Why Integrating Mental Health and Addiction Services is Hard and What To Do About It

David Mee-Lee, M.D. Davis, CA
(530) 753-4300; Mobile: (916) 715-5856
davidmeelee@gmail.com davidmeelee.com
tipsntopics.com instituteforwellness.com

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A. Terminology

- Co-Occurring Mental and Substance-Related Disorders

In "A Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders", SAMHSA defines people with co-occurring disorders as "individuals who have at least one mental disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person…at least one disorder of each type can be diagnosed independently of the other". The report also states, "Co-occurring disorders may include any combination of two or more substance abuse disorders and mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV). There are no specific combinations of….disorders that are defined uniquely as co-occurring disorders."

(www.samhsa.gov/reports/congress2002/foreword.htm)

- "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)

- One Team, One Plan for One Person

B. **Cultural Clashes in the Behavioral Health Field**

1. 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

2. 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

C. **Why Diagnostic Confusion**? - Diagnostic Confusion due to:

- Alcohol/drugs can cause psychiatric symptoms in anyone (acute toxicity)
- Prolonged alcohol/drug use can cause short or long-term psychiatric illness
- Alcohol/drug use can escalate in episodes of psychiatric illness
- Psychiatric symptoms and alcohol/drug use can occur in other psychiatric disorders
- Independent addiction and psychiatric illnesses ("Dual Diagnosis")

(Marc A. Schuckit: Am. J. Psychiatry, 143:2 p. 141 - modified)

D. "**Every Door is the Right Door**"

"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

Underlying Principles

Services and programs focused on substance use disorders and mental disorders - whether experienced as co-occurring disorders or not - are driven by a number of key principles or precepts.

1. First and foremost is the simple fact that people of all ages who have co-occurring disorders are people first, fully deserving of respect.

2. At the same time, consumers, recovering persons and their families need to be involved in all aspects of their treatment and recovery.

3. People with co-occurring disorders can and do recover. Everyone must be optimistic about their prospects for achieving stability and recovery and provide the long-term support they need to maintain their progress.

4. People with co-occurring disorders deserve access to the services they need to recover. To put these beliefs into practice, the development of this report has been guided by the following principles:

- Ensure development of a system in which "any door is the right door" to receive treatment for co-occurring disorders. This means that people with co-occurring disorders can enter any appropriate agency in the service system and be provided or referred to appropriate services.
- Develop client-centered, individualized treatment plans based on an accurate assessment of the person's condition and the degree of service coordination he or she requires. Family members must be involved in treatment, where appropriate.
- Ensure the maximum feasible degree of integration for individuals with the most serious substance abuse disorders and mental disorders.
- Provide prevention and treatment services that are culturally competent, age, sexuality and gender appropriate and that reflect the diversity in the community.
- Promote the expansion and enhancement of service providers' capabilities to treat individuals of all ages who have co-occurring substance abuse disorders and mental disorders.

5. Finally, this report is not recommending the creation of a separate system of care for people who have co-occurring substance abuse disorders and mental disorders. Indeed, people with co-occurring disorders must be able to receive their treatment in mainstream systems of care that are well-prepared to support their recovery.

6. The formation of partnerships should be developed at all levels, from the national to the community and the neighborhood, for developing/enhancing seamless systems of care that allow people to move freely between and among the entire constellation of services they require.

E. **Medication Treatment Adherence Problems – Differential Diagnosis and What to Do About It**

It is important to diagnose why the person does not adhere to medication, otherwise the strategy may be counterproductive:

1. Cognitive – (a) client had a bad side effect or felt meds have not worked before and so won't take medication anymore – treat the fear of side effects and/or the lack of confidence in medication.
   (b) readiness to change issues – client not ready to accept medication as necessary for an illness which s/he may accept or about which is ambivalent – motivational enhancement, stages of change work.
   (c) wants to use natural substances rather than psychotropic medication.

2. Cultural – believes the medication is dangerous from his/her cultural perspective – get a bi-cultural outreach worker.

3. Unconsciously non-adherent; somatic complaints; sick role; characterological; the more the therapist is involved, the more it shows they care and the more the sick role pays off; love Assertive Community Treatment (ACT) for example, because the more you go to their home to count pills, the more they are non-compliant to keep you coming back.

4. Drug addicted – overusing pills due to an addiction.

5. Psychotic – delusional – maintain the relationship and don't struggle over the diagnosis; ACT is appropriate in such situations.

6. Malingering external incentives for the behavior e.g., keep getting workers compensation.

7. Recovery Environment problems – Insufficient funds to pay for medication and/or transportation and/or childcare to keep appointments for medication monitoring.

LITERATURE REFERENCES AND RESOURCES

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