

Dual Diagnosis Anonymous of Oregon

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Many people with addictions report that support from peer groups fosters recovery. For people with co-occurring mental illnesses, dual-diagnosis peer support groups are considered helpful, but they are often unavailable. Recently, Dual Diagnosis Anonymous peer support groups have spread widely throughout Oregon as a complement to integrated dual diagnosis treatments. This column describes Dual Diagnosis Anonymous and its rapid implementation in Oregon. (*Psychiatric Services* 61:738–740, 2010)

Approximately half of adults with severe and persistent mental illnesses also experience co-occurring substance use disorders (1,2). This combination of co-occurring disorders (often called dual diagnosis) is associated with adverse outcomes in a variety of clinical, psychosocial, general medical, and economic domains (3). For over 30 years the U.S. mental health and addiction treatment systems have struggled with the goal of helping people with dual diagnoses to overcome both disorders. In the 1980s treatment programs began to combine mental health and addiction services into integrated programs. Watershed events at the end of this

era included federal reviews (4) and a series of demonstration projects funded by the National Institute of Mental Health (5). The results of these early demonstration programs and more formal research studies began to appear in the 1990s, and by 2008 nearly 50 controlled studies of integrated dual diagnosis interventions had been published (6). Positive and negative results from these studies helped to clarify the effectiveness of different types of interventions.

To achieve and sustain recovery, people with co-occurring disorders need safe places to live, social networks that support abstinence, meaningful activities, and treatment (7). The strongest research findings support peer-oriented groups led by professionals. Several pre-post studies and nine controlled trials have shown that group interventions help clients to reduce their use of substances and attain remission (6).

Despite the encouraging findings regarding integrated interventions in general and group interventions in particular, these services are rarely available. Only 10% of clients with co-occurring disorders receive any treatments, even nonintegrated treatments, for both disorders (8), and only 4% receive integrated interventions (Blyler C, personal communication, 2009). Even within integrated treatment programs, groups led by professionals are often unavailable, in part because groups are difficult to start, sustain, and fund.

Peer support groups complement integrated treatments by offering role models, mentors, healthy friendships, recovery strategies, support, and spirituality. Although the potential importance of peer supports has long been recognized, many individuals with co-occurring disorders have experienced

difficulties connecting with traditional 12-step meetings (5). Peer supports specifically for people with co-occurring disorders have, however, become more prevalent. At least three peer support organizations have been established: Dual Recovery Anonymous (draonline.org), Double Trouble Anonymous (doubletroubleinrecovery.org), and Dual Diagnosis Anonymous (www.ddaoforegon.com). Each of these organizations is founded on the 12 steps of Alcoholics Anonymous (AA). Although randomized controlled trials are lacking, participation in 12-step peer support programs is associated with positive mental health and substance abuse outcomes for clients with co-occurring disorders (9–11). In addition to complementing professional services, peer support groups address the large unmet need for supports by utilizing a potential workforce of thousands of people in recovery and by reaching some individuals who avoid traditional services.

This column describes the rapid emergence of Dual Diagnosis Anonymous (DDA) of Oregon (www.ddaoforegon.com). We discuss the history of the organization, the program features, its current status in Oregon, and several factors related to widespread implementation.

DDA

DDA is a self-help organization for people with co-occurring mental illness and substance abuse or dependence. To the traditional 12 steps of AA and Narcotics Anonymous, DDA has added five steps: acknowledging both illnesses, accepting help for both conditions, understanding the importance of a variety of interventions, combining illness self-management with peer supports and spirituality, and working the program by helping others.

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Meetings of DDA resemble traditional 12-step meetings. The role of chairperson rotates among members from meeting to meeting. The chairperson may decide on an open discussion meeting or choose a topic in advance. Meetings begin with introductions, are followed by approved DDA readings, and usually last one hour. Unlike many AA meetings, DDA encourages “cross-talk” in which participants can give feedback, ask questions, and respond.

The DDA symbol combines a triangle, a sphere, and a five-petaled flower. [A copy of the DDA symbol is available as an online supplement at ps.psychiatryonline.org.] Key messages are listed above and below the flower: “Just for today in DDA” and “To live without hope is to cease to live.” The letters DDA in the center represent the core of the fellowship. The triangle surrounding DDA emphasizes the connection to other 12-step fellowships. The sphere encircling the triangle reminds members that they are always connected to one another. Every DDA meeting closes with the formation of a group circle and the traditional AA Serenity Prayer. The spaces within the petals of the flower symbolize the extended family: those who may not identify as dually diagnosed but support the DDA program as well as those who are directly in the fellowship. The extended family may include family members, friends of DDA members, doctors, clinicians, and other concerned individuals.

Each petal of the flower represents one of the five additional steps. Step 1, acceptance, is the beginning of the recovery journey. Step 2 is willingness to accept help. Step 3 recognizes the importance of therapy, medications, and remaining clean and sober. Acknowledging the importance of mental health interventions does not imply that all DDA members are taking medications or participating in therapy, but members are encouraged to keep an open mind regarding these treatments. Each individual's right to choose is respected. Step 4 reminds members that they are not alone. Step 5 emphasizes ongoing recovery and service to others. Working an honest program includes helping others.

DDA of Oregon

DDA began in 1996 in Fontana, California, as a result of an individual with co-occurring disorders being asked not to return to a traditional 12-step meeting because of psychiatric symptoms. AA World Services in New York soon granted DDA permission to use DDA's revised version of the 12 steps.

Following its inception, DDA spread in San Bernardino, California, and came to Oregon in 1998. Although Oregon has long been a leader in offering integrated treatment for people with co-occurring disorders, implementing and sustaining dual diagnosis groups led by professionals within mental health programs has proved difficult. A 2009 Addictions and Mental Health Division survey (unpublished) revealed fewer than 20 such meetings per month in Oregon.

In 2005 Oregon's Addictions and Mental Health Division funded a small grant to assist DDA and to increase its meetings throughout the state. DDA has since spread dramatically to include regular meetings in 32 of Oregon's 36 counties. As of December 2009 a total of 101 DDA chapters were holding 450 meetings per month. Current chapters meet in outpatient behavioral health facilities, inpatient psychiatric units, residential treatment facilities, mental health drop-in centers, state hospitals, state correctional facilities, local jails, independent housing settings, community-based forensic facilities, churches, homelessness programs, and other sites. Attendance, recorded by each chapter's secretary, is about 3,700 members each month.

A private nonprofit DDA office facilitates and monitors implementation in Oregon. Its contract with the Addictions and Mental Health Division specifies that DDA will provide ongoing education, technical assistance, and support to fellowship meetings throughout Oregon; brochures and outreach to local National Alliance on Mental Illness and other family groups; books, materials, and travel expenses for local chapters; and monthly and annual reports regarding numbers of meetings and attendees.

Discussion

The Oregon experience demonstrates that a small organization can implement and sustain DDA groups in a variety of settings and thus provide peer support recovery services for thousands of people with co-occurring disorders. Steady growth—new sites, meetings, and members—indicates that people with co-occurring disorders find DDA peer support beneficial and that DDA is highly valued by a variety of host organizations.

Leaders of DDA of Oregon identify several reasons for success. First, DDA has maintained the time-tested 12-step vision and approach to recovery. The steps have been revised and expanded only to convey the additional challenges of co-occurring disorders. Second, DDA emphasizes tolerance and compassion for others. Thus far, few problems among the diverse participants (such as those with severe and nonsevere types of mental illness) have occurred. Third, DDA encourages relationships between the fellowship itself and other programs that provide critical resources. People pursuing recovery from two major disorders often need professional services; DDA encourages and complements these services. Fourth, DDA is entirely directed by consumers and peers. Supporters have helped by providing meeting spaces, referrals, and finances, but DDA does not belong to any specific mental health or addictions program. Fifth, Oregon has avoided conflicts between the addictions and mental health communities. The state authorities for mental health and addictions were merged in 2002 and receive continued support from the Department of Human Services and the state legislature. Sixth, Oregon's approach to contracting and performance measurement established clear accountability for DDA (for example, documenting numbers of meetings and attendees). DDA leadership has exceeded every expectation throughout the four-year history of the partnership.

Whether DDA can or should be independent of state and local funds in the future remains uncertain. In the early years of AA, the Rockefeller Foundation played a similar instru-

mental and critical role in its survival and viability.

Implementing and standardizing DDA meetings requires training and leadership. DDA of Oregon does this primarily by distributing a manual to group leaders and providing consultation, usually through telephone contacts, with local leaders to reinforce standards. The DDA of Oregon Board of Directors is currently considering a more systematic training process to ensure fidelity.

Peer support groups obviously differ from groups led by professionals. They are intended to complement, not substitute for, professional treatment. However, because peer support groups are more available and many individuals find them useful, they deserve careful study. Further research on access, acceptability, process, and effectiveness would be valuable. At the same time, research on peer support requires nontraditional approaches, such as qualitative methods and quasi-experimental designs, because of the basic assumptions of anonymity within self-help organizations (12). DDA of Oregon is currently addressing this challenge.

Conclusions

DDA of Oregon has experienced a rapid four-year phase of develop-

ment and implementation. The organization has demonstrably increased access to peer supports for thousands of individuals with co-occurring disorders. It now faces additional challenges related to maintaining quality, sustaining funding, transitioning leadership, and demonstrating effectiveness.

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