

In-patient treatment for dual diagnoses

It is unrealistic to expect stable motivation for change among patients with a dual diagnosis. They need help with both substance abuse and mental disorders even though they continue their substance abuse, or with the substance abuse even though they refuse other treatment. We therefore never discharge patients who take intoxicants during their stay in our in-patient department.

■ Patients suffering from both serious mental disorders and substance abuse – especially those with extensive functional problems – have for some time been offered extremely unsatisfactory treatment. This recognition resulted in the establishment of an interdisciplinary unit for dual diagnosis at Vinderen District Psychiatric Centre in Oslo in 2007 – so far the only dual-diagnosis programme at a district psychiatric centre.

Dual diagnosis

The term dual diagnosis refers to co-occurring substance abuse problems and serious mental disorders, in particular schizophrenia and bipolar disorders with psychotic symptoms. The term «complex disorders» is probably more apt since the patients frequently struggle with anxiety and depression as well as having considerable occupational, social, financial and housing difficulties. They may also suffer from somatic disorders. The combination of mental disorders and intoxicants has negative consequences for the course and effect of treatment, with a high risk of drop-outs and of repeated admissions to emergency units, a greater risk of suicide and severe infections, deterioration of psychosis, depression and other psychopathological symptoms, in addition to increased substance abuse. The patients easily abandon out-patient treatment and have lower compliance with treatment with medicines than patients with only psychotic disorders (1, 2).

Several treatment studies from other countries show that effective treatment for these patient groups includes measures based on cognitive and behavioural principles and the integrated treatment of mental disorders and substance addiction (3). Such measures are often combined with updated and evidence-based medical treatment and with substitution treatment of opioids.

The treatment model

The interdisciplinary unit for dual diagnosis at Vinderen has 12 beds. We recruit patients from the primary and specialist health services for voluntary or enforced mental health care. Priority is given to those who are the most difficult to reach through other treatment options.

The treatment model is so-called integrated dual-diagnosis treatment, which currently has the best research knowledge

base (2, 4). This entails patients being given a continuous treatment option – from the establishment of the outreach contact, via detoxification, examination and treatment, to the offer of permanent housing in cooperation with the municipal help network. The unit offers detoxification, stabilisation, interdisciplinary examinations and individual and integrated treatment, i.e. co-occurring measures for both substance abuse and mental disorder. Cognitive environmental therapy is a key component (5), including elements such as motivating interviews (6) and treatment with medication, and if relevant, substitution treatment along with organised physical activity that promotes coping strategies and positive experiences for the patients. We try to

define the patient's objectives and help to draw up a cognitive treatment plan. The patient is given an information folder on cognitive environmental therapy. The treatment environment is organised so that patients will learn about the different ways of thinking and the skills and tools that can help them to handle problems such as depression, anxiety, psychotic symptoms, substance addiction and insomnia, as well as helping them to achieve important goals.

The patients

More than three-quarters of the patients are homeless when they come to the unit and they all suffer from extensive substance addiction. Most of them use several illegal substances, the most common being a com-

Frame 1

The man who stopped talking

Einar, about 30 years old, has in recent years lived in low-threshold accommodation for people with dual diagnosis problems without permanent housing. His life has been characterised by intense substance abuse, and there have been many episodes of bizarre behaviour and restlessness. He has appeared to have disturbed thought processes, and his speech has constantly been incoherent. It has been difficult to understand him, and it is uncertain how much he has understood of what others have said to him. His ability to look after himself was totally absent – for example he went outdoors in winter in his socks.

One autumn a few years ago Einar was committed to an acute psychiatric department. He was then psychotic and was transferred to a department for long-term treatment since the interdisciplinary unit for dual diagnosis did not have a place for him. He was then transferred to us some months later. He had tried being allowed out while he was in the long-term department, and had without exception returned after taking intoxicants. He was still psychotic when he came to us, in spite of taking adequate antipsychotic medication for two months. He said very little, and in general there was a long time-lag before he answered any queries.

In the cognitive environmental therapy, emphasis was placed on behavioural interventions with written weekly plans and on reinforcement and encouragement of the desired behaviour. He struggled with social anxiety, which was reinforced by low self-esteem and disturbed thought processes. He needed clear confirmation of his qualities as a human being as well as encouragement and guidance in handling social situations. It was crucial that he gradually felt ownership of his treatment, and he perceived hope that change was possible. He saw an alternative to a desperate life situation.

The psychotic symptoms diminished during the winter, and Einar was transferred to voluntary treatment. He now participated actively in the unit's activities. He was allowed out during the last few months, was reliable and compliant, looked after himself well, and conscientiously followed up both his own plans and the tasks he was assigned. The contact and relationship of trust with his parents was strengthened through systematic work with next of kin, and he re-established contact with his family.

Einar wanted to work, and started work training in a café. He carried out the tasks he was given properly, but struggled when talking to others. The greatest changes could be seen in his ability to make facial expressions and eye contact and in his sense of humour.

Einar had periodically drunk some beer before he returned to the ward, and he immediately informed us of this himself, but he did not misuse illegal substances. He was discharged to a supported housing unit for patients with mental problems. It soon became clear that he struggled with ordinary daily activities: he bought beer in the shop but not food, and had to be given training in how he was to do this. He also needed a little more time in the interdisciplinary unit for dual diagnosis. After three weeks he moved back to the supported housing unit with the goal of acquiring his own permanent accommodation. During the past year he has gone to work every day and is now moving into his own place.

bination of amphetamine, hash, benzodiazepines and alcohol, and roughly half also use opiates. The majority of our patients are discharged with a psychotic disorder. Two-thirds are men, and the average age is 30 (frame 1). The average duration of stay is less than three months.

Many patients need considerable time and an untraditional approach to persuade them to accept support, but it is seldom that they refuse support from us. It is common for patients not to come on the agreed day, and many are under the influence of intoxicants when they do come. This we do not sanction, but – to spare the patient and to protect the other patients – we can isolate the patient if he/she is extremely mentally unstable or intoxicated. Urine samples are taken to acquire information on substance abuse («It's a good idea to find out what you've taken») or to create motivation («It's three weeks now since you've had positive tests»). Patients are informed that they are not permitted to remain in the environment when they are under the influence of intoxicants, and that it is the staff who determine whether or not they are intoxicated.

We are always willing to admit patients who leave without the permission of the staff and who come back to the unit after taking drugs – at any time and with the offer of transport back to the department. Since we do not threaten to discharge patients, they themselves do not threaten to leave. Very few of the patients discharge themselves from the unit against our advice.

A treatment plan is drawn up in the department in collaboration with the patient, with goals and sub-goals that are changed as things progress. All the patients have their own treatment plan and their own rules in the department. The department is responsible for the structure that is to form the basis for treatment plans and goals. The daily rhythm and meals can be a problem at the start. The treatment includes organised activities, individual therapy consultations, group sessions, instruction, classes and physical activity.

We try to progress to gradual discharges where the services are wound down at the same time as the new option involving where the patient is to live is built up. New relationships are established while the patient is still with us. Much of this activity

takes place outside the unit. Some patients have continued to work while they have been in the unit.

We do not discharge patients to low-threshold initiatives such as social welfare centres and bed-sit accommodation, and there is a

«The patient can lose heart – but we as healthcare staff cannot.»

huge need for specially-adapted and permanent housing. Currently we have a two-year project financed by *Husbanken* bank and the regional resource centre for the dual diagnosis of substance abuse and psychiatry that aims to find better solutions (7).

We do not view re-admissions as a defeat but rather as part of the patient's change process. We offer planned short re-admissions for particularly vulnerable patients, and in some cases a reserved crisis place for some patients for a period after discharge.

Motivation is no prerequisite

The starting point for treating patients with a dual diagnosis is that it is unrealistic to expect stable motivation for change. Motivation comes and goes and must be continuously worked on by informing, accepting, comforting and encouraging. The patient can lose heart – but we as healthcare staff cannot. We cannot expect patients who have such comprehensive problems and who have previously experienced so many disappointments and defeats to be motivated for making changes in their lives. From both a professional and ethical standpoint we disagree with the view that these individuals will be more motivated if they «do another lap». Nobody's situation improves by having worse experiences beforehand.

Our experience is that the motivation that the patients manage to express on admission is a poor prediction for how successful the treatment will in fact be. In addition, we often find that motivation does not come until the patient has been detoxified and stabilised. Of course fluctuations and setbacks occur, but we are prepared for that. We therefore never discharge patients because they take intoxicants during their stay with us.

These patients must be offered assistance when they are ready to accept it. The help

network must contribute to making the patients motivated; it must encourage them to feel that everything is not hopeless and to see opportunities. We cannot seek their motivation and then exclude them from treatment because they «are not sufficiently

motivated». The patients must be given help with the mental disorder even though they continue their substance abuse, and with the substance abuse even though they refuse other treatment. When the patients are given help and realise that they benefit from it, they are willing to accept more.

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