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## **Why Integrating Substance Abuse and Mental Health is Hard and What To Do About It**

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July 21, 2011

Austin, TX

### **A. Terminology**

“Co-Occurring Disorders refers to substance use disorders and mental disorders”

- “Integrated interventions are specific treatment strategies or therapeutic techniques in which interventions for both disorders are combined in a single session or interaction, or in a series of interactions or multiple sessions. Integrated interventions can include a wide range of techniques.”

(Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005, page 27, 29)

- “The key to effective treatment for clients with dual disorders is the seamless integration of psychiatric and substance abuse interventions in order to form a cohesive, unitary system of care.”
- “The integration of services represents the organizational dimension of treatment: Services for both mental illness and substance abuse need to be provided simultaneously by the same clinicians within the same organization, in order to avoid gaps in service deliver and to ensure that both types of disorders are treated effectively.”

(Mueser KT, Noordsy DL, Drake RE, Fox L (2003): “Integrated Treatment for Dual Disorders – A Guide to Effective Practice” The Guilford Press, NY. page xvi, 19)

- “Integrated treatment is the interaction between the mental health and/or substance abuse clinician(s) and the individual, which addresses the substance and mental health needs of the individual.”

(From page vi in “A Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders” 2002, from the Substance Abuse and Mental Health Services Administration (SAMHSA). Resource: [www.samhsa.gov/reports/congress2002/foreword.htm](http://www.samhsa.gov/reports/congress2002/foreword.htm))

- One Team, One Plan for One Person

### **B. Polarized Perspectives about Presenting Problems**

3 D’s      Deadly Disease – consider addiction in differential diagnosis; ask questions to screen, diagnose  
              Denial – conscious lying; amnesia of blackouts; unconscious survival mechanism  
              Detachment – healthy distance; don’t pin your professional self esteem to client’s success or not

3 P’s      Psychiatric Disorders – not all mental health problems are symptoms of addiction and withdrawal  
              Psychopharmacology – medications often necessary; can prevent psychiatric & addiction relapse  
              Process – often no quick, easy answer to decide addiction versus psychiatric versus dual diagnosis

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### **C. Different Theoretical Perspectives; Different Treatment Methodologies**

1. Addiction System versus Mental Health System
  - 3 D's and 3 P's - implications for medication, staff credentials, attitudes towards physicians, role of staff and team, programs
2. Integrated Treatment versus Parallel or Sequential Treatment
  - hybrid programs - staffing difficulties; numbers of patients and variability, but one-stop treatment
  - parallel programs - use of existing programs and staff, but more difficult to case manage
3. Care versus Confrontation
  - mental health - care, support, understanding, passivity
  - addiction - accountability, behavior change
4. Abstinence-oriented versus Abstinence-mandated
  - treatment as a process, not an event
  - respective roles in both approaches
5. Deinstitutionalization versus Recovery and Rehabilitation
  - role of "least restrictive" setting
  - role for individualized treatment with continuum of care

### **D. Assessment Dilemmas**

- Pharmacological and psychosocial aspects of addiction can mimic psychiatric disorders
- Take a good history - A definitive psychiatric diagnosis by history requires the psychiatric symptoms to have occurred during drug-free periods of time
- Observe the client for a sufficient time drug-free - shorter time for objective, psychotic symptoms; longer for subjective, affective symptoms; non-drug ways of coping; addiction is a biopsychosocial disorder, so encourage active involvement in a recovery program; incorporate meetings, tools, techniques, and a wide variety of non-drug coping responses to help client deal with the stresses of everyday living; diagnosis as a process, not an event

### **E. Treatment Dilemmas**

- For co-occurring disorders, treat vigorously every diagnosis you are reasonably sure of, but only if the assessment steps have excluded the mimicking effects of addiction.
  - Because mental and substance-related disorders are biopsychosocial disorders in etiology, expression and treatment, assessment must be comprehensive and multidimensional to plan effective care. The common language of the six assessment dimensions of the ASAM Criteria (Second Edition, Revised, ASAM PPC-2R, 2001) are used to focus assessment and treatment.
1. Acute intoxication and/or withdrawal potential
  2. Biomedical conditions and complications
  3. Emotional/behavioral/Cognitive conditions and complications
  4. Readiness to Change
  5. Relapse/Continued Use/Continued Problem potential
  6. Recovery environment

- Regardless of the particular setting and client population, there are “generic” treatment strategies:

#### 5 M's:

Motivate - dual diagnosis clients can have denial, resistance and passivity about their addiction and mental health problems; deal with resistance at a pace that keeps the patient engaged in treatment; family and healthcare workers may also need “motivating” to deal with both addiction and psychiatric issues equally. (Dimension 4)

Manage - because dual diagnosis clients easily present to both addiction and mental health programs, treatment is more case management across the addiction and mental health treatment systems, social welfare, legal, and family systems and significant others, than individual therapy; case management especially important for high risk, multiproblem and chronic relapsing clients; take a total systems approach; to improve outcomes, alternative services may be necessary e.g. educational or vocational services, child care and parenting training, financial counseling, coping with feelings and dual relapse groups, daily living skills, tutoring or mentoring services, transportation. (Dimensions 1 - 6)

Medication - for a diagnosed co-morbid psychiatric disorder, but only after sufficient assessment strategies exclude addiction mimicking; also for detoxification if necessary; educate clients about their medication and interaction with alcohol/drugs; prepare them on how to deal with conflicts about medication at AA/NA meetings; anti-addiction medication: naltrexone (Vivitrol), acamprosate (Campral); disulfiram (Antabuse); methadone; buprenorphine; opioid antagonists. (Dimensions 1, 2, 3, 5)

Meetings - mainstream into AA and NA as much as possible, but prepare clients on how to not alienate themselves eg. too readily discussing medication and mental health issues unless with an understanding member or group; help clients deal with their “dual identity”; help identify appropriate meetings in the area and locate or develop special support groups for those unable to be “mainstreamed”. (Dimensions 3, 4, 5, 6)

Monitor - to ensure continuity of care, be alert to missed appointments; hospitalizations and professionals unfamiliar with dual diagnosis and the treatment goals eg. drug-free diagnostic trial; promote accountability for an ongoing treatment plan, rather than fragmented response to crises; recognize treatment as a process, not an event. (Dimensions 1 - 6)

## **F. Evidence-Based Principles and Practices for an Integrated Treatment Model**

(“Dual Diagnosis – An Integrated Model for the Treatment of People with Co-Occurring Psychiatric and Substance Disorders” by Kenneth Minkoff, M.D. The Dual Network, Volume 2, Edition 1. Summer 2001)

**First Principle** - Comorbidity is an expectation, not an exception

#### Key Implications

- Initial assessment includes sufficient data to diagnose and assess both mental and substance use disorders

**Second Principle** – Successful treatment requires most importantly the creation of welcoming, empathic, hopeful, continuous treatment relationships, in which integrated treatment and coordination of care are sustained through multiple treatment episodes

#### Key Implications

- The client’s goals for treatment are the central focus that drives the treatment plan.
- Access to treatment is convenient, open and readily available.
- Opportunity to return to treatment is readily accessible.
- Staff and systems are skilled to identify client needs and access necessary services wherever the client presents.

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**Third Principle** – Within the context of the continuous integrated treatment relationship, case management and care taking must be balanced with empathic detachment and confrontation in accordance with the individual's level of functioning, disability and capacity for treatment adherence

Key Implications

- Interfacing with consumers should be in the spirit of hope and expectancy for change.
- Appropriate and continuous supports go beyond acute medical needs and extend to community and family supports. (flexible funding programs) (case management)
- Staff has healthy detachment to understand and accept relapses and expect accountability for change while at the same time providing support and compassion for the client.
- Mental health and substance abuse providers need to learn from each other the balance between nurturing support and accountability, and expectation for change.

**Fourth Principle** – When mental illness and substance disorder coexist, both disorders should be considered primary, and integrated dual primary treatment is required

Key Implications

- Staffing and services should reflect equal emphasis on both disorders in accord with the prevalence of co-occurring disorders in the populations served.
- Treatments are balanced to effectively address both mental health issues and substance abuse or addiction issues in a client-centered manner.

**Fifth Principle** – Both psychiatric illness and substance dependence are examples of chronic, biological mental illnesses, which can be understood using a disease and recovery model. Each disorder is characterized by parallel phases of recovery: acute stabilization, engagement and motivational enhancement, active treatment and prolonged stabilization, rehabilitation and recovery.

Key Implications

- Holistic multi-dimensional assessment is available to guide matching of services to need.
- Identify gaps in the system in order to determine where resources are needed.
- Explore ways to break down barriers in funding/resource allocation to better meet consumer needs.

**Sixth Principle** – there is no single correct dual diagnosis intervention. Appropriate practice guidelines require interventions to be individualized according to the subtype of dual disorder, specific diagnosis of each disorder, phase of recovery/stage of change, and level of functional capacity or disability.

Key Implications

- Content and length of stay reflects the needs of the individual and their response to treatment.
- Helping clients identify what skills they have achieved in managing their illness during successful periods of recovery.
- Staff should remain strengths based and solution focused

**Seventh Principle** – Within a managed-care system, any of the individualized phase-specific interventions can be applied at any level of care. Consequently, a separate multidimensional level of care assessment is required.

Key Implications

- Services are abstinence-oriented but not abstinence-mandated.
- Staff should be skilled in assessing and working with all levels/stages of change.
- Services exist to facilitate clients through stages of change. A broader range of “discovery” services is required to balance existing “recovery” services.
- Broad continuum of care to allow matching of intensity of services to client's level of functioning.
- Episodes of care are seen within the context of on-going continuous service

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## **G. Example Policy and Procedure to Deal with Relapse or Continued Use Crises**

Relapse or Continued Use Crises result from a variety of situations that can arise while a patient is in treatment. Examples include, but are not limited to, as follows:

1. Slip/ using alcohol or other drugs from overconfidence; 2. Suicidal, and the individual is feeling impulsive or wanting to use alcohol or other drugs; 3. Loss or death, disrupting the person's recovery and precipitating cravings to use or other impulsive behavior; 4. Disagreements, anger, frustration with inadequate skills to deal with the feelings.

The following procedures provide steps to assist in implementing the principle of re-assessment and modification of the treatment plan:

1. Set up a face-to-face appointment as soon as possible. If not possible in a timely fashion, follow the next steps via telephone.
2. Convey an attitude of acceptance; listen and seek to understand the patient's point of view rather than lecture, enforce "program rules", or dismiss the patient's perspective.
3. Assess the patient's safety for intoxication/withdrawal and imminent risk of impulsive behavior and harm to self, others, or property. Use the six ASAM assessment dimensions to screen for severe problems and identify new issues in all biopsychosocial areas.
  1. Acute intoxication and/or withdrawal potential
  2. Biomedical conditions and complications
  3. Emotional/behavioral/cognitive conditions and complications
  4. Readiness to Change
  5. Relapse/Continued Use/Continued Problem potential
  6. Recovery environment
4. Discuss the circumstances surrounding the crisis, developing a sequence of events and precipitants leading up to the crisis. If the crisis is a slip, use the 6 dimensions as a guide to assess causes. If the crisis appears to be willful, defiant, non-compliance with the treatment plan, explore the patient's understanding of the treatment plan; level of agreement on the strategies in the treatment plan; and reasons s/he did not follow through.
5. Modify the treatment plan with patient input, to address any new or updated problems that arose from your multidimensional assessment in steps 3 and 4 above.
6. Use the "What, Why, How, Where and When" to reassess the treatment contract, if there appears to be resistance to developing a modified treatment plan in step 5 above.
7. Determine if the modified strategies can be accomplished in the current level of care; or need a more or less intensive level of care in the continuum of services.
8. If, on completion of step 6, the patient recognizes the problem/s; understands the need to change the treatment plan to learn and apply new strategies to deal with the newly-identified issues; but still chooses not to accept treatment, then discharge is appropriate.
9. Document the crisis and modified treatment plan or discharge in the medical record.

## H. **Staff Issues**

- collaborative, concurrent interdisciplinary team
- vulnerabilities inhibiting team cohesiveness e.g., recov. vs non-recov.; M.D. vs counselor; psych. vs addiction-trained; biomedical vs psych. orientation; education vs. life experience; ambiguity tolerance
- team communication - documentation skills; use of jargon and technical terms e.g., “confused”, “disoriented”, “delusional”
- staff-program match
- stress of working with multiproblem patients - need to be in control; countertransference; overwhelmed with the needs and lack of resources; group supervision and conflict resolution

Incorporate the following into your personal approach to care:

- Tolerance: To listen to another professional’s opinion
- Open-mindedness: To give up old views of addiction or psychiatric problems
- Patience: To explore the history and treatment progress carefully before jumping to diagnostic conclusions
- Education: To learn more about addiction & mental illness; meds.; motivating strategies
- Serenity: To realize that professionals cannot always know the answers immediately.

## I. **Program Issues**

- mission of the program, department, institution or agency
- equal emphasizes both mental health and addictions issues
- admission criteria and patient mix - what can staff/program manage
- terminology and treatment tools e.g., “alcoholism vs “addiction
- non-cognitive, activity groups e.g., time use charts; collages
- groups - education about dual identity; feelings group to learn about relapse cues, signs and symptoms
- family involvement; systems work and continuing care
- self/mutual help groups - preparation for AA/NA mainstreaming; Dual Recovery Anonymous
- staff composition reflects training proportionate to program’s clientele

J. There are many **systems boundaries** that work against effective continuity of care:

- Excessive boundaries, exclusion, and territoriality - policy, funding and practice ignore and sacrifice the complexity of individual needs to achieve and maintain bureaucratic simplicity; continuity of care is nearly impossible under these circumstances.
- Inadequate assessment and diagnosis - on an individual basis, addiction and mental illness are often not diagnosed; inadequate assessment of community needs affects system planning and development of services.
- Lack of trained staff - the polarization of the mental health and addictions fields, historically, has resulted in knowledge gaps only now beginning to improve; lack of experience in both addiction and mental health fields results in fear and resistance to learn and broaden counseling knowledge
- Inadequate array of services - dual diagnosis services either do not exist, or represent a few model programs; even in states where it is more of a priority, there are too many gaps.

- Rigid funding streams - there still are inadequate resources, turf battles and a reluctance to pool resources for training, research or service delivery.
- Lack of a strong shared constituency - because there is little common ground between the addictions and mental health constituencies, the ability to influence policy and service delivery is greatly limited.
- Limited dissemination of effective program models - too little is done to publicize what works in model programs; programs are too infrequently evaluated, or if evaluated, the findings are often not applied in future funding or program planning
- Fragility - when barriers have been overcome, it is usually due to individual efforts that are too fragile and dependent on that person's leadership; positive changes are therefore not sustained by basic structural changes in the mental health and addiction service systems.

(Wayne Thacker, MSW., Leslie Tremaine, Ed.D: "Systems Issues in Serving the Mentally Ill Substance Abuser: Virginia's Experience" Hospital and Community Psychiatry, Vol. 40, No. 10 pp. 1046-1049, Oct. 1989.)

### **Case Presentation Format**

#### **Before presenting the case, state why you chose the case and what you want from the discussion**

##### I. Identifying Client Background Data

Name  
Age  
Ethnicity and Gender  
Marital Status  
Employment Status  
Referral Source  
Date Entered Treatment  
Level of Service Client Entered Treatment (if this case presentation is a treatment plan review)  
Current Level of Service (if this case presentation is a treatment plan review)  
DSM Diagnoses  
Stated or Identified Motivation for Treatment (What is the most important thing the clients wants you to help them with?)

#### **First state how severe you think each assessment dimension is and why (focus on brief relevant history information and relevant here and now information):**

##### II. Current Placement Dimension Rating (See Dimensions below 1 - 6)

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

(Give a brief explanation for each rating, note whether it has changed since the client entered treatment and why or why not)

**This last section we will talk about together:**

- III. What problem(s) with High and Medium severity rating are of greatest concern at this time?
  - Specificity of the problem
  - Specificity of the strategies/interventions
  - Efficiency of the intervention (Least intensive, but safe, level of service)

**C.W.**

February 18

The following is a report on C.W. The consultation issue involved the question of whether primary alcohol dependence or primary psychiatric interventions were needed; and also recommendation for level of care and treatment plan given this patient’s three hospitalizations since age 15 with the current admission involving high risk suicidal behavior. CW is a 19 year-old, white, single, unemployed tire worker who was admitted 2/13 intoxicated on alcohol and also positive for marijuana in his drug screen. He was depressed and suicidal and had cut his chest; written “Die” on his chest; and taken an overdose of Prozac

**K. Increasing Co-Occurring Disorders Capacity through Collaboration**

- Policy, payment and systems issues cannot change quickly. However, as a first step towards reframing frustrating situations into systems change, each incident of inefficient or in adequate meeting of a client’s needs can be a data point that sets the foundation for strategic planning and change
- Finding efficient ways to gather data as it happens in daily care of clients can help provide hope and direction for change:

**PLACEMENT SUMMARY**

<p><b>Level of Care/Service Indicated</b> - Insert the ASAM Level number that offers the most appropriate level of care/service that can provide the service intensity needed to address the client’s current functioning/severity; and/or the service needed e.g., shelter, housing, vocational training, transportation, language interpreter</p>	
<p><b>Level of Care/Service Received</b> - ASAM Level number -- If the most appropriate level or service is not utilized, insert the most appropriate placement or service available and circle the Reason for Difference between Indicated and Received Level or Service</p>	
<p><b>Reason for Difference</b> - Circle only one number -- <b>1.</b> Service not available; <b>2.</b> Provider judgment; <b>3.</b> Client preference; <b>4.</b> Client is on waiting list for appropriate level; <b>5.</b> Service available, but no payment source; <b>6.</b> Geographic accessibility; <b>7.</b> Family responsibility; <b>8.</b> Language; <b>9.</b> Not applicable; <b>10.</b> Not listed (Specify):</p>	
<p><b>Anticipated Outcome If Service Cannot Be Provided</b> – Circle only one number - <b>1.</b> Admitted to acute care setting; <b>2.</b> Discharged to street; <b>3.</b> Continued stay in acute care facility; <b>4.</b> Incarcerated; <b>5.</b> Client will dropout until next crisis; <b>6.</b> Not listed (Specify):</p>	

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## **LITERATURE REFERENCES AND RESOURCES**

Center for Substance Abuse Treatment. “**Substance Abuse Treatment for Persons With Co-Occurring Disorders**” Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005 (TIP 42 available online at Health Services/Technology Assessment Text (HSTAT) section of National Library of Medicine Web site at URL: <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.part.22441>)

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Tel: (773) 404-5130; Fax: (847) 841-4874; Mobile (773) 454-8511

Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffith JH, eds. (2001). ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, Inc. (American Society of Addiction Medicine - 4601 Nth. Park Ave., Arcade Suite 101, Chevy Chase, MD 20815. (301) 656-3920; Fax: (301) 656-3815; [www.asam.org](http://www.asam.org); (800) 844-8948)

Mee-Lee, David (2001): “Treatment Planning for Dual Disorders”. Psychiatric Rehabilitation Skills Vol.5. No.1, 52-79.

Mee-Lee D, McLellan AT, Miller SD (2010): “What Works in Substance Abuse and Dependence Treatment”, Chapter 13 in Section III, Special Populations in “The Heart & Soul of Change” Eds Barry L. Duncan, Scott D. Miller, Bruce E. Wampold, Mark A. Hubble. Second Edition. American Psychological Association, Washington, DC. pp 393-417.

Mee-Lee, David with Jennifer E. Harrison (2010): “Tips and Topics: Opening the Toolbox for Transforming Services and Systems”. The Change Companies, Carson City, NV

Mueser KT, Noordsy DL, Drake RE, Fox L (2003): “Integrated Treatment for Dual Disorders – A Guide to Effective Practice” The Guilford Press, NY.

## **CLIENT WORKBOOKS AND INTERACTIVE JOURNALS**

The Change Companies’ MEE (Motivational, Educational and Experiential) Journal System provides Interactive journaling for clients. It provides the structure of multiple, pertinent topics from which to choose; but allows for flexible personalized choices to help this particular client at this particular stage of his or her stage of readiness and interest in change.

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