Things That Don’t Make Sense

by David Mee-Lee, M.D.

No. 1 — Agencies recognize that 50 percent of the client population has co-occurring disorders, yet only one or two clinicians on the treatment team is skilled or competent in the other disorder.

It is not unusual for me to ask a mental health program how many of their clients have co-occurring mental or substance use disorders. Most estimate 40 percent to 50 percent or even more. Then I ask, “Who on the staff is a certified addiction counselor?” Again it is not unusual to hear silence or; “I think Joe used to work in a detox once. He’s here on weekends.” And the same is in the reverse on addiction programs: “I think Joe used to work on a psychiatric unit once. He’s here on weekends.”

What to do about it:
If there are not resources to hire more people, make sure that the next staff member who leaves is replaced with whatever expertise is needed: someone with addiction or mental health competency. Or start trading staff to co-lead a group; or spend a week at the other program.

No. 2 — Agencies claim that addiction is a chronic, relapsing illness but, on intake, tell a client that if he uses alcohol or some other drug that he should not show up for group that day or the policy is to send him away if he shows up.

I have never heard of a program or clinician telling their mental health clients, on intake, about a policy like this. If you should get depressed or suicidal, manic or psychotic, panicky or anxious, do not come to treatment that day. I could not imagine a program turning someone away because they showed up to a session with the very problem for which they are getting help.

What to do about it:
First decide whether you really believe that addiction is often a chronic, relapsing illness that can be true for schizophrenic disorder, bipolar disorder, major depressive disorder and panic disorder. Examine the stigma and attitudes of the lay public. Often they view addiction as willful misconduct with a need for consequences. It is hard to treat co-occurring disorders, if there are such different attitudes about mental disorders versus substance use disorders.

No. 3 — Clinicians exclude an addiction client from group treatment when he shows with alcohol on his breath for fear that he might trigger other group members. In contrast, they are quite comfortable with a mental health client talking about domestic violence or sexual abuse even though that talk may trigger others in the group.

Do not misunderstand:
The treatment milieu should be safe and therapeutic. I am not saying that if a person is severely intoxicated — slurred speech, cognitively unable to participate — we continue to do group or psychotherapy with them. These are urgent needs that must be addressed. Nor am I saying that if the client is intent on using substances and trying to get others to use with them that we just ignore that and continue treatment as usual. But their condition can be used to help both the client who relapsed and any others who could identify with the same struggles and loss of control.

What to do about it:
Make it clear to all clients that recurrence of use is a treatment alert. Similarly recurrence of psychosis, mania, depression or suicidal thoughts and behavior are also significant events that need professional assistance. If a client is willing to reassess their treatment and change their plan in a positive direction, then treatment continues.

No. 4 — Clinicians have assessed a client as being out of control, severe and a chronic relaper who needs residential treatment, but then the client is placed on a waiting list for anything from days to weeks.

I have never heard of a patient who needs the intensive care unit being placed on a waiting list. I cannot imagine a pregnant mother who is in labor and coping with increasing labor pains being told to come back later when a bed is available. By the Patient Placement Criteria of the American Society of Addiction Medicine (ASAM) a client who needs residential treatment has one or more dimensions that are of such severity that the client would be in imminent danger if not in a 24-hour setting. Placing such a person on a waiting list does not make sense.

What to do about it:
Use residential treatment and 24-hour care for those who are truly in imminent danger. This frees up beds that allows timely admission of people who really need a residential level of care. If someone is safe enough to be on a waiting list, then by definition, they do not need residential treatment. These clients still need services but can be started immediately through a combination of outpatient, intensive outpatient, or partial hospital care and structure; coupled with supportive living.

I realize that I may be stomping all over your sacred cows or core beliefs. Accept whatever stage of readiness to change you select. My goal is not to step on your toes, but to have you think about what you or an agency does — to ponder Things That Don’t Make Sense.