One of the promises of the recovery movement is that it will facilitate the integration of mental health and substance abuse treatment, one of the Achilles heals of our entire system. Most of our cost problems, most of our bad outcomes, and most of our social failures are due to our dually diagnosed consumers. Yet we struggle to do much about it. Surely if we are both talking about recovery integration will be easier.

In 2004 I was invited as a mental health delegate to a large 2 day forum bringing together leaders from mental health, substance abuse prevention, and substance abuse treatment for the purpose of finding new ways to "break down silos" and work together. It turned out to be anything but easy. There were numerous things separating us ranging from our treatment paradigms to our emotional relationships with the people we're trying to help to our funding sources and system designs. Probably more importantly, though, was the fact that almost everyone in the room was over 40 years old. We were all veterans of past failed efforts to integrate. We all carried scars from being hurt by each other's systems. We all were wary and guarded. One woman said that when you build a collaboration it's more important to know what people won't bring to the table, what they'll hold back, than to know what they do bring to the table. Only one young researcher couldn't understand what our problem was. Weren't we talking about the same people and the same brain chemistry? Why was this so hard?

I've continued with these efforts as a mental health representative to the Partners for Recovery advisory board in the Center for Substance Abuse Treatment and this article comes from my attempts to contribute with very concrete proposals. The further I go the less easy it seems, but the better we're getting along. Perhaps we can work together in the future.

Integrating Mental Health and Substance Abuse Treatment Within a Recovery Framework

(2006)

One of the great struggles in mental health treatment is how to help people with both mental illnesses and substance abuse problems. A consensus has been reached that integrating the treatments for each of the conditions is essential. This has been very difficult for a variety of professional, funding, and cultural reasons. The emerging transformation of the mental health system into a recovery based system opens opportunities for new approaches to these problems.

Diagnosis:

Mental health treatment plans have been predicated on diagnosis and symptom reduction. Substance abuse treatment plans have traditionally been based on "working a program." Instead of being interviewed by a professional, people tell their stories repeatedly in supportive settings, a narrative diagnosis approach. Their "diagnosis" is more narrative than medical, more person based than illness based.

Strangely enough, the two fields are going in opposite directions.

As substance abuse treatment has become increasingly professionalized and required funding driven documentation these narratives are being replaced by medical, illness based diagnoses. This has opened up the possibility of comparing mutual diagnoses and determining which condition is primary and which is secondary to prescribe treatment. As we all know, this approach has been disastrous. Even efforts to improve things by saying that both conditions are primary remain within an illness centered model and have failed.

Meanwhile, mental health is becoming more person centered instead of illness centered, opening up the possibility of collaboration based on narrative diagnoses. I believe that will be a more promising approach.

Research has shown that all effective psychotherapeutic interventions require three things: 1) a trusting, working relationship, 2) a shared explanation for how the person got this way, and 3) a shared vision of how to recover.

Our current DSM diagnostic system is terribly inadequate for the purpose of being a shared explanation. It is basically research and epidemiological in origin. Its terms are highly technical and esoteric. It is very fragmented, dealing with personal complexity by piling multiple syndromic diagnoses on multiple axis. It virtually eliminates all causality and separates childhood from adulthood, and mental illnesses from substance abuse making it hard to describe inter-relatedness (or collaboration).

What we need instead is an explanatory story of the person's life and problems, including both substance abuse and mental illness features in words they share with us. I always read my assessment out loud to people on the second visit to make sure we've understood each other and can proceed to work together. If we expect to integrate complex use of medications, 12- step recovery approaches, and psychotherapy, we need to use narrative diagnosis.

Treatment Planning:

Recovery based treatments are aimed at improving peoples lives, rather than just treating their symptoms. We're moving from symptom based treatment to goal based treatment.

Traditionally our triage and treatment planning have been based on illness type and acuity. Recovery bases triage and treatment planning on people's progress in recovery (not dissimilar to asking what step someone is working on to decide what further help they need).

At its simplest, we can divide people in three groups: Unengaged, Engaged but not self-coordinating, and Self-responsible. Regardless of diagnosis or symptom level, there are common needs for each group. Also, these groups apply can to mental illness and/or substance abuse, and therefore can be the basis for integrated treatment plans.

Being "Unengaged" does not mean not being treated. It means not collaborating in the treatment process. Many of these people receive large amounts of treatment almost all in emergencies and frequently involuntarily. Traditionally mental health took the bulk of the responsibility for these people

or let it fall to jails. In California although there exist involuntary treatment laws for both mental illness and substance abuse, only the mental illness laws have ever been used. With the rise of criminal diversion and drug courts for substance abusers the burden is shifting to substance abuse programs. Increasingly, they are reaching out to mental health for collaboration. They are finding us to be too often unresponsive, inflexible (hospital or nothing) and fragmented. They are also finding that requesting "psychiatric clearance and a 30 day supply of meds" isn't really what people need. Many dually diagnosed people are not becoming engaged.

Many "Engaged but not self-coordinating" people are still actively using substances and "noncompliant" with mental health treatments frustrating both systems. Both mental health and substance abuse systems tend to respond to these people with structure and taking over decision making. Many people disengage as a result. Also, it's hard for two controlling systems to collaborate with each other. For example, many residential substance abuse treatment programs forbid all visitors for 30 days including mental health staff and most mental health facilitations resent and restrict the influence of outsiders as well. I've never seen 12 Step sponsors welcomed into mental health treatment teams. The recovery approach promotes supported risk taking, personal growth, and skill building for these people. That will be a major shift for both systems, but has more potential for collaboration than shared control does.

"Self-responsible" people are desirable in both systems. They are no longer abusing substances, make appointments, take their medications regularly if needed, and have limited crisis. Our usual "collaborative" model, where they work with two separate systems, profiting from both, works quite well, because they take care of the coordination for us. Too bad everyone isn't in this group.

Treatment Approaches:

By working alongside people of differing trainings and backgrounds, we've been exposed to each other' approaches and found new applications. For example, as my substance abuse coworkers have struggled to add harm reduction and motivational interviewing to their approaches, I've learned not only how to use these skills with substance abusers, but also with "Unengaged" people with mental illnesses. Similarly, as I've learned to target psychiatric medications, not just for symptom relief, but to improve people's quality of life, I've begun to target medications not just for cravings or withdrawal symptoms, and not just to treat co-occurring mental illnesses, but to improve people's quality of life so they're less likely to abuse substances. I've also learned how to support 4th Step exercises as a tool of emotional healing and how to incorporate the spiritual aspects of the 12 Step program into helping people overcome their suffering by finding higher meanings. Integrating our separate approaches into an overall recovery transformation can create a fertile ground for developing hybrid and novel treatment approaches.

The vast majority of dually diagnosed people are rejected by normal society and by our present treatment programs. An integrated program must create an internal "counterculture of acceptance" to welcome them and create a sanctuary and healing relationships, and then advocate for the spread of acceptance into the community. This requires having staff with unusual personal experiences so they

will have unusual personal acceptances. A treatment team needs to be multi-experiential as much as multi-disciplinary.

Treatment Programs:

Treatment programs often face a choice between collaboration and integration. As we divide people into recovery groups, it becomes clear that integration is required for "Unengaged" or "Engaged, but not self-coordinating", but either approach is possible for "Self-responsible". There is a large difference between having two agencies referring people to each other and having one agency try to engage everyone. There is a large difference between "cross training" staff in each other's specialties and having fully trained staff in both fields working on the same team.

For example, in the mountains outside Los Angeles we have a 3 to 6 month residential substance abuse program that averages about 300 residents. About one third of them arrive with 30 days of medications. There are no mental health professionals on staff and it's miles to take them to reluctant clinics and emergency rooms for medications. Collaborative agreements have repeatedly failed. It would be an amazing improvement to have a psychiatrist and mental health workers hired directly by the program and creating an integrated program. I believe our results would improve if meds were readjusted on site weekly, and ongoing close contact with therapy maintained. This first period of active treatment, of new sobriety, is a time of enormous changes and needs to be followed closely and integrated to reduce relapses. We'd do better if we worked together.

Interagency collaboration rarely works. It is too vulnerable to personalities, conflicting cultures, protectionism, blaming, and fragmentation. Neither a continuum of services nor a spectrum of services actually works. Integrating all services at all levels of need into one self-contained "one stop shop" does work.

Each person should perceive the agency as seamlessly offer everything they need, like watching a TV getting every color, sound, and multiple channels. Behind the scenes the agency's administration will have had to coordinate multiple sources of diverse funding, like the wires in back of a TV to achieve that effect. The Village has funding from mental health, jail and homeless diversion state funds, Medicaid, HUD, vocational rehabilitation, city homeless outreach, and United Way. Of course a single large cable would be better. Having two TVs one that gets blue and one green wouldn't work. Neither do two specialized agencies.

I believe we should be focused far more on developing integrated programs than collaborations between programs. The recovery transformation makes it possible to create a culture for these integrated staff to share.

Community mental health centers and substance abuse treatment clinics should be replaced by Integrated Service Agencies. The purpose of these agencies is not to treat mental illnesses, but to help people with mental illnesses and substance abuse to have better lives. There would be an integration of mental health services, substance abuse services, rehabilitation, housing, employment, community

integration, and financial services, legal and family services. The Village ISA in Long Beach is an outstanding model of this approach.

When services are integrated new integrated program descriptions emerge:

1) Welcoming center: outreach and engagement, "no wrong door", connecting and building therapeutic relationships
2) Sanctuary: a safe place of acceptance, where one can lower defenses and vulnerably look at what needs to change, to get hope, physical safety through shared community, there are consequences for behavior without rejection and "no fail" policies
3) Refugee center: many people have lost their roots and connections, drifting or excluded as refugees in their own country. They need charity, re-documentation, benefits assistance, "good citizenship" training, developing a community "niche" and belonging, and social advocacy.
4) Healing center: True healing requires work on many levels: biological, cognitive, emotional, and spiritual.

For example, a comprehensive homeless assistance program can be structured as an Integrated Services Agency. By my estimates only 20 – 30% of homeless mentally ill people meet the classic description of formerly institutionalized severely biologically ill, usually psychotic, people that are most targeted by our present mental health centers. The other 70 – 80% are severely disturbed children grown up. They have experienced child abuse and neglect, foster care, special education, illiteracy, school drop out, very early substance abuse, childhood homelessness, and/or juvenile justice. The vast majority have ongoing severe substance abuse problems. The above set of integrated programs directly address their needs without fragmenting services.

Treatment Relationships:

Traditionally, mental health, especially biological psychiatry, has used a professional - patient model of relationship. We expect little from our patients beyond giving us control over their lives, accepting care taking, and following our treatment orders. This model has driven away quite a number of people, including historically the entire AA movement. The recovery transformation is requiring massive changes in our treatment relationships emphasizing consumer inclusion, choice, empowerment, collaboration and self-responsibility. Many of these changes should be welcome by the substance abuse system. Unfortunately, many substance abuse programs have themselves "professionalized" and moved away from these value and may need to reconnect with their roots. Mental health programs can learn, and some substance abuse programs can relearn, a lot from accessible sponsorship, helping someone work a program, "accepting" self-help groups, and pride in and rituals appreciating recovery.

Hiring consumer staff, while relatively new and unsettling in mental health is perfectly normal in substance abuse treatment. Mental health can learn that our worst fears are unfounded.

Mental health has become overly burdened and restricted by our professionalism, our strict boundaries, and our restricted roles. Keeping people at a distance while purporting to help them is

counterproductive. The addition of consumer and paraprofessional staff will likely lead us to reexamine our rules and return to their ethical and healing underpinnings.

However, not all is perfect in entirely consumer run programs. It is sometimes difficult to help people who are very poor at relating to other people – for example because of psychosis, serious personality disorders, or past trauma – and unlike substance abuse programs, mental health cannot resort to kicking out and abandoning large numbers of difficult people. We must do better together.

Stigma:

Our social responses to mental illness and substance abuse are very different. People with mental illnesses are generally considered deserving of help rather than punishment. For the most part, their condition is not considered to be their fault and they are expected to be limited in their ability to handle life because of their illnesses. They should be protected from the stresses of normal life and not held responsible for the consequences of their own actions. Other people should take responsibility for them, take care of them and offer asylum from life itself. On the other hand, people who abuse substances are considered at fault for their problems. They can be held responsible for their actions including the substance abuse itself. Generally, they deserve punishment rather than help. However, if they are able to take responsibility and recover they are able to return to a full life.

I believe that some people chose which condition to identify themselves as having by which stigma they wish to live with. Are they trying to avoid responsibilities or be welcomed back into their community? It is difficult to convince some people to participate in integrated treatment where they will be exposed to both sets of stigma, where they will feel blamed and excluded.

The recovery movement in mental health seeks to change the social response to mental illness. Instead of taking care of people or protecting them, we seek to support them to take responsibility for their illness and their lives and to participate fully in our community. Meanwhile, criminal diversion and drug courts for substance abusers seek to reduce blame, but not responsibility, and to replace punishment with support. These two trends have the opportunity to come together into one social response and stigma. This would be a supportive response that emphasizes responsibility and inclusion. This would facilitate integrated treatment.

Patients' rights takes a strikingly different form in our two fields. In mental health patients' rights are focused on protecting people from the treatment professionals who society has turned all power over to and are feared and often perceived to abuse our power. In substance abuse, society turns almost no power over to the treatment system, punishing and abusing them itself. As a result, patients' rights are focused on protecting people from society, especially the criminal justice system. As we work together we must be careful how we use fear and power.

We have enormous opportunities available to work together in ways that are more than skin deep, to learn from each other while preserving our special talents. The recovery transformation is pushing all of us to re-examine how we do things and why we do them. I suspect that as we all recover why our hearts brought us to this work in the first place, we'll find we aren't two separate systems at all.

This year I was asked to present a day long workshop "Integrating Mental Health and Substance Abuse Within a Recovery Model" in which I used the ideas from all three of these substance abuse articles. It was well received, primarily, I believe, because people on both sides are beginning to be ready to work together. The last portion of the day was spent on small group discussion where they generated new integrated ideas for our work. My instruction was that I didn't want them to create "compromises" like "we'll have both a Christmas tree and a Hanukah menorah." I wanted them to create new merged products. They responded by creating everything from a new approach for the social work department at the general hospital to include both mental health and substance abuse to an integrated jail diversion program for youth aging out of Juvenile Hall to a new hybrid job description of sponsor/case manager. I left hopeful.

Although, like most of us, I didn't become a psychiatrist to treat drug addicts, it may ultimately turn out that recovery's most important contribution is better lives for people with both mental illnesses and substance abuse.