

# Integrating Psychiatric & Substance Use Disorder Treatment: Models, Evidence & System Transformation Opportunities

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## Dr. Buttlare

Hello everyone and welcome to today's RECADEMY webinar, Integrating Psychiatric and Substance Use Disorder Treatment, Models, Evidence and System Transformation Opportunities. I'm Dr. Stuart Buttlare, Vice President of Clinical Excellence and Leadership with *OPEN MINDS*.

Across the country, provider organizations, health systems and policy makers are increasingly recognizing that substance use disorders and mental health conditions rarely occur in isolation.

For many individuals, particularly those with opioid use disorder, co-occurring psychiatric conditions such as depression, anxiety, PTSD, and serious mental illness are common and often complicate treatment, engagement, and outcomes.

Yet, despite decades of research demonstrating the benefits of integrated care, psychiatric and substance use disorder treatment systems often remain fragmented, delivered through separate programs.

Workforces, and sometimes entirely separate regulatory and financing systems.

Today's conversation focuses on how organizations are beginning to close that gap and what it takes to design care models capable of addressing both psychiatric illness and addiction in a coordinated and effective way.

If you have any questions during the discussion, please submit them via the Q&A option in the Team platform.

To get into this discussion, I want to briefly frame why this topic matters. For many patients, particularly those with opioid use disorders, co-occurring psychiatric conditions are not secondary. They are central to whether patients engage, stay in treatment, and ultimately improve.

So the question for today is, what does it actually take to move the fragmented care to integrated models that work in real-world practice?

I'm pleased to be joined today by Doctor Charles Whitehill and Doctor Louai Bilal, whose experience sits at the intersection of psychiatric and substance use disorder care.

**Dr. Bilal** is a board-certified psychiatrist and director of inpatient psychiatry at Kaiser Permanente, where he leads high acuity medical psychiatric care and brings deep expertise in psychopharmacology, diagnostic evaluation, and multidisciplinary team-based treatment.

His global background in culturally informed research further strengthened his ability to care for complex and diverse patient populations. **Dr. Whitehill** is Chief of Addiction Medicine and Recovery Services for Kaiser Permanente in the Napa-Solano region and is a board certified in both

**Dr. Buttlare**

Family and addiction medicine. He brings extensive experience designing and scaling evidence-based addiction treatment within an integrated health systems with a focus on improving access, engagement, and outcomes. Together, they offer both the clinical and system level perspective needed to advance truly integrated care. Doctors, thank you both for joining us today.

**Dr. Whitehill**

Thank you for having us, Stuart.

**Dr. Buttlare**

So I'm going to, you're very welcome. Nice to have you both. So I'm going to launch into the questions if you don't mind.

**Dr. Bilal**

Thank you, Stuart.

**Dr. Buttlare**

So, to start at a high level, when we talk about opioid use disorder treatment today, how often are clinicians encountering significant co-occurring psychiatric conditions? From your perspective, you know, how central are those conditions to the overall treatment picture?

And let me start with you, Doctor Whitehill.

**Dr. Whitehill**

All right, thank you. A very good question, and it's, if you had to guess 50%, you're pretty close, and it runs 40 to 60%, and in some populations, 80% of our patients will have a...

**Dr. Whitehill**

A psychiatric component due to their, or along with their substance use disorder, and it would be very easy to confuse or leave out a diagnosis if you just started treating substance use disorder, did not consider another psychiatric illness, or if you were treating a psychiatric illness.

You probably also got a substance use disorder there as well.

**Dr. Buttlare**

Thank you. **Dr. Bilal**, your thoughts?

**Dr. Bilal**

No.

I would agree with that. And I think we teach trainees that for a condition like major depression, it's very prevalent. So, one of five or six patients might have that. But in the substance abuse population, opiate use disorder is one of them. It may go up to one in two or one in three. So, then you would expect that the prevalence is much higher. And this is really the case for other major psychiatric conditions like bipolar disorder, anxiety disorders and post-traumatic disorders. So, these are almost expected to be present in those patients.

**Dr. Buttlair**

So it sounds like the two of you agree that really from your perspectives, you know, the co-occurring conditions really are central to the treatment of substance use disorder and psychiatric care. And so moving to question two, historically, psychiatric care and substance use disorder treatment have often

**Dr. Bilal**

Yes.

**Dr. Buttlair**

Been delivered in separate systems. In most areas, that's the case. What are some of the most common ways fragmentation affects patient outcomes? Where do you see patients falling through the cracks? This is a critical issue with maintaining patients and treatment and getting them to care.

I'm gonna start with you again, Doctor Whitehill.

**Dr. Whitehill**

Yeah, okay. Yeah, I guess we would call that sequential care and it's very common to see this. We're going to postpone mental health treatment until this person is stable. And where that creates a problem is, number one, you're going to miss, probably miss a significant diagnosis of something that's going on.

You're going to have somebody who's much more difficult to stabilize. Either the substance use disorder doesn't get stabilized or the mental health disorder gets destabilized by ongoing use. So right at the start, when you do sequential care, you're leaving out half of half of the problem and expanding the time, the energy and the resources needed to take care of that. Other places where these people fall through the cracks is in the transition. The transition between a hospitalization for a mental health disorder or a hospitalization for a detox, a residential treatment, or even add an emergency department visit. That time in between is crucial to stabilize a patient and they're frequently missed.

**Dr. Buttlair**

Thank you for that, **Dr. Bilal**.

**Dr. Bilal**

Absolutely.

I agree with what Charles said, and what I can add is maybe the stark and striking examples where the

fragmentation actually can be dangerous. And that's sort of for patients who have severe impulse control related to depression or suicidal ideation and not being offered.

The treatment. So, this you can see either in the emergency room at the point of entry or in actually the point of discharge from a psychiatric facility where it's a little flipped here, they don't have access to substance use treatment. And so we know that the risk of suicide can be very high at the time of discharge from a psychiatric hospital if we don't give them access to substance use treatment right after.

**Dr. Buttlair**

Doctor, **Dr. Bilal**, just to follow up to that, you know, we see a lot of, you know, readmissions in psychiatric disorders. And I'm curious, do you see the substance use issue and the gaps in discharge planning as being one of the

**Dr. Buttlair**

Relevant issues related to readmission.

**Dr. Bilal**

Highly relevant. So, if you don't treat it, then you set up the patient for relapse. We know from neuroscience now that relapse is almost inevitable for a lot of these patients. And if you don't treat them, we often see them come back to the emergency room and the hopeful scenarios that they're safe and they came back to treatment, but in many cases, unfortunately, they may have serious morbidity or even mortality.

**Dr. Buttlair**

And **Dr. Whitehill**, do you see that similarly, you know, in terms of people coming back to you again and again, not only because of their substance use urges, but also because of their psychiatric condition making things worse related to their substance use?

**Dr. Whitehill**

Very much. I think that mental health issues and substance use disorders have common pathways, common neurotransmitters that are disrupted and out of balance. And you will see people seeking to stabilize, self-medicate themselves.

So if you had an uncontrolled anxiety or depression, you may see ongoing relapse as a way to feel better. So, it's very important to approach these relapses with curiosity to see

**Dr. Bilal**

Ohh.

**Dr. Whitehill**

What's driving it, and to consider the mental health of the patient.

**Dr. Buttlair**

Thank you both. So many treatment systems historically expected patients to stabilize one condition before addressing the other one. For example, requiring sobriety before addressing trauma or depression. How has

thinking evolved around simultaneous treatment of co-occurring disorders. I think you sort of got this, Dr. White, a little earlier when you talked about sequential. So, I'll start with you.

**Dr. Whitehill**

Yeah. As I mentioned before, that's the sequential. We still see that. There's still pressure to do that. But I think it's largely been abandoned in care systems where you have coordinated care. You need to begin mental health treatment and stabilization on day one, even before.

Where the patient is fully sober. So, this has its roots in harm reduction, which is taking incremental steps towards sobriety, meeting the patient with where they're at, and establishing safety and boundaries.

**Dr. Buttlair**

Mhm.

**Dr. Whitehill**

So we can begin addressing trauma, depression, anxiety, the same time that we're doing that assessment for substance use and starting detox medications.

**Dr. Buttlair**

Doctor Bilal.

**Dr. Bilal**

And I work in the hospital setting at what Charles is saying also resonates well in the sense that now we're moving away from this sequential thinking for a patient, for example, who was struggling with alcohol dependence and had serious depression. In the past, we would want them to leave the hospital, go connect with their outpatient clinic and then get some sort of authorization or approval to go to a residential program. So, we don't do that anymore. We consult with our chemical dependency colleagues in the hospital. We start the treatment for the depression. If they recommend, for example, we give them a treatment for preventing relapse like naltrexone injection, we go ahead and do that. We obtain approval to step them down from the hospital and straight into the residential program from the hospital. So, this works much better and the data builds it out. We see that the outcomes are better, they're much safer, and they tend to stay in recovery much longer.

**Dr. Buttlair**

Mm.

Thank you both. So, when integrated treatment programs work well, what are the key components that tend to be present? What's really helpful about these programs? And are there particular staffing models, treatment approaches, or clinical workflows that are especially important to have?

Charles.

**Dr. Whitehill**

Yeah, I think you have to start with the idea, a commitment to having integration, which is having a variety of staff and a commitment towards a longitudinal process. So in that model, you would have therapist, psychologist, preferably an addiction psychiatrist, physicians, nurses that specialize in addiction medicine. You would need

to have regular staff meetings for case discussion, to be thinking outside of people's comfort zone, outside of people's knowledge base. So, it takes more than just a staff that's been exposed to different disciplines. It needs an experienced staff to follow the patients. And when we do that, we get, I think, more successful outcomes right out of the box.

**Dr. Buttlair**

Mm.

Thank you for that, Louai.

**Dr. Bilal**

Yeah, absolutely. And I think one infrastructure point is for many systems are now self-evidence. The electronic medical record, having that in one instance and integrated across specialties improves tremendously with communication, with consultation.

And I agree with Charles having access to addiction medicine specialists because they're very skilled at motivation and interviewing and very skilled at prescribing medications for relapse prevention and are sort of an essential link to the chemical dependency teams facilitating referrals. So really having that relationship across different settings, whether it's a hospital, the clinical, the residential program, or the community, and a mode to communicate with all those teams is crucial. And any inbuilt education would be very helpful because there are core skills that the chemical dependency teams have that are not very prevalent, unfortunately, but having access to those and educating about the resources, I think improves integration and I think would be a good component of any system to make sure that these patients get.

**Dr. Buttlair**

Mm.

**Dr. Bilal**

The the best care.

**Dr. Buttlair**

I also hear you both saying, and I'm interpreting, as team-based care leads to improvement, that whether you're integrating with electronically or medical records or providers with different backgrounds and skills,

**Dr. Bilal**

Yeah.

**Dr. Buttlair**

It's really about a team that's bringing that expertise.

**Dr. Bilal**

Yes.

**Dr. Buttlair**

I hear a lot of team-based work here.

**Dr. Bilal**

Which makes sense for a chronic care condition like substance use that is comorbid with psychiatric disorders, you really do need a multidisciplinary team because the care requires different skill sets.

**Dr. Whitehill**

I brought up a really great point and I think something we love about Kaiser is that we have a electronic medical record that is usable across, you know, Northern California, any place. If Lou I sees a patient, I'm going to know.

**Dr. Bilal**

Ohh.

**Dr. Whitehill**

At the same time, what he's prescribed, what he was thinking. If our patient has now in the emergency department in Sacramento, we can see that, we can see the results, we can see the condition. So, we're able to communicate effectively back and forth and see each other's work in real time.

**Dr. Buttlair**

This next question, I think, touches some of what you both have said. Workforce specializations can sometimes create barriers to integration. Psychiatrists, addiction medicine physicians, therapists, and counselors are often trained in different traditions. What workforce strategies.

Have you seen in either your organization or other organizations to bridge those type of divides?

**Dr. Whitehill**

I think that what I really appreciate the most about where I work is that team approach. There's not just one person. We have addiction medicine providers and addiction psychiatrists, nurse practitioners, therapists, marriage and family therapists. We have social workers.

**Dr. Bilal**

Yeah.

**Dr. Whitehill**

And we have regular case conferences to meet, you know, with the patients to discuss our plan with the patient going forward so that nobody stays stuck in a role of just being the prescriber or just being the therapist. It really takes a team to help move somebody along through recovery and into better health.

**Dr. Bilal**

Yes.

Yeah. And I think one of the ways to maybe help those providers who may be wedded to one way of looking at the problem is just by improving consultation. So, one to explain what one sort of approach to ensuring that the patient gets a chemical dependency consultation and maybe get the assessment and the treatment is to agree that for a patient that we've diagnosed with any substance use disorder, that the standard would be that we would consult with chemical dependency. So then that removes sort of this onus on the provider to think, well, does this really

require medication? Does it require referral? So, removing that struggle and then most of the time you find that these colleagues bring in tremendous expertise and it really benefits the patient. So that is one way to realize that.

**Dr. Buttlair**

Kerr.

Thank you both. Medication management is often a critical component of both psychiatric and addiction treatment. How do organizations, you know, successfully integrate medications for opioid use disorders, psychiatric medications, and coordination across prescribers?

**Dr. Whitehill**

I think having an agreement of no wrong door and having providers comfortable with managing prescriptions and also comfortable reaching out so that your mental health workers can consult with addiction medicine on any issue they need. Our psychiatrists can also consult the most effective medicines or maybe even medicines you want to avoid because of a substance use disorder. So having everybody comfortable with the medications.

And this is where that electronic medical record really is invaluable. You can see what somebody's on. You can foresee problems coming through. It's not unusual for me to reach out to some of our clinicians out there and say, hey, you may not want to prescribe this medicine anymore because of this use disorder or this tendency for the patient. So, communication and comfort in that communication.

**Dr. Bilal**

And related to communication, I would add education, really educating not just the physician workforce, but also the other clinicians about the availability of these treatments and also the ease of use. And another really underutilized piece of information is just how effective they are. I mean, if we look Charles and I work with the Kaiser, if you just look at what the outcomes are for patients who are being prescribed naltrexone, long-acting, for example, or Suboxone for opioid use disorder, just really seeing what that means for the morbidity and mortality over time.

It really just would help our colleagues in other departments, for example, the ED or on the hospital floors, our internist or psychiatrists and inpatient unit, just to really see how effective these treatments can be, I think would be a good way of

**Dr. Buttlair**

Mm-hmm.

**Dr. Bilal**

Educating people that these are accessible and can be life-saving and effective for patients.

**Dr. Buttlair**

You know, in my practice, I often worried about polypharmacy.

And people misusing the medication and even at risk. How do you manage that? Because now we're dealing with multiple medications for these patients and, you know, different dosages at different times. You know.

Is that a challenge and how do you overcome that?

**Dr. Whitehill**

That would be a huge challenge if you were blind. Blind to what's going on in the world. If you're working in a silo and you weren't able to share records, you'd have no idea what other people are doing. Not only can we share records, and I can see what...

that Lou I is prescribing or recommending and he can do the same with me. We also have the ability to look out on the cures database and use that and see if the patient's going outside of our network or to other providers that haven't been mentioned. So that's an important part of any patient contact is.

**Dr. Buttlair**

Yeah.

**Dr. Bilal**

Mhm.

**Dr. Whitehill**

When we're doing that intake assessment, looking at the medicines, looking at the cures database and anticipating, you know, any of the problems.

**Dr. Bilal**

Ohh.

Yeah, and.

Yeah, cures, the database has been a lifesaver for sure. And then also leveraging pharmacists. So, pharmacists actually are really good at looking at drug interactions, at picking up a high-risk medication combination. So, in any system,

to the extent that we use them for other high-risk medications. They're really very good at monitoring, so that really helps. And the second thing I would say to that is really to, as much as possible, increase consultation with an addiction psychiatrist or

and addictionologist from any other specialty because they really are experts at understanding which medications are appropriate and which are not. One salient example is patients with severe post-traumatic stress disorder who are also addicted to alcohol, for example, of opiate.

Their medication combination may seem at face value to be very complicated at relatively high doses. But for trained specialists, they know that these medications are instrumental in keeping them well and keeping them alive. So, it's important to have that oversight from consultant from addiction medicine.

**Dr. Buttlair**

You mentioned PT. Yep, go ahead.

**Dr. Whitehill**

Lou I brings up, oh, he, I was gonna say, he brings up like just another important aspect of, I think, one of the things we both love about where we work at that, even at a much higher level, there is a policy of being careful with medications, with oversight at the pharmacy. So, if you get prescribed at one pharmacy and then another, or I write for a prescription, it's not uncommon to have a pharmacist contact me in real time. Hey, did you mean to do this?

Were you aware that this is, you know, happening? And, oh, okay.

I can adjust, you know, my plan. So not only at our operational level, the day to day, but we have this oversight from the pharmacy and policy, which is very important for patient safety.

**Dr. Buttlair**

Thank you both. And bringing up PTSD reminds me that many individuals with co-occurring substance use and psychiatric disorders also have significant trauma histories, right? And how should trauma-informed care fit into integrated treatment models in both substance use disorder programs as well as in psychiatric treatment.

**Dr. Whitehill**

It's got to be built in from the day one. It's A trauma-informed care where we establish safety with the patient, recognize some of the unique history that accompanies some of our patients, and we can begin stepwise treatment in small doses to address post-traumatic stress disorder on day one.

**Dr. Bilal**

Okay.

Ohh.

**Dr. Whitehill**

Doctor Bilal.

**Dr. Bilal**

Yeah, and then I think...

We've been lucky that now we're mandated to have regular training on trauma-informed care by the state. And I don't know to what extent nationally that kind of training is being widespread, but it's very good, even as a psychiatrist and someone who practiced with these patients for many, many years, I found it to be extremely helpful, such an eye-opener about what aspects can actually be traumatizing to the patients and what we can do to mitigate those. One big thing that I hope we

continue to do is really to remove obstacles to care for those patients and to really make it easier for them to access the care they need. When you have a history of trauma, it really does diminish your access and make it very hard for you to obtain care.

So really, if there is no mandate to do that training, it's good for hospitals to be proactive and do widespread annual trainings about that, because it's not really the kind of intuitive thing that people would get on their own. It really does require training and it can be

**Dr. Buttlair**

The.

**Dr. Bilal**

Done very efficiently in any hospital system.

**Dr. Buttlair**

Training and program development are both important aspects of this. And also, you know, thinking about moving from fragmented systems to integrated care often is about organizational transformation. You know, a lot of organizations sit with this kind of fragmentation.

**Dr. Bilal**

Mm.

**Dr. Buttlair**

So what operational leadership strategies have you seen at Kaiser or other organization used to redesign services successfully? What has it taken? Charlie, I know you've been in a lot, several different systems.

**Dr. Whitehill**

Multiple different systems and I love where I'm at right now because of our level of integration. It's baked into our system. With the variety of talent we have at our disposal, with the availability of information, quick consultation, our ability to follow our patients, whether they're in addiction medicine or they're in a behavioral health class or treatment. So that's what makes our organization, I think, successful at treating substance use and mental health disorders, having that variety of talent and expertise that is cross-trained. So that takes a commitment and it takes patience.

to develop because the results are not immediate. The results are something that you see longitudinally. You know, do people, people's level of recovery, their ability to remain sober, their ability to return to work and family life. Those are things that are harder to measure. So it takes more patience if you're looking for an outcome to measure. It's a little bit harder to measure.

**Dr. Buttlair**

Mhm.

**Dr. Bilal**

Yeah.

And in the hospital setting, some of the things I liked is this no wrong door policy when it comes to where you would start treatment. So, I've seen Suboxone, for example, started in the emergency room or in the ICU. So that's really good thinking is that you know, wherever the patient is at within the hospital system, they can get the treatment. And I also learned of the use of what they call substance abuse navigators. So, these are sort of clinicians maybe who are not licensed or not with an advanced degree, but they're able to sort of screen and assess all the patients with any substance use issue and then consult with one of the doctors who have a background in chemical dependency, but an internist or a psychiatrist. So, I like that system A lot. And then.

**Dr. Buttlair**

Mm.

**Dr. Bilal**

Really taken advantage of some of any helpful legislation. For example, in California, I think many people have heard of the expansion of commitment law to include patients with substance use. So what that's useful for in the short term, because I don't think and Charlie may correct me on this, there's no evidence that coercive treatment works long time, but in the short term, changing the commitment laws to include substance use as a reason for someone being a danger to themselves or others or disabled is a very good entry. And so taking advantage of that,

if appropriate, is a good expansion.

And even better legislation is really allowing general hospitals to detoxify patients. So, then you wouldn't really be this situation where the hospital is struggling to really place people in detox units. So, with these helpful legislations, you don't have to do that. It's just a matter of knowing that you do have the legal cover to do it and just offer the patient the treatment where they're at.

**Dr. Buttlair**

Makes good sense. Both of you make really good points with this. And, you know, you're talking about how it might improve, but I'm also wondering about some ways in which it gets in the way of integrated care through financing and regulatory structures. I even think about 42 CFR part 2.

Being a, you know, a way in which it creates barriers. So, you know, what policy or reimbursement challenges most commonly stand in the way of integrated treatment in your experience and within your organization and looking outside of it?

**Dr. Bilal**

Yeah.

**Dr. Whitehill**

We experience a lot less of that in Kaiser because it's a physician-run organization. Physicians can largely make the choices. We do interface with other, the Medicaid population. It's Medi-Cal in California.

And that's a huge challenge because the treatment benefit for substance use and largely mental health is held by the county, but the medication benefit is held by Kaiser. And this creates a lot of confusion out there in the community. Like you're a Kaiser member.

Go to Kaiser, like, you know, no, your Medi-Cal, you get your treatment outside of Kaiser with the county. So that's where a situation where we can't see what the county is doing, what their treatment plan is, where the patient's going.

We can see the patient and follow up for medications. So when insurance status or reimbursement affects how we deliver care, this is where coordinated care can fall apart. And it's an ongoing challenge for us.

**Dr. Buttlair**

Mhm.

So carve outs are really make it difficult, particularly if there's no coordination between the county and the health plan and the provider.

**Dr. Bilal**

Yeah.

**Dr. Buttlair**

Exactly. **Dr. Bilal**, Louai, do you have any comments about this one?

**Dr. Bilal**

Yeah, I mean, like Charles said, we do have less of that within the Kaiser system, but again, it's really when we interface with the other, I mean, the patients are the patients and they're trying to access care and where you find these problems. And I think any system.

We'll do better to sort of maybe have more of a value-based approach to this rather than sort of paying by service. And if we can focus on just getting the patient the care without really putting any strictures on billing or referrals would be good and I just go back to really looking at what that means to any system in terms of cost saving. The treatment for this disorder is highly effective and we can show that in both literature and in just.

**Dr. Buttlair**

Mhm.

**Dr. Bilal**

And the administrative data.

**Dr. Buttlair**

Speaking of research, you know, looking at the evidence and looking, you know, at a lot of different organizations, you know, there's a lot of arguments for treating integrated models for co-occurring disorders. You know, and this has been going on for many years, this research, but, you know, what does the evidence actually specifically tell us about outcomes when psychiatric and substance use disorder treatment are delivered together? What are the outcomes that you've seen?

**Dr. Whitehill**

We.

Clearly, I think we have a very clear advantage when we're able to treat these together. I think our patients clearly do better and they're happier for their care. That's a beautiful thing to see.

We were just talking about interface with other insurance systems and we struggle to have that, you know, same level of care, you know, when we're interfacing with it with the Medicaid system. So, when you fracture the system and you start siloing the care, we're going to do medicine here.

We're going to do care here. The care isn't as good. We see higher relapse rates. And we know that because people keep coming back to us, I need to be detoxed again. Like detoxed again, really. That means, you know, treatment wasn't, you know, as successful as we'd like to see it.

**Dr. Buttlair**

It.

**Dr. Whitehill**

And I experience more of that when we interface with other systems like the Medicaid or Medi-Cal system. So not as often with somebody who stays within the Kaiser system and we can coordinate to care better.

**Dr. Bilal**

Yeah, I think people now meaningfully speak of a gold standard, and that is to treat both together. The evidence is overwhelming, the literature. Anyone can just Google the question and you will find enormous literature. Many of them you can find the reference in the Columbia University or Cleveland Clinic sites and they give you access to all the relevant studies. Really just I think it's already one of the successes in medical care and overall medicine, really. It's a good success story and we like to integrate some of that into our care. As I mentioned earlier, I love the example of treating a patient in the inpatient psychiatric unit.

But also giving them medicines that would prevent relapse, reduce craving, and also stepping them down to substance use residential program from there. And for those cases, we can look in our own system, Kaiser, and we know for a fact that these patients do better.

**Dr. Buttlair**

You know, outside of Kaiser, I'm curious, I think you probably would answer this with Kaiser as the system, but I'm curious, as you look outside of Kaiser, are there particular programs or health systems or community models that you believe are demonstrating promising approaches to integrating psychiatric substance use disorder treatment.

Any other organizations or programs you see?

**Dr. Whitehill**

I've never worked for the VA, but I understand it's one of the largest integrated systems for health care substance abuse at the biggest scale that you could imagine.

And that's been, you know, quite successful.

And you did mention, you know, Kaiser. Kaiser does a pretty good job of this as well at a large scale, providing substance use, mental health, treatment that's fairly coordinated. And I'm sure there's a few, there's a lot of community-based organizations.

**Dr. Bilal**

Yeah.

**Dr. Whitehill**

Not familiar with any one name, but I understand that there's some community-based, you know, programs out of New York, San Francisco that are pretty successful as well.

I know, **Dr. Bilal**, if you have any experience with other organizations or the same.

**Dr. Bilal**

Yeah.

**Dr. Buttlair**

Louai.

**Dr. Bilal**

No, it's really similar. And actually, the example that came to mind is the VA, but especially the VA as it's linked to an academic center, which most of them really are, Stanford, for example, UCSF, and those tend to have really good programs, and the focus is the same. They really do integrate care and they offer both psychiatric and substance use treatment as just one treatment. So, I think they tend to do well.

**Dr. Buttlair**

So we'd love your advice for health system leaders, behavioral health executives and policy makers who might be listening today. You know, what are the most important steps they should consider if they want to move toward more integrated care for co-occurring disorders?

**Dr. Bilal**

Yeah.

**Dr. Buttlair**

What steps should they take?

**Dr. Whitehill**

I think you'd probably start with a very clear plan of what you want to do. A commitment to integration and start small. Start small and have patience for results.

**Dr. Buttlair**

But.

**Dr. Whitehill**

You're not going to see results in numbers immediately. What you're going to do is you're going to see results in outcomes over time. And if you have success scaling upwards to include more diversity of talent, more diversity of knowledge,

The research has proven this is a much more effective way to deliver care, but it takes a little bit more resources to get there.

**Dr. Buttlair**

Thank you, **Dr. Bilal**.

**Dr. Bilal**

Yeah.

Yeah, and I would add to that, even though we take for granted now that EMR is widespread, but for those still lagging to really invest in improving that, because it can be very powerful in this kind of clinical scenario with substance use and co-caring and psychiatric disorders. It improves communication, it improves prescribing safety, and it improves documentation. So, it's really a win all around. So that would be one big thing. And then I would really, we think of those as sort of a chronic disease condition where if you compare it to sort of diabetes or to congestive heart failure, for example, you would think that leveraging pharmacy resources is a straightforward thing. So yeah, leverage pharmacy resources for substance use treatment as well.

They help you not only with prescribing, but with safe monitoring. So that would be really needed. And then one of the easiest or maybe slightly less expensive investment is education. And I would educate in a positive way and just showing the outcomes when you actually make these treatments available. It's really one of the great success stories we have. So really advertising the use. And then the last thing is really

**Dr. Buttlair**

Mm.

**Dr. Bilal**

Looking at your individual systems and going with that mentality of no wrong door to access and see where you can improve access to care within your system in each respective clinic, emergency room, hospital floor, community-based, so all that, wherever your patients are, try and give them an access point to treatment.

**Dr. Buttlair**

Neither of you mentioned AI and we're just approaching near the end, but I wondered, do either of you have a have you seen the use of AI improve integration?

**Dr. Bilal**

Yeah.

**Dr. Buttlair**

As yet.

Yeah.

**Dr. Whitehill**

Yeah. I'm, yeah, I'm not sure of that. And maybe I'm not using it to the level I need. It makes our jobs easier. It makes documentation easier, makes it easier to look up, you know, information. But there's just no substitute for Colin, you know, somebody, you know, hey, Louai, you just saw a patient, where Sharon, you know, I want to let you know that X, Y, or Z, you know, nothing, nothing will replace that physician.

**Dr. Bilal**

No.

Yeah, yeah.

**Dr. Whitehill**

The provider-provider communication, team communication. But we will start to see more of this. I don't know what your experience is, Louai.

**Dr. Buttlair**

Gotcha.

**Dr. Buttlair**

No.

**Dr. Bilal**

Yeah, so far I agree with that, Joseph. So, to my knowledge, no pervasive use yet, and I agree that the human touch is sort of essential for this kind of thing. I don't know how good AI-based therapists would do motivational interviewing.

But we can't get humans to do it well. So that's one thing. But what I see promise for it is really some of the things we've discussed in terms of alerting the patient for medications to pick up, maybe preventing relapse, and that way, to the extent we can use it

**Dr. Buttlair**

Yeah.

**Dr. Bilal**

To improve medication compliance, compliance with visits. I'm sure that there are ways we can leverage it the same way for other conditions, but I don't think it's been adopted widely yet, but always open to you know, using this new technology to help the patients.

**Dr. Buttlair**

I want to thank you both. This has been a terrific conversation. Integrating psychiatric and substance use disorder treatment is not simply a clinical preference. It really is increasingly a clinical necessity, you know, given the complexity of patients entering care today. You know, as health systems, providers, and policy makers.

**Dr. Bilal**

The.

**Dr. Buttlair**

Continue to respond to the opioid crisis and broader behavioral health challenges, building care models from the beginning capable of addressing co-occurring disorders will be essential to improving outcomes and reducing preventable suffering and suicides, as you guys have talked about.

You know, I want to thank both **Dr. Whitehill** and **Dr. Bilal** for sharing their expertise and insights with us today. And thank you all of you for being able to join us today. This webinar is part of RECADEMY's 12-part series for 2026, and we invite you to join us for the future sessions.

Again, thank you.

**Dr. Bilal**

Thank you.

**Dr. Whitehill**

Thank you.