The prevalence of co-existing substance misuse and psychiatric disorder (dual diagnosis, comorbidity) has increased over the past decade, and the indications are that it will continue to rise.

In recent years there have been unprecedented developments in the pharmacological treatment of alcohol, opiate and nicotine misuse. In this module we have evaluated the evidence on the use of some of these treatments in dual diagnosis (with psychotic, mood and anxiety disorders). The evidence base is limited by the exclusion of mental illness when pharmacological agents for substance misuse are evaluated and vice versa.

Key facts about dual diagnosis

- About 30% of patients with mental health problems have a substance misuse problem as well.
- Substance misuse is overrepresented among those who commit suicide.
- Recognition and treatment of depression is the single most important intervention in reducing suicidal behaviour.
- Alcohol dependence is linked with anxiety, depression and bipolar disorder.
- Prevalence of independent rather than concurrent depression in alcohol dependence is not higher than in the general population.
- Medication non-compliance, substance abuse and severe mental illness are linked to violent behaviour.
- Bipolar disorder has the greatest risk of any Axis 1 disorder for co-existence of an alcohol or drug disorder.

Notes about treatment

- Patients presenting with depression complicated by substance misuse pose particular challenges in their management.
- Their depressive symptoms are very likely to be caused or exacerbated by their substance misuse.
- In alcohol misuse, a one-month period of abstinence and then further evaluation are recommended before the commencement of pharmacotherapy.
- Opiate users should be stabilised before pharmacotherapy.

British Association of Psychopharmacology guidelines

- The BAP guidelines for the treatment of substance misuse, addiction and comorbidity with psychiatric disorders are presented as recommendations to aid clinical decision-making for practitioners alongside a detailed review of the evidence.

**Recommendations**

- Antidepressants may improve mood but may not affect drinking behaviour.
- SSRIs are the drugs of choice in severely depressed patients who are drinking.

**To be avoided**

- TCAs are not recommended because of the risk of interactions with alcohol, which may result in cardiac problems or death from overdose.
• **Uncertainties**
  - There is no clear evidence on what doses of SSRI to use and for how long.
  - There is no clear evidence of the effectiveness of drugs such as mirtazapine and venlafaxine.
  - There is no clear evidence on the best approach for treatment-resistant depression in this group.

**Conclusions**

- Having an alcohol problem is no reason for not treating depression. However, the diagnosis of depression should be made following a period of abstinence to enable the diagnosis to be accurate.
- The BAP guidelines are very clear that the first-line pharmacological treatment is SSRIs, and that tricyclic antidepressants carry a high risk, particularly in this patient group.
- In terms of the management of people with comorbidity, depression, anxiety, and alcohol or drug problems, treatment should be undertaken by mainstream general psychiatrists, but with active support from specialist addiction services.

**Further reading**

