

Bridging the Gap: What We Know and Don't Know about Dual Diagnosis

Conventional misconceptions of mental illness, addiction and homelessness are reinforced by chronic disconnections among science, clinical practice, public policy and public opinion. The resulting information gaps compound misunderstanding of homeless, mentally ill substance abusers, their capacity for rehabilitation and the relative merits of therapeutic alternatives. Bridging these gaps is crucial to both individual and public health.¹ Multidisciplinary groups such as the HCH Clinicians' Network and the National Health Care for the Homeless Council are particularly well suited for this task. In this issue of Healing Hands, we present current information from multiple perspectives relevant to the care of mentally ill addicted persons who are homeless. In response, readers are invited to examine their clinical practices, consider how they might contribute to research, and reflect on related public policy issues

Dual diagnosis is a descriptor used by clinicians and insurance companies to categorize persons with severe, co-occurring mental illness and substance use disorders. Symptoms of each disorder exacerbate those of the others, complicating diagnosis and treatment.¹ Street people who display obvious symptoms of severe mental illness and drug addiction embody many peoples' stereotype of homelessness.² Although only 10–20 percent of homeless people are dually diagnosed, they are indeed among the most visible and vulnerable of an increasingly heterogeneous homeless population. Moreover, dually diagnosed housed persons are disproportionately at risk for homelessness.³

BASIC SCIENCE During the past two decades, research in the neurological and behavioral sciences has begun to reveal the biochemical mechanisms by which mood-altering drugs—including caffeine, nicotine, alcohol, cocaine and heroin—change brain structure and function, thereby triggering addiction. There is evidence that the biological changes persist long after drug use has ceased. From these findings has evolved the current theory of addiction as a chronic brain disorder with intrinsic behavioral and social-context components, similar to other forms of mental illness.^{4,1}

Contrary to the common stereotype of addiction as a failure of character, “we now need to see the addict as some-one whose brain has been fundamentally altered by drugs,” concludes **Alan I. Leshner, MD**, of the National Institute on Drug Abuse. “Treatment is required to deal with the altered brain function and the concomitant behavioral and social functioning components of the illness.”⁴

“Understanding addiction as a brain disease explains in part why historic policy strategies focusing solely on the social or criminal justice aspects of drug use and addiction have been unsuccessful. They are missing at least half of the issue.”

– Alan I. Leshner, MD, National Institute on Drug Abuse, NIH

An important clinical implication of this research is that addressing one component exclusive of the other—either the biological basis of mental illness and addiction or the social/environmental cues that trigger both—will fail. Another implication is that like diabetes and hypertension, addiction is typically a chronic, relapsing disorder, requiring long-term care to control progression of the disease and alleviate its worst symptoms; management of the illness, not cure, is a reasonable treatment goal.¹

CLINICAL PRACTICE Treatment modalities for the dually diagnosed are various, and continue to evolve. Strict medical or social models, focused exclusively on pharmacological treatment or behavior modification, have been succeeded by more eclectic models that meld successful features of both in a community-based setting, emphasizing continuity of care through intensive case management.^{3,4} The sheer variety of alternatives and conflicting opinions about their effectiveness tend to confuse policy makers and the general public, many of whom have forgotten—or never knew—that clinical knowledge grounded in scientific method does not grow without controversy and careful testing.

Concurrent treatment of mental illness and substance use is now considered essential for clients with co-occurring disorders. This integrated approach features four stages of treatment – engagement, persuasion, active treatment and relapse prevention. Long-term abstinence, psychiatric stability, community support networks and stable housing are concurrent treatment goals.^{2,5} Though familiar concepts to many clinicians, they are consistently applied by only a few. With integrated treatment, the illness becomes manageable, according to **Ed Hendrickson, MS, MAC**, clinical supervisor for the Alcohol and Drug Treatment Program in Arlington County, VA. Without it, dually diagnosed clients find themselves “only half understood.”²

“Homeless people with co-occurring disorders are not easily engaged by treatment professionals,” says **Tony Halton**, substance abuse counselor at the Downtown Clinic in Nashville, TN. “They require subtle outreach. Clinicians try to help clients meet basic needs first, building trust and rapport that can lead to treatment later.”

The reality is that in many communities, even basic needs are hard to meet for the dually diagnosed homeless. “We see the lack of safe, affordable housing as a major issue,” report **Gail Arsand, MS, RN** and **Mary Ann Patti, MSW, CICSW** of the Recovery Community Support Program, HCH of Milwaukee. “Our biggest challenge is keeping clients in stable housing, which is essential to the success of their clinical treatment.” These clinicians are beginning to apply aspects of the Miller and Rollnick motivational interviewing model to facilitate engagement and persuasion of dually diagnosed clients through peer support groups.⁶

Where they exist, housing programs tend to follow two basic models. In the “level-of-care” or “continuum” approach, clients move from more to less supervised and restrictive settings as they achieve treatment goals. In the “supported-housing” model, the residential setting is constant, but the intensity of support services varies with client need. Proponents think this approach fosters better social integration, increased independence and smoother transition from one level of care to another.⁴

Other issues are whether treatment can or should be separated from housing, and whether or not use of drugs and alcohol is tolerated or prohibited (“wet” or “damp” housing vs. “dry”). Most residential programs currently prohibit substance use. A recent controlled study of community-based residential programs in New York City found the greatest reduction of substance abuse and psychopathology in clients housed in a therapeutic community.⁴

There is evidence that the biochemical abnormalities associated with addiction can be reversed through learning and that a variety of psychosocial therapies can and do help.¹ A number of interventions have been shown to be effective through clinical trials. Others that appear promising are in early stages of testing.

Among the latter is a form of behavior modification using EEG biofeedback, which is being used to treat a variety of conditions including depression and substance abuse. Proponents claim a significantly lower relapse rate using neurofeedback (“alpha-theta training”) than with traditional treatment for alcoholism.⁷ Although these results have yet to be demonstrated for dually diagnosed homeless persons, Network member **James White Jr., PhD, ARNP, RN** of Detroit Health Care for the Homeless reports a positive experience using neurofeedback in combination with intensive case management to treat homeless addicts, some of whom are dually diagnosed.

An important take-home message from the clinical literature is that “one type of treatment doesn’t fit all,” warns Hendrickson. “The dually diagnosed are a heterogeneous population with a wide range of severity in substance abuse, mental illness and functioning levels. Reciprocal relationships exist among mental illness, substance abuse and homelessness. Engagement, treatment and recovery is a long-term, multi-step process. It is important for clinicians and clients to keep their eyes on the prize and appreciate each step forward.”² ■

See references on page 4.

INCIDENCE OF DUAL DIAGNOSIS

- 29% of persons with a mental disorder also have a substance abuse disorder.
- 37% of persons with an alcohol disorder also have a mental disorder.
- 53% of persons with other drug disorders also have a mental disorder.

Overall rates for the general population – NIMH

Work Stories: Case Management Tools for Dually Diagnosed Adults

Clinicians at Community Connections, Inc., Washington, D.C., conducted a three-year project to enhance vocational opportunities for dually diagnosed adults enrolled in intensive case management. Following is a summary of their findings, published last summer in *Psychiatric Quarterly*.¹

The study was designed to help case managers discover and interpret clients' understanding of and expectations about work, as revealed through stories about job finding and job retention shared in focus groups over a nine-month period.

Of 113 participants (70 women and 43 men), all had histories of literal homelessness and/or multiple inpatient hospitalizations for severe or persistent mental illness and/or substance abuse. Nearly 90% of the participants were 30 – 50 years old, and more than 85% were African American. Clients typically had no more than a high school education, and one-third had never worked 12 consecutive months in competitive employment.

Clinicians discovered in the work stories told by these participants five recurrent themes: anxieties about coping with mental illness in the workplace (“*me and my mental illness*”), unrealistic expectations about work (“*work as a magic pill*”), the misconception that substance abuse is compatible with work (“*demon num*”), ignorance of the relationship between money and work or personal effort (“*work is work*”), and the perception of vocational support as an effort to control or dominate (“*Whose job is it, anyway?*”).

Each story type engendered particular responses from clinicians, many of whom inadvertently reinforced client misconceptions. The authors describe the likely impact of attitudes suggested by each story type on a client's ability to obtain and retain employment, and compare actual clinician responses with optimal ones. Finally, they specify the following constructive strategies which clinicians can employ to help their clients have positive work experiences:

¹Harris M, Bebout R, Freeman D, Hobbs M, Kline J, Miller S and Vannasse L, “Work Stories: Psychological Responses to Work in a Population of Dually Diagnosed Adults,” *Psychiatric Quarterly*, 68:2, Summer 1997, 131-153.

WHAT CLINICIANS CAN DO

Address fears about mental illness in the workplace:

- Help client learn about illness and relapse patterns.
- Define work so client can imagine a manageable job.
- Match client's capacities to job requirements.
- Prepare client to deal with work-related stress.
- Readjust medications to minimize negative side effects.
- Help determine who needs to know history and who doesn't.
- Don't be overly protective.

Help clients alter unrealistic views of work:

- Emphasize value of work, not job as symbol of success.
- Encourage focus on positive aspects of job.
- Reframe amount of time required for desired job impact.
- Consider first job a learning experience.
- Expose client to multiple work sites.

Be proficient in addiction treatment and relapse prevention:

- Match work initiatives with substance abuse treatment stage.
- Begin serious addiction treatment before job seeking.
- Note how work environment may affect substance use.
- Don't withdraw support or treatment when work begins.
- Help client find meaning in small accomplishments.

Address complaints about how hard work is:

- Every job has stages; advise client to reserve judgment.
- Encourage positive self-talk, positive image of work.
- Learn to listen without acting; act only when necessary.

Assess own motivation for having client seek work:

- Distinguish between support and control or ownership.
- Change level of involvement as client motivation varies.
- Don't feel accountable for client's success or failure.

THE MAP IS NOT THE TERRITORY

Eskimos have a hundred words for snow.
Here in the land that made dysfunctional famous
we have one word for one thousand realities —
depression.

open your eyes to the faded ceiling
stare without interest
fall asleep again

rock on the toilet
stare at the razor on the sink
teetering on the edge

walk through a crowd
stare ahead fixedly
ignoring all the saw-edged
whispers of your name

walk through a crowd
hearing nothing

my bones have turned to concrete
my flesh bruises itself on them

I do not touch
I do not taste
my body is a feather
anchored in nothing
I will never stop weeping
I will never cry again
rock and bone have turned villain
I am everything that is wrong with Life

Daddy came in at midnight
it has been midnight ever since

I lost my Daddy to cancer
I am lost

everything is fine
and I don't give a damn

I need more than a hundred words.

— Anitra L. Freeman
from *Friendship Quilt*: a publication of
the 1997 Homeless Women's Forum
Seattle, Washington

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