

Creating a Dual Diagnosis Treatment Culture

By Mark Ragins, M.D.

Several years ago I realized that I could imagine myself married to someone with a serious mental illness—even if they were taking medications poorly and had lots of disruptive symptoms. I wasn't trying to imagine this scene, as you might be guessing, because I was in love with one of my patients, or because things were going particularly poorly with my wife. I was sitting working with a man who was actively abusing drugs and creating lots of problems. His wife had come with him to ask my advice in helping her husband. As I often do before I give advice, I tried to imagine myself in her situation, and realized I couldn't. I couldn't imagine staying married to an actively using, disruptive substance abuser. That's when I tried to imagine being married to a disruptive mentally ill person, and I realized I could. Then it struck me that on some deep emotional level, I was able to accept and connect with people with mental illnesses but not substance abuse; and that inability was probably getting in the way of helping them.

I see myself as helping people by accepting them and connecting to them wherever they are and then trying to guide them into recovery. How could I do that effectively, if I was unable to accept them and connect to them until after they stopped using drugs? That would be like being a tour guide who has never been where you are, won't meet you, and then if your trip goes poorly says you must not have wanted to travel in the first place. A caricature perhaps, but that sounds a lot like the problem with a lot of our dual diagnosis treatments.

This isn't just my personal problem. I'm "normal" for American culture today. In the movies [A Beautiful Mind](#) and [Shine](#), we admired the tenacious, accepting wives of poorly compliant disruptive mentally ill men. They seem almost heroic and ultimately their love is portrayed as very healing. On the other hand, in the movie [Leaving Las Vegas](#) we do not admire Nicholas Cage's girlfriend as she sticks with him while his alcoholism destroys them. We wonder what's so terribly wrong with her that she would stay with him. We don't find her love healing. It might even be enabling. Maybe he would've done better without her, we speculate. Several years ago, I was a visiting lecturer in Amsterdam. One of the psychiatrists, who was telling my fascinated teenage sons about their liberal marijuana policies, told us that in Amsterdam her character is admired. She was acting exactly as a loving, connected partner is supposed to act. At that moment, I realized that on a very deep level their cultural view of drugs was different than ours, not just their policies.

Our cultural rejection of substance abusers is translated into numerous rejecting policies. Addicts can't get Social Security disability benefits, they get kicked out of HUD housing, they're refused jobs if they drug test positive, they're put in jail instead of treatment facilities if they're disruptive, our Medical benefits won't pay for their treatment, and they're expelled from school, ("zero tolerance") no matter how young they are, or what the situation is.

If we really want to help these people we are going to create within our treatment centers a “counter-culture” that accepts them and connects with them. If we look to learn from 12-step groups, probably the most effective help available, we find them to be profoundly accepting and connecting, while maintaining a strong rule of anonymity to keep out the larger rejecting society. The nods of recognition and the laughing with people as they tell their devastating stories are the beginnings of healing.

At the Village, we try very hard to create this counter-culture of acceptance. Almost all of my teammates are “abnormal” in their reaction to substance abuse, mental illness, homelessness and even jailing. They have experiences of being an addict or mentally ill or both. They’ve been raised by family members with addiction or mental illness. They’ve been homeless or in jail. They’ve formed “abnormal” attitudes because of deep personal experiences. I’m not saying that all people with these experiences become accepting. In fact, many become even more rejecting or judgmental than the rest of us. But some do. And it’s very hard for us “normals” to break away from our societal culture of rejection. At the Village, we spend a great deal of time during our job interviews trying to find out if potential hires are able to be accepting and connect with people actively abusing substances. “Will you get frustrated or angry?” “How will you handle it?” “Will you become primitive? Cut people off from services, or medications?” We can’t have a psychiatrist work with us who threatens to get people’s social security cut off, if they don’t stop using drugs.

When staff at most places do try to help people who are using drugs, they are criticized and made to feel there’s something wrong with them. “You’re naive, you’ll learn.” “They always look for new staff to take advantage of.” “You’re not helping, you’re enabling them.” Most places actively train their staff to reject substance abusers.

I was beginning my standard four-stage dual diagnosis treatment lecture with the psychiatric residents at the USC clinic when I paused to ask them what proportion of their patient abused drugs. I expected the standard answer of “almost everyone,” or “60-70%” both of which are usually over estimates. It only seems like so many people use drugs, because they make so many problems and use so much of our time. Typically clinics run about 30% substance abusers although everyone believes it is much higher. However, I was stunned when they told me almost none of their patients used drugs. They told me they could’ve really used my lecture in the inpatient ward or in the emergency room, where “almost everyone” used drugs but those people didn’t come to the clinic. I questioned them to find out why. This particular clinic is a little unusual because it is a university-based clinic. There are no homeless services, limited case management, employment services, no consumer staff or housing services. There is, however, a good supply of psychiatric residents for medication, groups, and even psychotherapy all by appointments. There are security guards, metal detectors, and rows of small doctor’s offices with closed doors.

I started wondering if the intake and appointment structure itself had eliminated the dual diagnosis patients. Waiting six weeks for an appointment on a set day and time is unlikely to work for a disorganized, crisis oriented, addict whose “life has become unmanageable.” Even regular appointments are likely to be missed and walk-ins are usually told to make another appointment. By contrast, again, the 12-step program has widespread availability of groups, and sponsors, that welcome people whenever they come in, regardless of missed groups and without “intake evaluations”. In fact, its expected for people to hang out quietly for a while to build trust before they tell the group why they’re there. I wonder what would happen if mental health workers were held accountable for creating a relationship within 30 days instead of held accountable for doing intake evaluation paperwork within 30 days.

I once read that JRR Tolkien was a visiting professor in Arizona teaching a classroom of Navajo Indians. Unfortunately his students didn’t share the same sense of time with the University. They rarely came to class as the appointed class hours although they appeared irregularly at other times. Instead of getting frustrated and failing them, he began sitting out in the grass all afternoon teaching whoever came by, whenever they came by, for as long as they stayed. While such an arrangement might seem impossible in our efficiency oriented, billing driven system, it would probably allow us to begin treating substance abusers. There are people around the country working on “open accessibility” models of clinic treatment. It’s not actually impossible.

It is the daily job of every mental health program to divide people into those “deserving” of our help and those “undeserving” of our help. A good deal of this division depends up on what we are being funded to do. Most mental health programs are funded to serve people with Major mental illnesses – schizophrenia, major depression, manic depression – only, regardless of the amount of emotional or psychological suffering or disability the person has. There is also a moral / social division. Substance abusers, criminals, “predators” and “manipulators” are all “undeserving”.

All people with dual diagnosis are perched precariously between “deserving” and “undeserving”. According to funding criteria, they have one diagnosis, their mental illness, that is “deserving” and another co-existing diagnosis, their substance abuse, that is “undeserving.” Almost absurdly, the way this dichotomy is resolved is by deciding which disorder is primary. All pretense of integral care must disappear from the very beginning.

In reality, our diagnostic tools fail us and we make a moral/social division instead. Since almost all clients feel deserving, they try hard to make the cut. They tell their stories in ways to appeal to us. And if they succeed we make a primary diagnosis of a major mental illness. This would be only a bureaucratic curiosity if it didn’t lead to so many mistaken prognosis and misguided treatments. I met a man once in Skid Row who wanted to know why he was given a shot of Haldol in the Emergency Room that made him stiff and feel like he was going to suffocate. As I inquired he told me he’d gone to

the Emergency Room cold, homeless, and hungry after spending his Social Security check on drugs. He wanted them to take him into the hospital so he told them he was hearing voices telling him to kill himself. “But you never were?” I asked. “No,” he admitted, “but that’s what you have to say to get help there.” “So you want to know why after you pretended to have symptoms you didn’t have, they gave you a treatment you didn’t need and you got bad results.”

It’s not just people with substance abuse disorders who have to find new diagnosis. I recently heard in a lecture by the director of the Borderline Personality Disorder clinic at Harvard that only one in forty of his patients had received the diagnosis of Borderline Personality Disorder. Most believed they had Bipolar II, a “deserving” diagnosis. The problem is that the treatment for the two conditions should be different. We need to stop rationing by diagnosis and start rationing by suffering and disability if we expect helpful treatment to follow from our diagnosis.

There are three general categories of “help” we can provide people: charity, treatment, and social advocacy. Agencies often have a culture of providing only some kinds of help often without being aware of what categories they’re not providing. Mental health agencies tend to specialize in treatment to the exclusion of charity and social advocacy. When people came for help, especially initially, they are often looking for charity instead of treatment – food, money, housing, clothes, blankets, etc. – and find us useless. They move on to charitable agencies, without realizing they’ve turned their back on treatment that might change their lives. It is usually only after some basic needs are met, or perhaps more importantly that they trust that we are helpers, that they will begin to want treatment. By then, unfortunately, they are working with an agency that provides only charity and have rejected us. To engage most substance abusers, as well as many other destitute people, in treatment we must be charitable.

Funding sources for these three categories of help are usually separate. Therefore, mental health agencies have to either obtain multiple sources of funding to offer multiple services seamlessly, or closely partner with other agencies with staff working at each other’s sites. I’ve often found that I can get people to take medications only after they’ve gotten a lunch and a shower and the homeless worker tells then they can trust me, because “He’s different there these doctors in the hospital and the clinic”. Then I have to prove I’m different by being charitable too.

I believe that for most dual diagnosed people to recover they will have to make major changes in their lives. Not just practical changes like getting benefits or housing or changing friends, but major emotional and spiritual changes. Once again, if we look to the 12-step program, most of those 12-steps deal not with sobriety, but with emotional and spiritual change. They work hard on shame and guilt, taking a “moral inventory,” sharing our emotions, forgiveness and reparations, honesty and purpose—all very deep

issues. In fact, they believe these issues are so deep, people will need help from a “higher power” to truly change.

The present culture of our mental health system relies on medication to change people. Unfortunately, almost none of that list of deep emotional issues responds to medication. What we offer in place of that hard emotional work is blunting feelings, “stabilizing moods,” and tranquilizing. While these effects may well be comforting and welcome, they do not lead to the necessary emotional and spiritual changes.

Our mental health culture discarded highly valued spiritual techniques (“moral treatment”) about a century ago. Our mental health culture is in the process of discarding highly valued emotional techniques (“psychotherapy”). The tools that we have left, despite various psychopharmaceutical claims, are simply not enough. I recently met a talented art therapist working in a transitional program helping mostly dually diagnosed people find and express their emotional strengths in art. Hope was her main product. Our mental health culture needs to welcome people like her back again and treasure them. We need to change our mental health culture if we are going to reclaim and renew our lost tools.

It’s hard to help people truly change. It takes a lot of time and talent, and a lot of caring and respect. It takes emotional connections, and, yes, some help from God.

Some of the most amazing recoveries I have seen have been with dual diagnosed people. Several of my favorite people were addicted and highly symptomatic when I met them. I’m pleased to have been part of their recoveries. Now I turn to them at times to help me with the next person in need. In the meantime, I keep working on our program’s culture and myself.