
Integrated Services for Co-Occurring Disorders: How to Make it Really Work

David Mee-Lee, M.D. Davis, CA
(530) 753-4300; Voice Mail (916) 715-5856
dmeelee@changecompanies.net www.changecompanies.net

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I. 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)

- One Team, One Plan for One Person

II. Philosophical Clashes

A. 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

B. 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

III. What to do about Philosophical Clashes

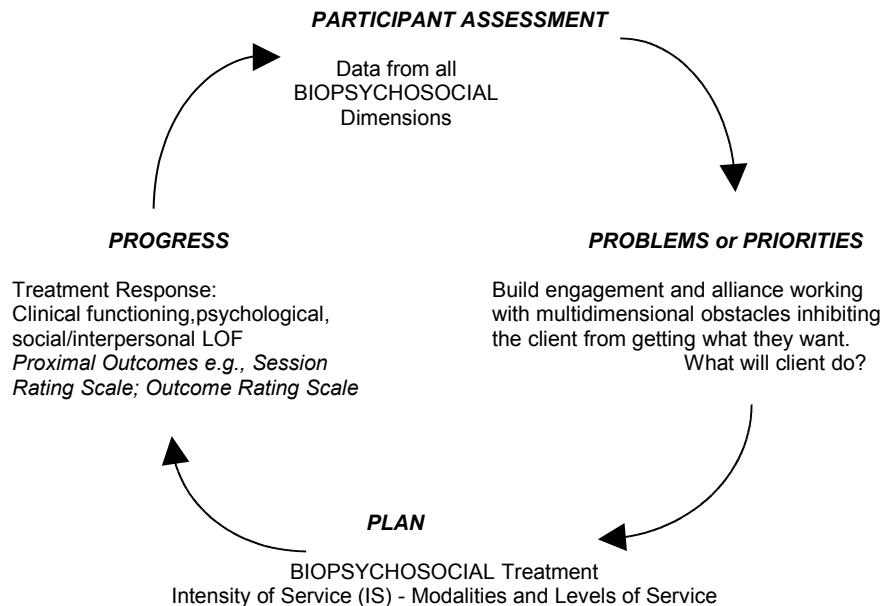
C. Person-Centered Assessment and Individualized Treatment Services

1. Biopsychosocial Perspective of Addiction and Mental Disorders

A common view allows a common language of assessment and treatment for all involved.

2. Client-Directed, Outcome Informed Treatment

A diagnosis is a necessary, but not sufficient determinant of treatment. A client is matched to services based on multidimensional needs and the focus of treatment, not placed in a set program based on diagnosis



3. Multidimensional Assessment

The common language of the six assessment dimensions can be used to determine multidimensional assessment of obstacles and needs to help the client get what they want. Also to identify what the client is willing to do in the context of the alliance and the focus of 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

Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	Assessment for intoxication and/or withdrawal management. Detoxification in a variety of levels of care and preparation for continued addiction services
2. Biomedical Conditions and Complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services
3. Emotional, Behavioral or Cognitive Conditions and Complications	Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services
4. Readiness to Change	Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change
5. Relapse, Continued Use or Continued Problem Potential	Assess readiness for relapse prevention services and teach where appropriate. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies.
6. Recovery Environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services

4. Biopsychosocial Treatment - Overview: 5 M's

- * Motivate - Dimension 4 issues; intervention; "raising the bottom"; motivational enhancement
- * Manage - the family, significant others, work/school, legal
- * Medication - detoxification; disulfiram; naltrexone, acamprosate; opioid antagonists; methadone, buprenorphine; psychotropic medication
- * Meetings - AA, NA, Al-Anon; Smart Recovery, Dual Recovery Anonymous, etc.
- * Monitor - continuity of care; relapse prevention; family and significant others

5. Treatment Levels of Service - ASAM Levels of Care/service to match severity of problems

- I Outpatient Services
- II Intensive Outpatient/Partial Hospitalization Services
- III Residential/Inpatient Services
- IV Medically-Managed Intensive Inpatient Services

IV. **People and Personnel Clashes and Solutions**

- 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.

V. **Policy and Program Clashes and Solutions**

A. **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

B. 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.)

C. 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 inadequate 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

Level of Care/Service Indicated - 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	
Level of Care/Service Received - 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	
Reason for Difference - Circle only one number -- 1. Service not available; 2. Provider judgment; 3. Client preference; 4. Client is on waiting list for appropriate level; 5. Service available, but no payment source; 6. Geographic accessibility; 7. Family responsibility; 8. Language; 9. Not applicable; 10. Not listed (Specify):	
Anticipated Outcome If Service Cannot Be Provided – Circle only one number - 1. Admitted to acute care setting; 2. Discharged to street; 3. Continued stay in acute care facility; 4. Incarcerated; 5. Client will dropout until next crisis; 6. Not listed (Specify):	

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>)

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](http://www.asam.org) - 4601 Nth. Park Ave., Arcade Suite 101, Chevy Chase, MD 20815. (301) 656-3920; Fax: (301) 656-3815; www.asam.org; (800) 844-8948)

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

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RESOURCE FOR ASSESSMENT INSTRUMENTS

A variety of proprietary assessment instruments for identifying substance use disorders, psychiatric diagnoses for adults and adolescents. To order: The Change Companies at 888-889-8866. www.changecompanies.net.

For clinical questions or statistical information about the instruments, contact Norman Hoffmann, Ph.D. at 828-454-9960 in Waynesville, North Carolina; or by e-mail at evincesassessment@aol.com

CLIENT WORKBOOKS AND INTERACTIVE JOURNALS

1. “Successful Living with a Dual Disorder” – Motivational, Educational and Experiential (MEE) Journal System. Interactive journaling for clients. This Journal is designed specifically for individuals who are suffering with a dual disorder. It provides important information that allows clients to understand the facts and challenges regarding their addiction and mental disorder.
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