Substance Misuse in Depression and Bipolar Disorder: A Review of Psychological Interventions and Considerations for Clinical Practice.

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Review Paper

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Abstract

Research has documented high levels of co-morbidity between mental illness and substance misuse. This essay explores clinical practice issues relating to 'dual diagnosis' substance misuse in bipolar disorder and depression. Such misuse is common in this population, and presents a number of challenges to clinicians. Those with substance misuse have more severe symptoms and an increased risk of relapse. Assessment is complicated by factors such as a lack of standardised measures specifically for use with dual diagnosis clients. The effectiveness of specific psychological interventions for this population is somewhat unclear, though integrated interventions where both problems are treated together are often used. CBT has been used with depression and substance use though its effectiveness with bipolar is unclear, and motivational interviewing is often used as a supplement to this. Integrated group interventions are being developed and appear to be superior to groups focusing on substance use alone. Other therapeutic such as Acceptance and Commitment therapy are starting to be developed for use with dual diagnosis clients. A number of variables predict outcome from interventions, and there may be considerable gender differences which need to be taken into account. At present integrated dual diagnosis services are developing slowly within the National Health Service though there have been some notable service innovations in recent years. It is concluded that those with substance misuse in addition to bipolar disorder or depression need to be given special clinical consideration, though more research on how this can be effectively done is needed.

Keywords: Bipolar Disorder, Depression, Substance Misuse, Drug Misuse, Psychological Interventions.

Introduction

In recent years there has been an increasing recognition that those with mental illness are at increased risk of having 'co-morbid' drug and alcohol problems, known collectively as 'substance misuse'. 'Dual diagnosis' is often used to refer to those with mental illness and substance misuse. Those with substance misuse may experience problems in functioning, put themselves in danger from their misuse and continue to use despite these negative problems (American Psychiatric Association, 2000). Those with 'dependence' develop tolerance and experience withdrawal symptoms, and have previously unsuccessfully tried to reduce their use (APA, 2000).

Those with dual diagnosis present a number of challenges to mental health professionals. This essay will discuss clinical practice issues relating substance misuse in bipolar disorder and depression. Depression is characterised by feelings of sadness, reduced interest in usual activities, sleep disturbances and loss of energy (APA, 2000). Those with bipolar disorder experience episodes of mania (Bipolar I disorder) or hypomania (Bipolar II disorder), usually with episodes of depression (APA, 2000). Hypomania and mania are characterised by symptoms such as impulsivity, racing thoughts, elevated mood and reduced need for sleep (APA, 2000).

This essay will discuss the challenges of working with clients with bipolar disorder or depression and co-morbid substance misuse, by emphasising the differences between those with and without substance misuse. The effect of substance misuse on symptoms and the complexities of assessment with this population are discussed, and current research on psychological interventions will be evaluated. Finally, other clinical considerations such as

service issues will be discussed in order to illustrate the complexity of working with this population.

Epidemiology of dual diagnosis

Prevalence of co-morbidity

Research has shown that people with depression are four times as likely to have alcohol problems (Grant & Harford, 1995), and those with bipolar disorder are eleven times more likely to have substance misuse disorders than those with no mental health problems (Regier et al., 1990). Bipolar disorder has higher levels of co-morbid substance misuse than any other Axis 1 mental illness (Regier, et al., 1990). A third have a current problem (Bauer et al., 2005), and the majority have had problems with drug or alcohol at some point in their lives (Bauer, et al., 2005; Levander et al., 2007). Research has also shown relationships between substance misuse and symptoms of depression (Van Laar, Van Dorsselaer, Monshouwer, & De Graaf, 2007), mania (Henquet, Krabbendam, de Graaf, ten Have, & van Os, 2006) and hypomania (Richardson & Garavan, 2011), in the general population. In addition depression is present in 25% of those with alcohol dependence (Lyne, O'Donoghue, Clancy, & O'Gara, 2011), and 43% of those with cocaine misuse (Brown et al., 1998). Thus there are high levels of substance misuse in those with depression and bipolar disorder, and high levels of depression in those with substance problems, suggesting co-morbidity is common in a range of clinical settings.

Theoretical Explanations of Co-Morbidity

A number of theories attempt to explain the relationship between mental illness and drug and alcohol misuse (Mueser, Drake, & Wallach, 1998). Firstly, there are common factors, such as low socio-economic status, which increase vulnerability to both mental illness and substance

misuse. Secondly, those who are high risk for mental health problems have their initial symptoms triggered by substance misuse. Finally, drug and alcohol could be misused in an attempt to self-medicate symptoms of mental illness (Mueser, et al., 1998). Strakowski and DelBello (2000) review potential explanations for bipolar and substance misuse co-morbidity and conclude that all possible explanations seem to play a part. Though it is somewhat unclear why there are such high levels of co-morbidity, it is clear that those with substance misuse present a number of challenges to clinicians. This essay will now explore such challenges by examining the impact of substance misuse on those with depression and bipolar disorder.

Impact of Substance Misuse

Effect on symptom severity and relapse

Research has demonstrated that those with depression and substance misuse have more severe symptoms and have been symptomatic for longer (Howland et al., 2009), with half the likelihood of long-term recovery (Mueller et al., 1994), than those with depression only. Similarly, those with bipolar disorder and substance misuse have slower and poorer recovery from an acute affective episode (Gaudiano, Uebelacker, & Miller, 2008; Goldberg, Garno, Leon, Kocsis, & Portera, 1999; Weiss et al., 2005). Substance misuse also leads to an increased risk of relapse and rapid cycling (Ostacher et al., 2010), as well as severe mania and an increased likelihood of psychosis (van Rossum et al., 2009). This negative impact is seen even in those with remitted substance misuse (Gaudiano, et al., 2008). Thus those with substance misuse have more severe mood symptoms and an increased risk of relapse, suggesting the need for psychological interventions that address substance misuse.

Importance of Self-medication

Those with depression and bipolar disorder often misuse substances for self-medication of symptoms, and use specific drugs in attempt to alleviate specific symptoms (Blume, Schmaling, & Marlatt, 2000; Weiss et al., 2004), or cope with stress (Healey, Peters, Kinderman, McCracken, & Morriss, 2009). Importantly such beliefs about substance misuse appear to increase the risk of problematic use; Johnson and Gurin (1994) found that the co-morbidity between depression and alcohol dependence was higher in those who believed alcohol would elevate their mood. Similarly drinking to cope in those with depression has been found to predict increased alcohol misuse 10 years later (Holahan, Moos, Holahan, Cronkite, & Randall, 2003). It has therefore been suggested that unrealistic beliefs about the effectiveness of self-medication need to be assessed and tackled in therapy (Blume et al., 2000).

Other correlates of substance misuse

Those with bipolar disorder and alcohol dependence have poorer neuropsychological functioning (Shan et al., 2011), raising questions for ability to engage in therapy. There is also elevated impulsivity (Holmes et al., 2009), suggesting that interventions to tackle this may be useful. Substance misuse in bipolar disorder is linked to lower quality of life (Weiss, et al., 2005), poorer occupational functioning (Goetz et al., 2007), higher levels of aggression (Grunebaum et al., 2006), frequent suicide attempts and earlier symptom onset (Richardson, 2011). Alcohol misuse elevates suicide risk in those with depression (Yaldizli, Kuhl, Graf, Wiesbeck, & Wurst, 2010) and bipolar disorder (Comtois, Russo, Roy-Byrne, & Ries, 2004). Those with substance misuse are therefore high risk and may require more intense intervention and monitoring. There is also an increased likelihood of having a co-morbid anxiety disorder (Richardson, 2011), or personality disorder (Mazza et al., 2009), so appropriate psychological interventions for these may be needed. Finally, there appear to be

demographic differences; bipolar patients with drug and alcohol problems are younger and predominantly male and unmarried (Richardson, 2011). Richardson (2011) suggests that these demographic variables may be used to identify those who are high risk for the development of substance misuse so that preventative interventions can be employed.

Medication Issues

Medication is recommended by the National Institute of Clinical Excellence (NICE) for bipolar disorder (NICE, 2006) and severe or treatment resistant depression (NICE, 2009). However, those with co-morbid substance misuse are less compliant with medication regimes (van Rossum, et al., 2009), and have a greater risk of complications such as anti-depressant induced hypomania (Goldberg & Whiteside, 2002). There are few controlled trials on the effectiveness of medications for depression or bipolar disorder with substance misuse (Azorin et al., 2010; Torrens, Fonseca, Mateu, & Farré, 2005), and medications for depression and substance misuse are more effective when psychosocial interventions are also used (Nunes & Levin, 2004). Therefore there is an increased need for psychological interventions with this population. This essay will now look at issues relating to diagnosis and assessment in this population.

Assessment and Diagnostic Issues

Primary/Secondary Distinction

Whilst the term ‘dual diagnosis’ suggests an equal emphasis on the mood disorder and substance misuse, diagnostic classification systems rely on defining a primary and secondary diagnosis (APA, 2000). However, research has found that the primary/secondary distinction does not predict outcomes from treatment (Hasin, Trautman, Miele, & Samet, 1996), and whether the mood disorder or substance misuse is dominant changes over time (Crum,

Brown, Liang, & Eaton, 2001). Thus it has been suggested that interventions should focus on impaired functioning and distress regardless of specific diagnoses or models of aetiology (Schuckit et al., 1997).

Challenges in Assessment

Substance misuse is often missed in those with mental health problems (Weaver et al., 2003). Conversely, those using cocaine are frequently incorrectly diagnosed with bipolar disorder on the basis of mood instability (Goldberg et al., 2008), which is a feature of both bipolar disorder and dependence. There is also overlap between the symptoms of depression and drug withdrawal, so separating the symptoms is complex (Myrick & Brady, 2003). Incorrect assessments are often made when mood symptoms are assessed before detoxification (Goldberg, et al., 2008), so it is important to conduct assessments when patients are stable in mood and not under the influence (Whicher & Abou-Saleh, 2007).

Research has shown that both mood symptoms and substance misuse are under-reported in the general population (Andrews, Henderson, & Hall, 2001). However, work with dual diagnosis populations has shown that discrepancies between self-report and urine tests occur less than 5% of the time (Weiss et al., 2007; Weiss et al., 1998). It has been suggested that self-report is more accurate when patients are not psychotic, with familiar staff, and where honesty about misuse is encouraged (Weiss, et al., 1998). Collateral reports from friends and family are often used to assess substance misuse; however research suggests that asking families may be of little value compared to self-report (Weiss, Greenfield, Griffin, Najavits, & Fucito, 2000).

Assessment needs to determine the age of onset of problems in order to determine whether mood symptoms or substance misuse came first (Kay-Lambkin, Baker, & Carr, 2007). Due to high suicide risk (Comtois, et al., 2004; Yaldizli, et al., 2010) a risk assessment is vital. Discussing the frequency and duration of misuse may help identify triggers, and examining how substance misuse affects mood is important in developing a formulation (Kay-Lambkin, et al., 2007).

Psychometric Tools

The utility of commonly used psychometric tools with dual diagnosis patients is unclear. Tools such as the 'Chemical Use, Abuse and Dependence scale' and 'Dartmouth Assessment of Lifestyle Instrument' have adequate sensitivity and specificity in detecting substance misuse in those with mental illness (Appleby, Dyson, Altman, McGovern, & Luchins, 1996; Rosenberg et al., 1998). The 'Psychiatric Research Interview for Substance and Mental Disorders' has been found to be reliable for detecting affective disorders in those with heavy drug and alcohol misuse (Hasin, et al., 1996).

The 'Beck Depression Inventory' (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) can be used to distinguish substance misuse patients with or without depression (Lykke, Hesse, Austin, & Oestrich, 2008), though it may have good sensitivity but poor specificity (Holtzheimer et al., 2010). A modified version (Beck, Steer, & Brown, 2000) has a reduced focus on somatic symptoms, and therefore may have less overlap with substance withdrawal and be more appropriate for those with dual diagnosis (Kay-Lambkin, et al., 2007). A modified version of the 'Hamilton Depression Rating Scale' has good reliability when used with those with bipolar disorder and substance misuse (Kolodziej, Griffin, Bender, & Weiss, 2008). The 'Centre for Epidemiological Studies Depression Scale' has limited overlap with

substance misuse symptoms and can be used to detect depression, though it may be more accurate for those using alcohol than drugs (Eaton, Smith, Ybarra, Carles, & Tien, 2004). The 'Substance Abuse Treatment Scale' can be used to assess treatment progress in those with dual diagnosis (McHugo, Drake, Burton, & Ackerson, 1995), and measures of readiness to change can be used with dual diagnosis patients (Nidecker, DiClemente, Bennett, & Bellack, 2008). Thus a number of questionnaires have been developed for use with dual diagnosis clients specifically, though for some questionnaires the reliability is unclear at present. This essay will now explore the effectiveness of specific psychological interventions for this dual diagnosis population.

Psychological Interventions

Integrated Interventions

In recent years interventions have changed from treating substance misuse and mental health separately to treating them together (Watkins, Hunter, Burnam, Pincus, & Nicholson, 2005). Farren and McElroy (2008) have developed such an 'integrated' inpatient programme for those with bipolar or depression and substance misuse. This includes detoxification and mood stabilisation, followed by psychoeducation, individual therapy and group sessions with a relapse prevention focus. A case series demonstrated this intervention reduced substance misuse and improved affective symptoms (Farren & McElroy, 2008).

Some reviews have concluded that integrated interventions are more effective than separate interventions (Drake & Mueser, 2000; Reedy & Hall, 2008). Though those with depression and substance misuse can be given addiction treatment alongside those with substance misuse alone (Galanter, Egelko, Edwards, & Katz, 1996), those with depression have more severe dependence (Burns, Teesson, & O'Neill, 2005; Leventhal, Mooney, DeLaune, & Schmitz,

2006), higher levels of drop-out (Brown, et al., 1998) and poorer outcomes from addiction treatment (Brown, et al., 1998; Burns, et al., 2005; Curran, Booth, Kirchner, & Deneke, 2007; Dodge, Sindelar, & Sinha, 2005). Thus whether those with depression can be treated using standard substance dependence interventions is unclear.

Research suggests that integrated interventions for bipolar disorder reduce substance misuse but have little impact on affective symptoms (Drake, Xie, McHugo, & Shumway, 2004). Due to little research and methodological limitations there is insufficient evidence at present to support the effectiveness of integrated interventions over treating substance misuse alone (Donald, Dower, & Kavanagh, 2005; Hesse, 2009). Despite this a number of specific integrated interventions have been developed.

Cognitive Behaviour Therapy

Cognitive Behaviour Therapy (CBT) is recommended for bipolar disorder (NICE, 2006) and Depression (NICE, 2009). However, many randomised controlled trials exclude those with current (Lam, Hayward, Watkins, Wright, & Sham, 2005; Lam et al., 2003), or past (Kessler et al., 2009) substance misuse. Recent research has begun to adapt CBT for those with co-morbid substance misuse, using CBT to address thoughts and behaviours which underlie both mood and substance problems. These include elements such as mood, substance misuse and craving monitoring, scheduling activities unrelated to drug misuse, working on automatic thoughts, problem solving, relapse prevention, and social skills and assertiveness training (Baker & Velleman, 2009; Brown, Evans, Miller, Burgess, & Mueller, 1997; Lydecker et al., 2010). It has been suggested that an important component should be testing beliefs about the effectiveness of self-medication (Blume et al., 2000)

Research has shown that integrated CBT reduces both substance misuse and depression (Lydecker, et al., 2010), more so than focusing on either depression or substance misuse (Baker et al., 2010). CBT has also been found to improve depression in those with alcohol dependence (Brown, et al., 1997) and amphetamine misuse (Bauer, et al., 2005). A computerised CBT intervention has been found to be effective for those with depression and alcohol or cannabis problems (Kay-Lambkin, Baker, Lewin, & Carr, 2009). Work suggests that improvements in depression are related to reduced substance misuse (Baker et al., 2005), and an increased perceived ability to cope with low mood without drinking (Ramsey, Brown, Stuart, Burgess, & Miller, 2002). This suggests that work on beliefs about alcohol misuse and self-efficacy to control mood should be key components of CBT interventions. Despite encouraging results from individual studies, a recent systematic review concluded that the efficacy of CBT for depression with substance misuse is relatively unclear at present (Hides, Samet, & Lubman, 2010).

There is even less research examining the effectiveness of CBT for bipolar disorder with substance misuse. Schmitz et al. (2002) found that CBT improved medication compliance, reduced treatment drop-out and moderately improved in affective symptoms. However, substance misuse was not reduced (Schmitz et al., 2002). Thus integrative CBT interventions have been developed but their evidence base is limited at present.

Motivational Interviewing

Motivational Interviewing (MI) has been adapted for those with dual diagnosis, with a focus on the pros and cons of change, and the relationship between mental health and substance misuse (Martino, Carroll, Kostas, Perkins, & Rounsaville, 2002). Such motivational techniques have been found to increase appointment attendance in those with dual diagnosis

(Swanson, Pantalon, & Cohen, 1999), and reduce alcohol misuse in psychiatric inpatients (Hulse & Tait, 2002). There has been little work applying this specifically to depression or bipolar disorder, though a small study without a control group showed that MI for those with cocaine dependence and depression increased treatment adherence (Daley, Salloum, Zuckoff, Kirisci, & Thase, 1998). MI components have also been used alongside CBT for those with mood and substance misuse problems (Baker & Velleman, 2009; Kay-Lambkin, et al., 2009). A systematic review concluded that MI is the most effective intervention for reducing substance misuse in those with dual diagnosis, and combining this with CBT also improves mental health (Cleary, Hunt, Matheson, & Walter, 2009). Thus MI may be useful to reduce drop out and improve substance misuse outcomes as part of a wider intervention.

Group Interventions

Group interventions developed for dual diagnosis can lead to improvements in both substance misuse and mental health (James et al., 2004). An integrated CBT group intervention has been developed specifically for those with depression and substance misuse (Osilla, Hepner, Munoz, Woo, & Watkins, 2009), though its effectiveness has not yet been studied. Weiss, Najavits and Greenfield (1999) developed a 20-week relapse prevention group for those with bipolar disorder and substance misuse, which aimed to provide education, peer support and enhance motivation. An important component of these group interventions is the idea that similar thinking and behaviour patterns underlie both mood and drug problems (Weiss, 2004; Weiss, et al., 2007). The authors have tried to encourage such an integrative view by asking participants to consider themselves as having a diagnosis of 'bipolar substance misuse' (Weiss, 2004). This integrative focus includes discussing the effect of drug misuse on mood, coping with high risk situations and alternative ways to cope with mood symptoms (Weiss, et al., 1999).

This group intervention has been found to reduce addiction severity and increase the likelihood of abstinence (Weiss et al., 2000). Whilst it leads to more pronounced improvements than group drug counselling on substance misuse outcomes, there is no difference on bipolar severity (Weiss, et al., 2007). A shortened version of this intervention has been shown to be superior to group drug counselling in reducing misuse (Weiss et al., 2009). It also reduced the risk of a depression relapse by 70%, though the impact on mania was not as pronounced (Weiss, et al., 2009). This group intervention has been found to lead to improvements only in those who use drugs to self-medicate their affective symptoms (Weiss, et al., 2004). Thus it has been suggested that such interventions should be targeted at those who believe that substance misuse helps their mood (Weiss, et al., 2004).

Other approaches

A behavioural intervention where those with depression are given vouchers for attendance has been found to improve depression but not drug misuse (Carpenter, Aharonovich, Smith, Iguchi, & Nunes, 2006). Brief sessions and phone contact with the client and their family improve medication adherence in those with bipolar and substance misuse (Gaudiano, Weinstock, & Miller, 2011). Acceptance and Commitment Therapy has been adapted for use with depression and co-morbid alcohol misuse, though a small study showed improvements in depression were not greater than treatment as usual (Petersen & Zettle, 2009). As substances are often misused to cope it has been suggested that teaching distress tolerance skills may be of use (Blume et al., 2000). This could be done using Dialectical Behaviour Therapy, which has shown promise when used with those with borderline personality disorder and co-morbid substance misuse (Linehan et al., 1999; van den Bosch, Verheul, Schippers, & van den Brink). Mindfulness-Based Cognitive Therapy (MBCT) is

recommended for this with treatment resistant depression (NICE, 2009), and has shown promise for bipolar disorder (Weber et al., 2010; Williams et al., 2008). A number of authors have suggested that MBCT may be useful for depression with substance misuse (Brewer, Bowen, Smith, Marlatt, & Potenza, 2010; Kay-Lambkin, et al., 2007). Mindfulness components have been included in CBT interventions (Baker, et al., 2010), and an MBCT intervention has been developed specifically for those with co-morbid mood disorders and substance misuse (Hoppes, 2006). However as of yet there are no trials assessing its effectiveness. Thus a number of therapeutic techniques may be helpful but have yet to be evaluated in relation to this specific dual diagnosis population. There are a number of additional considerations for clinical practice which will now be examined.

Considerations for Clinical Practice

Detoxification and Abstinence

Polysubstance misuse is common in those with dual diagnosis (Gual, 2007). Some interventions require detoxification prior to therapeutic work (Farren & McElroy, 2008), whilst others allow use so long as clients are not under the influence in sessions, and therapy is scheduled for times when substance misuse is unlikely (Carroll et al., 2009). It has been suggested that demanding abstinence prior to therapy will create a 'revolving door' scenario and reduce help-seeking, thus the goal of total abstinence may be unrealistic for those with dual diagnosis and the focus should be on harm reduction (Blume et al., 2000).

Predictors of outcome

Outcomes after dual diagnosis are better for those with higher cognitive functioning (Hunt, Baker, Michie, & Kavanagh, 2009), suggesting that those with poor functioning should be offered more intense treatment and monitored carefully. Outcomes are also improved in those

with higher levels of social support (Warren, Stein, & Grella, 2007), and higher self-efficacy (Glasner-Edwards et al., 2007; Warren, et al., 2007). Thus work on social skills, and attempts to increased perceived self-efficacy over problems may be effective. Longer time spent in treatment and higher attendance also predicts greater improvements (Lydecker, et al., 2010; Warren, et al., 2007) so motivational interventions to increase attendance are important.

Outcomes are poorer for those who are younger (Farren & McElroy, 2008; Graff, Griffin, & Weiss, 2008), less educated (Graff, et al., 2008), unemployed (Farren & McElroy, 2010) or from an ethnic minority group (Carpenter, et al., 2006). Those who have more severe affective symptoms (Farren & McElroy, 2008), or a recent mood episode (Graff et al., 2008) also have poorer outcomes indicating the importance of a stable mood prior to intervention. High levels of anxiety or a co-morbid anxiety disorder (Farren & McElroy, 2010; Howland, et al., 2009; Nomarniukor & Brown, 2009), appear to impair outcome so psychological interventions to improve anxiety may be efficacious. Those who have more severe substance misuse show less benefit from treatment (Graff, et al., 2008; Nomarniukor & Brown, 2009; Stein et al., 2004; Warren, et al., 2007), indicating closer monitoring to prevent relapse. A measure of craving, the 'Obsessive Compulsive Drinking Scale' (Anton, Moak, & Latham, 1996) has been found to predict relapse in those with depression or bipolar disorder and alcohol problems (Farren & McElroy, 2010), thus this could be used to identify high risk clients. Stresses such as relationship and housing problems predict relapse in those with depression and substance misuse (Tate et al., 2008), thus coping skills to deal with these are important. Finally, the majority of relapses occur within two months after treatment (Tate, et al., 2008), so close monitoring after discharge and booster sessions are indicated.

Gender differences

A number of gender differences are present in those with dual diagnosis. Men under-report mood symptoms, whilst women under-report substance misuse (Andrews, et al., 2001). Men are more likely to be using drugs rather than alcohol (Westreich, Guedj, Galanter, & Baird, 1997), and have more severe problems with a greater likelihood of poly substance misuse (Comtois & Ries, 1995). On the other hand women are less likely to attend groups (Comtois & Ries, 1995). In those with depression and alcohol problems, if integrated interventions are not available then women respond better to a focus on depression, whereas men respond better to a focus on alcohol (Baker, et al., 2010). Thus different interventions may be required based on gender.

Service level issues

Mental health problems are common in drug and alcohol services, but are rarely documented (Cole & Sacks, 2008), whilst substance misuse is common but often missed in mental health settings (Weaver et al., 2003). Weaver et al. (2003) found that 44% of those seen by Community Mental Health Teams (CMHTs) had substance misuse, and 75% of those in drug and alcohol services had a mental health problem, but these were rarely detected. Research suggests that there are often few differences between dual diagnosis patients presenting to either mental health or addiction services (Havassy, Alvidrez, & Owen, 2004). Thus those with dual diagnosis can present to both mental health and addiction services.

Dual diagnosis services are developing slowly in the U.K. National Health Service (NHS), perhaps due to no specific models being identified in the National Service Framework (Lowe & Abou-Saleh, 2004). The Department of Health (2002) suggests that those with dual diagnosis should be offered integrated care within mental health services, with specialist addiction support only when essential as moving between services may increase the risk of

drop out. The NICE guidelines for bipolar disorder similarly state that co-morbid substance should be treated within mental health services (NICE, 2006).

The Department of Health (2002) suggests that staff in mental health settings should be given dual diagnosis training, indicating a training role for clinical psychologists and other dual diagnosis specialists. Such training has been offered to some U.K. assertive outreach teams with beneficial effects (Graham, 2004; Graham et al., 2006). Recent dual diagnosis service innovations of note include the COMPASS service in Birmingham which combines psychosis and substance misuse treatment (Graham et al., 2003) and the Haringey dual diagnosis service which aims to bring dual diagnosis insights to mental health teams, and help transfer between services (Lowe & Abou-Saleh, 2004).

Summary of Clinical Implications

Co-morbid substance misuse is common in depression and bipolar disorder and is associated with a number of negative outcomes. Thus it is important to screen those with depression and bipolar disorder for drug and alcohol misuse. Increased suicide risk, aggression, psychosis and impulsivity require close monitoring and appropriate risk assessments to be conducted. Those who are male, younger, unmarried, and have an anxiety or personality disorder are especially high risk for substance misuse and appropriate preventative interventions may be warranted.

It may be unclear what the 'primary' problem is though this is of limited importance for therapy. Assessments are best completed during times of stable mood and no acute intoxication. Self-report is usually accurate if patients are stable and collateral reports may have little additional benefit. Care is required when using standardised measures as many

have not been validated for use with dual diagnosis populations. Only appropriately validated measures such as the 'Chemical Use, Abuse and Dependence scale' should be used to screen for substance misuse in those with mental illness. In those with substance misuse, depression should be screened for using specifically modified versions of questionnaires such as the 'Hamilton Depression Rating Scale'.

Evidence is somewhat limited at present, but integrated interventions where mood symptoms and substance misuse are tackled together may be effective. Integrated CBT can be used with depression and substance misuse but there is little work relating to bipolar disorder. CBT appears to be especially effective if beliefs about substance misuse and self-efficacy are targeted, and motivational interviewing should be used as in addition to psychological therapy. Group interventions which use psychoeducation and peer support with a relapse prevention approach appear to be effective though the evidence is better for bipolar disorder than depression. These should include assertiveness and social skills training, and try to tackle beliefs about the effectiveness of self-medication. Other approaches such as MBCT need to be specifically adapted and researched before use with this population.

Clinicians' should emphasise harm reduction rather than total abstinence, though acute intoxication may interfere with therapy. Relapse is common and ongoing monitoring and care is required. Those with poor cognitive functioning, younger, of low socio-economic or ethnic minority status may have poorer outcomes so require extra intervention. More severe affective symptoms also lead to poorer outcomes so stabilisation of mood prior to intervention is warranted. Addiction severity and craving should also be assessed as they increase the risk of relapse. Clinicians' should be aware of gender differences and may need to focus more on substance misuse in men. Finally, integrated care should be offered within

CMHTs where possible, though staff in all clinical settings should be trained in dual diagnosis.

Conclusion

This essay has explored issues relating to working with co-morbid substance misuse in those with depression and bipolar disorder. Conclusions are limited to an extent as some issues discussed here relate to dual diagnosis in general, and there is often little research on depression and bipolar disorder specifically, despite the high levels of co-morbidity in this population. Previous reviews have similarly concluded that there is insufficient work on the effectiveness of dual diagnosis interventions for specific mental health problems (Tiet & Mausbach, 2007). In addition some therapeutic techniques have not yet been adapted for dual diagnosis work. Research so far often suffers from methodological problems such as short follow-up periods and small samples (Horsfall, Cleary, Hunt, & Walter, 2009).

However it is clear that substance misuse is common in depression and bipolar disorder, and such misuse has a number of negative effects. Co-morbid substance misuse therefore poses a number of challenges to clinicians, and the differences between those with and without substance use need to be taken into account. The necessity of integrated treatment is currently ambiguous and the effectiveness of a number of dual diagnosis interventions is unclear due to little research. Similarly dual diagnosis services in the U.K. are developing slowly and where such clients fit within the NHS is somewhat uncertain at present. Additional research on depression and bipolar disorder specifically will help better understand the clinical implications of dual diagnosis and assist the development of specific assessment and intervention techniques for this population. This will allow in turn for the development of more effective dual diagnosis services.

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