal studies are needed to explore this area further. Our results are not generalizable to primary care and community settings. However, this study has provided an overview of the profile of patients with dual diagnosis in a substance use treatment centre. In our mind, this would help in planning and delivering adequate and optimal services for this group of patients. In future more studies are needed to look at the service related aspects of an integrated dual diagnosis clinic in an Indian context.

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