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 addicts 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 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 amphetamines, hash, benzodiaze-
zones 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 intoxi-
cants 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
we are not permitted to remain in the
environment when they are under the influ-
ence 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 respon-
sible 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 activ-
ities, 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-thresh-
hold initiatives such as social welfare centres
and bed-sit accommodation, and there is a
need for specially-adapted and per-
manent 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-admis-
sions 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. Motiv-
ation comes and goes and must be continu-
ously 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 dis-
appointments 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 hav-
ing worse experiences beforehand.

Our experience is that the motivation that
the patients manage to express on admis-
sion 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 set-
backs 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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References
1. Gråwe RW, Hagen R. Kombinert rusmiddelavhen-
gighet og alvorlige psykosidelser. I: Berge T,
Repså A, red. Håndbok i kognitiv terapi. Oslo:
behandling av rusproblemer og psykiske lidelser.
3. Kavanagh DJ, Mueser KT. Current evidence on
integrated treatment for serious mental disorder
and substance misuse. Tidsskrift for Norsk Psyko-
4. Drake RE, Neal EL, Wallach MA. A systematic
review of psychosocial research on psychosocial
interventions for people with co-occurring severe
mental and substance use disorders. J Substance
Abuse Treatment 2008; 34: 123–38.
5. Oestrich IH, Holm L. Kognitiv miljøterapi. At skabe
et behandlingsmiljø i egerværdigt samarbejde. 2.
utg. København: Dansk Psykologisk Forlag,
2006.
6. Miller WR, Rollnick S. Motivational interviewing:
Preparing people for change. New York, NY: Guil-
7. Karagöz EMN. «Hvor lenge skal han bo på TEDD?»
Forståelse av bostedsløshet – kontra retten til en
egen bolig, et hjem. Tidsskrift for psykisk helse-

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