SPEAKER NOTES

Issues Surrounding Dual Diagnosis

Summarized by Thomas T. Thomas

The devastation of mental illness often co-occurs with the disorder of substance abuse, and this is generally referred to as "dual diagnosis." Bonita House, Inc. in Berkeley specializes in programs providing a humane, cost-effective alternative to institutional care for people working to recover from serious psychiatric and substance abuse disorders. The speaker at our May 27 meeting, **Mark Shotwell, CATC, CAADE,**[1] is program director for Bonita House's Homeless Outreach and Stabilization Team (HOST), which is funded under the Mental Health Services Act (MHSA), and is an expert in treating dual diagnosis clients.

Shotwell has worked in mental health services for 15 years, he said, and before that he was himself a consumer of mental health and substance abuse services in Alameda County. Bonita House had been a residential treatment center for mental health services until 1992, when it converted to treat patients with dual diagnosis.

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"In general," Shotwell said, "the profession has not done a good job of serving people with serious mental illness and substance abuse. The reason is the lack of a comprehensive assessment." Mental health workers are focused on the diagnosis and see substance abuse as a symptom—self-medication—while substance abuse professionals may be aware of the person's mental health issues but are not trained in screening, assessment, and treatment.

"For example," he said, "there's a myth that Medi-Cal won't pay for substance abuse treatment, but that's not true. You can get treatment if there's a co-occurring disorder." He noted that, anecdotally, more than 50% of people with mental health issues also have substance abuse issues.

Mental disorders like schizophrenia were once thought to be irreversible, lifelong conditions. Shotwell discussed studies by Courtney Harding of the University of Colorado and others that tracked patients released in the 1960s who, twenty years later, were determined to be living without symptoms, showing that recovery is possible. "The brain is plastic," he said, "and people tend to get better."

Alameda County Behavioral Health Care Services (BHCS) now has a Co-Occurring Disorders Initiative whose scope includes any two disorders, which may be mental illness and substance abuse but might also be chronic homelessness or disability. Traditionally, consumers with co-occurring disorders have been considered "difficult" patients, but Shotwell described this as blaming the person for failure to recover.

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There are several models of treatment for co-occurring disorders. One is **parallel treatment,** in which the consumer gets treatment for his or her mental health issues and substance abuse at the same time but not necessarily in the same place or in a coordinated fashion. This can lead to difficulties such as the mental health provider requiring the consumer to be clean and sober for 30 to 90 days before prescribing psychiatric medication. (In reality, Shotwell said, it's not necessary to stop using in order to benefit from medication.) And the substance abuse provider may define all medications as unacceptable. (However, he noted, the world view of Alcoholics Anonymous and Narcotics Anonymous accepts medications needed for physical and mental conditions.)

A second model is **sequential treatment,** in which the providers will not attempt to treat the consumer for one problem until he or she takes care of the other. This approach does not address the underlying problem.

The recommended approach is **integrated dual diagnosis treatment (IDDT),** which has the goal of providing a continuous, comprehensive, integrated system of care. This approach is usually more difficult because of the differences in the two systems: substance abuse providers think in terms of 30 to 90 days of intensive care followed by a maintenance program, while mental health providers think in terms of continuous care and ongoing case management.

IDDT relies on evidence-based practices, such as illness management and recovery, supported employment, assertive community treatment, family psychoeducation, and medication algorithms.[2] However, Shotwell noted that there is often a 20 year gap between a finding of what works as a best practice and actual implementation in the field. For more information on each of these practices, see the U.S. Health & Human Services Substance Abuse and Mental Health Service Administration's (SAMHSA) website at:
http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits.

Alameda County has asked its practitioners to become change agents in implementing IDDT according to the principles of Kenneth Minkoff, MD, of Harvard Medical School. These principles include:

- Making dual diagnosis an expectation rather than an exception;
- Considering both mental illness and substance abuse as primary diagnoses requiring treatment, and considering either to be "secondary" only if it resolves when the comorbid condition is baseline;
- Recognizing that both are chronic, biologic mental illnesses that fit into a disease and recovery treatment model;
- Recognizing that there is no one type of dual diagnosis program, and that for each patient the proper treatment depends on the specific diagnosis, phase of recovery, level of acuity, severity, and disability, and motivation for treatment for each disease;
- Recognizing that addiction treatment is basically similar in both psychiatric and non-psychiatric populations but requires modification for individuals with psychiatric disabilities and disorders; and

[2] Medication algorithms are used to prescribe based on the patient's diagnosis, age, demographics and other conditions, as opposed to prescribing on the basis of trial and error.

- Recognizing that the best predictor of success in treatment is an empathetic, hopeful, continuous relationship in which integrated treatment and coordinated care take place through multiple treatment episodes.

In the role of change agents, practitioners learn about other parts of the county's system, share substance abuse information to mental health hospitals, have substance abuse providers attend discharge meetings, and make sure incoming patients are not "sent through the wrong door."

Shotwell advocated "stage-appropriate interventions," recognizing that not all substance abusers or persons with mental illness were ready to accept treatment. In the **pre-contemplation stage,** the person may not accept that he or she has a problem. The goal of a potential provider is then to find a motivation—such as getting housing for a homeless person—that will lead the person to treatment. In the **contemplation stage,** the person recognizes a need for change, which can then lead to the stages of **action, relapse prevention,** and **maintenance.**

Shotwell also recognized the different approaches to substance abuse: harm reduction—that is, channeling the consumer into less debilitating patterns of usage—as opposed total abstinence. The choice does not have to be either-or, he said, and depends on what stage of treatment the person is in. It's also important for the dual diagnosis patient to be familiarized with Twelve Step programs, so that he or she is able to deal with the information acquired at meetings and learns how to use the steps. It's often best to refer the person to a dual-friendly group or fellowship, or to Dual Recovery Anonymous.

Family advocacy is also important in treating dual diagnosis, as the family member can provide the practitioners with information about the patient's history of illness, pattern of symptoms, type of usage, and instances of sobriety and abstinence.

The Mental Health Services Act was intended to reach out to people who were previously unserved or underserved, Shotwell said, and that includes people with dual diagnosis. Most California counties now have co-occurring disorders as a top priority for system transformation and offer full-service partnerships like HOST and education of the service teams and the mental health workforce in general in the principles of integrated dual diagnosis treatment.