Why current dual-diagnosis proposals will never work.

By David Webb, a regular contributor to New Paradigm, and a consumer representative on the Minister of Health's subcommittee on Dual-Diagnosis.

In my experience of drug and alcohol (D&A) and psychiatric services, it's hard to imagine a more stark contrast between two ostensibly similar services. Both services try to assist people who are in (psychosocial) distress of some kind. But that's where any similarity ends.

The D&A services I'm familiar with include short-term (about 10 days) residential 'detox', longer-term (5 weeks to 6 months) residential 'rehab', and also various self-help programs, most notably Alcoholics and Narcotics Anonymous (AA and NA). All of these you could probably call 'psychosocial' (i.e. non-medical/clinical) services. I also did a couple of medicated detoxes in hospital, and the other major medical 'treatment' I received was nearly a year on Methadone.

The psychiatric services that I also sought help from during this time (late 1990s) included a few stints on a hospital psych ward, once as an involuntary patient, and time with about six different psychiatrists – some I saw only once or twice, others for longer.

The first thing New Paradigm readers will notice from this history is that I had virtually no contact with what the mental health industry calls a PDRS, or psychiatric disability rehabilitation service. I suspect this was because my kind of madness was not of the so-called 'psychotic' variety, which seems to be who PDRS are mostly targeted to. So I can't compare D&A and psychiatric services with PDRS from my own direct experience. From what I hear though, PDRS sound much more like the non-clinical D&A rehabs.

With this history (and disclaimer), let's look at some of the stark differences I found – and I suspect you'll still find today.

The first difference is the welcome you get when you first walk in the door. At the D&A rehabs, a big effort is usually made to try and make you feel as welcome and comfortable as possible as you enter this scary new world that you're probably feeling very uncertain about. Typically this would include one of the residents who had already been there a while showing you around, introducing you to the others, showing you where to get a cup of tea etc, and generally showing you the ropes. Sometimes this is formalised into a 'buddy system' as part of the program. It's a scary thing to step into one of these places, but it helps when you're greeted by someone who has done it themself just a few weeks before you – and who seemed to be OK, friendly and wanting to help.

The psych wards were so very different. After the admission formalities (paperwork) are done, a nurse (probably) shows you where your bed is, where meals are served, the TV lounge-room and, for people like me, where to have a smoke. As you get this tour, you might be (quickly) introduced to the other residents, but maybe not. Social

interaction among patients is not facilitated or even encouraged. It feels like we are expected to be incompetent and incapable of just about anything – otherwise we wouldn't be there, right? And psych wards for me were so unbearably dull and boring that on one occasion I felt I had to leave after about three weeks or I'd go mad!

Which is the next big contrast. The D&A rehabs were mostly active, busy places – even the detoxes where lots of the residents are often feeling pretty crook with their withdrawals. Apart from the formal programs – seminars, workshops, homework etc – there were scheduled walks or other exercise, lots of informal 'meetings' among the residents, and we all pitched in with the cooking and keeping the place clean. Psych wards, in contrast, are characterised by passivity, dullness and boredom.

Another difference was the staff, where few, if any, were medical people. A lot of the staff in D&A, sometimes all of them, were ex-users. They knew what we were going through because they'd been through it themselves. And we knew that. And we knew that they knew, and they knew that we knew. And so on. This not only meant that there was an empathy and respect for the hard work of coming off drugs (or booze). It also meant that they pretty much knew all the games we played – with ourselves and with each other – to rationalise or deny our addiction or to think we were somehow different to others in our struggle to get clean/sober. That is, they could usually see through all the bullshit pretty quickly because they were experts themselves – and we all knew it. It made for some tough confrontations at times. But it also made for a lot of good humour, often pretty dark humour, and a lot of laughter. Another striking difference with the psych wards.

Next, the approach to 'therapy' – 'treatment' in psych wards, 'recovery' in D&A – is very different between the two services. In D&A, the approach to recovery could be called holistic – that is, a whole-of-person approach. Along with the busy routine, diet, exercise, activity, social contact, conversations both formal and informal, various responsibilities and duties – cooking dinner, being a buddy to a newcomer etc – were all recognised as important parts of the program. In the psych wards, treatment centred on medication. A couple of times a day the drug trolley would come around, staff would be watching for symptoms and/or side-effects, and the doctors would fine-tune the meds accordingly. That was it.

I found this focus on medication not only on the psych wards but also with most (but not all) of the psychiatrists I saw. And sometimes the emphasis on medication was coercive. I was deliberately deceived into taking an anti-psychotic drug that I later learned was inappropriate for me, and which caused considerable harm. Compare this to the genuine informed consent I gave to go on the Methadone. My Methadone doctor explained how the Methadone worked and how it might help. He answered all my questions – honestly – and made it clear that it was a bit of an experiment but one that he thought was worthwhile, given the mess I was in. Like the anti-psychotic drug, the Methadone didn't work either in the end, but I have no ill-feeling at all towards the doctor who put me on it. The difference? Genuine informed consent.

Coercive treatment is just a small step away from forced treatment, the last, biggest and most significant difference between the two services. The coercive, controlling, disempowering, 'father knows best' attitude of psychiatry relies upon the threat of

force and the legal power it has to back up this threat with real violence. Which it does on a daily basis. This threat of force – involuntary detention and involuntary treatment – is the foundation and distinguishing feature of psychiatry. All D&A services are voluntary – you can leave any time! They may not let you back (for a while) if you change your mind. But you can leave any time.

People with both mental health and substance abuse problems – or 'dual-diagnosis' or 'comorbidity' (what revolting language!) – are now being recognised by both services as the norm rather than the exception. But a lot of people are falling into the gaps – or chasm – between these two services as they play ping-pong with us. Like many others, I was told numerous times, 'Sorry, you need to go to the other service first', as I sought help for my drug-addicted madness.

Current thinking in Victoria about dual-diagnosis (sic) is aware of the significant cultural differences between the two services, some of which I've outlined here from the consumer perspective. But so far the most significant of these differences, the threat of force, has not been addressed. This represents a potential disaster for existing drug and alcohol services.

Everyone agrees that the first and biggest challenge in D&A, especially for young people, is to encourage people to seek help. But if the word gets out on the street that a so-called 'dual-diagnosis capable' D&A service will dob you in to psych services if they think you're mad, then this would be a disaster for those services and the people they seek to help. Few, if any, people with a drug or booze problem are going to knock on a D&A door and ask for help if there's any chance that it might lead to the lockup. To the user on the street, it makes little difference whether it's the police lockup or the psych lockup – you will do everything you can to avoid it.