BEST PRACTICES

What Is Integration? Part II

Kenneth Minkoff, MD

The previous edition of this column began to address the concept of "integration" as applied to mental health and substance abuse, and attempted to develop a broad conceptualization of the definition of integration, and then to apply that conceptualization to an understanding of "systems integration" and "services integration" at the system level. The goal of this edition of the column is to adapt that same conceptualization to an understanding of integration at the level of program design and at the level of clinical interventions provided to individuals and families with behavioral health needs: in short, to discuss "integrated programs" and "integrated interventions."

The definition of integration in the previous column was stated as follows.

CONCEPTUAL FRAMEWORK
FOR BEHAVIORAL HEALTH INTEGRATION

Integration, broadly defined, always includes two components: an organizational function component and a client/family interface component.

Address correspondence to: Kenneth Minkoff (E-mail: Kminkov@aol.com).

149

At the Client/Family Interface

Integration refers to any mechanism by which appropriately matched interventions for both mental health and substance use issues or disorders are combined in the context of a clinical relationship with an individual clinician or clinical team, so that the client or family experiences the intervention as a person-centered or family-centered integrated experience, rather than as disjointed or disconnected.

At the Organizational Function Level, According to Cline (2005)

Integration refers to those activities at the level of any behavioral health organization (state system, mental health system, county, agency, program) that organize both the structure of the organization and the functional processes of the organization so that mental health and substance abuse "components" are interwoven in a coherent manner in order to accomplish the organization's mission for its total population of individuals and families with mental health and/or substance disorders.

In the previous column, the relationship between systems integration and services integration was reflective of these two components. That is, systems integration referred to the organizational level structures and processes that ensure that integrated services are provided at the client/family interface throughout the system. (For further details on this topic, please refer to that column (Minkoff, in press)).

In the current discussion, the same relationship applies, but at a different organizational level. That is, an integrated program is designed so that the structures and processes of that program are organized in such a way that mental health and substance abuse "components" (in this instance, interventions) are interwoven in a coherent manner so that integrated services are appropriately provided to all individuals and families who are served by that program, within the context of that program's mission and function.

To understand this more clearly, let us review the definition of "program" supplied in TIP 42:

> A *program* is a formally organized array of services and interventions provided in a coherent manner at a specific level (or levels) of care in order to address the needs of particular target populations. Each program has its own staff competencies, policies, and procedures. Programs may be operated directly by public funders

(e.g., states and counties) or by privately funded agencies. A single agency may operate many different programs. Some agencies operate only mental health programs; some operate only substance abuse treatment programs, and some do both. (CSAT, 2005)

Interventions refer to any type of clinical behavioral health service that can be provided to a client or family, for either mental health or substance abuse or both, and can include welcoming and engagement, screening and assessment, motivational interventions, skill building, rehabilitative services, housing support, psychopharmacology, psychotherapy, and so on, all of which can be provided in individual, group, family contexts, as well as in the office, on the street, or in the home.

Historically, perhaps a decade ago, very few mental health or substance abuse programs addressed the needs of individuals or families with co-occurring disorders in any organized way. Consequently, the conceptualization of system and program design was based on the idea that mental health systems funded mental health programs with mental health funds to provide mental health services to individuals with mental health needs, and the substance abuse system funded substance abuse programs with substance abuse funds to provide substance abuse services to individuals with substance abuse or dependence. In such a universe, individuals with co-occurring disorders were experienced as "misfits," and services for both problems could occur primarily only through parallel or sequential treatment involving multiple systems, programs, and funding streams, and the individual (or family) was responsible for figuring out how to "integrate" the multiple services on his or her own. In this context, research supporting the development of "integrated services" in the delivery system was built on the creation of specialized program models for this population, and the evaluation of those program models through a steady accumulation of research efforts over the past two decades, to establish a variety of evidence-based (to varying degrees) specialized "integrated" programs for this population. Some of the better known examples of "integrated" programs are Integrated Dual Disorder Treatment (IDDT) teams as described in the SAMHSA IDDT toolkit (Drake et al., 2001), and the Modified Therapeutic Community, described by Sacks and others (Sacks & Sacks, 1999). Because these special integrated programs existed in a context where most elements of systems, services, programs, and interventions were NOT integrated, there has been an evolving assumption that the only "integrated program" is a specialized program providing specialized

interventions for individuals with co-occurring disorders, somewhat outside the mainstream of care.

In recent years, however, more and more programs of all types in all settings are recognizing the need to organize the provision of some type of integrated services or interventions to individuals and families with co-occurring disorders, because of the high prevalence and poor outcomes associated with this population. Consequently, at present, more and more systems are embarking on processes to develop broad "systems integration" within which to create routine access to "services integration" for the total population served. This has necessitated creating an array of programs that include both specialized "integrated" programs as well as "normal" programs that evolve the capacity or capability to provide appropriately matched integrated services to co-occurring clients, within the framework of their "normal" function or job to provide a set of services or interventions to a particular cohort of clients. This development has been reinforced by, and reinforces, a significant evolution of the research on this issue in the last decade–that is, moving from research primarily focused on "special programs" to research investigating specific "intervention strategies" that can be applied within ANY program. The outcome of this research has provided support for the development of consensus reports like TIP 42, which outlines research supported interventions, ranging from screening and assessment right through all the types of treatment approaches listed earlier (motivational interviewing, contingency management, etc.) that can be utilized for individuals with co-occurring disorders in any substance abuse program, and in any general mental health program. In the same way, Mueser et al. (2003) have built on the IDDT research to develop a textbook for any front line clinician working with adults with SPMI to apply a similar array of interventions in the IDDT program toolkit in any setting serving individuals with SPMI. Further, more recent research has demonstrated the efficacy of this approach (Essock et al., 2006). These development have bolstered the recognition that within a system of care, because co-occurring disorders are both an expectation and a high priority, ALL programs need to develop capability to provide appropriate evidence based "integrated interventions" to address the needs of their expected population of individuals and families with co-occurring disorders (and other complex problems), and further, that within the same system, there might be different "categories" of programs depending on the types of co-occurring services that are provided (Minkoff & Cline, 2004, 2005).

As a result of the evolution of the concept of universal (versus specialized) program capability to provide integrated interventions to clients and families who need them, the definition of an integrated program and its relationship to integrated interventions can be considered to be evolving as well, as follows:

> An integrated program is an organized program structure designed for the particular purpose of providing–to the particular cohort of clients or families served by the program–an appropriate array of properly matched and interwoven mental health and substance abuse interventions that are experienced as "integrated" by the clients and families who receive them.

Similarly to systems integration, program integration is not defined by administrative merger, blended funding, or physical co-location. In fact, it is possible to have mental health and substance abuse services administratively merged and co-located, but still operationally disintegrated, while it is possible to have separately administered and separately located clinicians organized to function as a team in such a way that the service delivery is effectively integrated from the perspective of the client.

Rather, integration is defined functionally, and a common term for the experience of this function is: "One Team, One Plan, for One Person" (CSAT, 2005).

Although this phrase is often interpreted to mean that the "one team" is defined as "one special program" caring for a special population, the concept of "one team, one plan, for one person" needs to be understood in the functional intervention framework referred to earlier. In this framework, interventions are person or family centered, and may include welcoming, empathic, hopeful integrated relationships, integrated screening and assessment, as well as motivational interviewing, skill building, contingency management, recovery support (including peer support) for each type of disorder, and so on. Integrated interventions can be organized within any type of program (outpatient mental health, residential substance abuse, inpatient psychiatric unit, and so on) in a manner that is matched to the overall mission of the program, and to the needs of the clients and families served in that program: Further, within any type of program, there can be differences in how co-occurring services are organized or which populations are addressed. This has led to the development of the concept of co-occurring disorder program "categories."

The definitions of these various program categories are beginning to be described, but are not by any means fully articulated. Based on earlier conceptualizations published in ASAM PPC 2R, TIP 42 has defined a range or continuum of programming in both mental health and substance abuse systems that can be termed Addiction or Mental Health Only, Dual Diagnosis Capable (MH or CD), Dual Diagnosis Enhanced (MH or CD), and Fully Integrated (CSAT, 2005). Putting the TIP 42 definition of "Fully Integrated" aside for the moment, let us look at the definitions of the other categories.

- *Addiction- or mental health-only services* refers to programs that "either by choice or for lack of resources (staff or financial), cannot accommodate patients" who have co-occurring disorders that require "ongoing treatment, however stable the illness and however well-functioning the patient" (ASAM, 2001, p. 10).
- *Dual diagnosis capable* (DDC) programs are those that "address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content, and discharge planning" (ASAM, 2001, p. 362). Even where such programs are geared primarily toward treating substance use or mental health disorders, program staff are "able to address the interaction between mental and substance-related disorders and their effect on the patient's readiness to change–as well as relapse and recovery environment issues–through individual and group program content" (ASAM, 2001, p. 362).
- *Dual diagnosis enhanced* programs have a higher level of substance abuse and mental health treatment services. These programs are able to provide unified substance abuse and mental health services to clients who are, compared with those treatable in DDC programs, "more symptomatic and/or functionally impaired as a result of their co-occurring disorders" (ASAM, 2001, p. 10), or require a higher level of service intensity in both domains. Enhanced-level services "place their primary focus on the integration of services for mental and substance-related disorders in their staffing, services and program content" (ASAM, 2001, p. 362).

To clarify further, for substance abuse programs, DDE programs or tracks are organized to provide an episode of substance abuse treatment to individuals who are more severely impaired by their psychiatric illness (either in terms of active symptoms or in terms of baseline dysfunction)

than would be commonly served in a DDC substance abuse treatment program. For mental health programs, DDE programming generally implies a higher level of service intensity or more comprehensive array of services for co-occurring substance use disorders, than would be found in a DDC program. For example, a DDE psychiatric inpatient unit would be more likely to focus almost exclusively on individuals with co-occurring disorders, and would have the availability of a more comprehensive array of substance abuse programming on the unit, than a DDC unit, which may be treating a more acute psychiatrically ill population who are less interested in substance abuse programming, or are less able to utilize it. The Integrated Dual Disorders Toolkit (IDDT) describes a particular type of dual diagnosis enhanced "case management" program for co-occurring disordered adults with serious and persistent mental illness (SPMI) (Drake et al., 2001), compared with a DDC program, which serves both co-occurring and non-co-occurring disordered clients, and incorporates toolkit based interventions into the service array as indicated for individuals who have co-occurring needs. Usually, enhanced IDDT programs will have higher staffing ratios (as in an ACT team) to deal with consumers who are more unstable, more poorly engaged, and more complex.

So, which of these categories of programs is "integrated"? According to this definition, actually, they ALL could be integrated. That is, the extent to which a program is integrated is measured not by the level of complexity of the clients nor the level of service intensity provided, and is not measured by whether all the clients served have co-occurring disorder. Rather, the measurement of integration would be the extent to which the program has fully organized its structure to provide interwoven components of matched mental health and substance interventions–seamlessly, so every client or family who needs those interventions gets what they need in a manner that they perceive as integrated and person-centered, that is legitimately experienced as "one team, one plan, for one person," regardless of where the team members are located, or who they report to, and so on. While it may certainly be easier when the team members are all part of a single program working with a special population, there are other mechanisms of creating this capability that can be functionally successful in any setting. (See Minkoff and Cline, "Dual Diagnosis Capability: Moving from Concept to Implementation," 2006). The ability of any program to develop this capability make it more likely that individuals with co-occurring needs can be served effectively in the "door" they enter, rather than always needing to be directed to a "special" program to receive integrated care.

This definition of "integrated program" is therefore *different* from the definition articulated in TIP 42, which was written as follows:

- *Fully integrated* programs are an evolution of DDE programs in which the distinction between mental health and substance abuse services in the program is absent, and the program is defined as neither providing substance services within a mental health context, nor vice versa, but in fact deals with each individual in a context that allows matching of services within the team of providers as flexibly and seamlessly as providing services for individuals addicted to multiple substances in an addiction program, or individuals with multiple mental health diagnoses in a mental health program (CSAT, 2005).

What I would propose as an alternative is a definition that recognizes integrated programs not as a special evolution of program category, but as a special evolution of program *function* to achieve the capacity to match services to co-occurring individuals as seamlessly as possible.

This definition might read as follows:

- *Integrated programs* are DDC or DDE programs that have evolved fully the capacity to function in such a way that they deal with co-occurring disorders as a normal expectation, and that each individual can be dealt with in a context that allows matching of services within the team of providers as flexibly and seamlessly as providing services for individuals addicted to multiple substances in an addiction program, or individuals with multiple mental health diagnoses in a mental health program.

The more a program is "integrated"

- the more that it proactively welcomes and engages completely comfortably with individuals with both mental health and substance disorders;
- the more that all members of the team are dually competent individually, and function collectively as a team with "one plan" for "one person" that addresses each of the person's primary problems in a person-centered manner; and
- the more that the full array of programming is designed to address routinely mental health and substance disorder issues in any combination as appropriate for clients and families.

As an example, any of the following might be an "integrated program" within this framework:

- An IDDT program as defined by fidelity to the SAMHSA IDDT toolkit.
- An "integrated psychiatric and addiction inpatient unit" in which programming can address patients with mental health only, addiction only, or co-occurring presentations, and all the staff is dually competent, and works with all types of patients (Minkoff, 1989).
- A DDC or DDE addiction residential program in which a mental health clinic partner contributes some staff resources that may bill or be funded separately from the addiction program, but who function as members of an integrated team with the addiction staff, and collaboratively develop an array of programming for clients.
- A freestanding mental health clinic or addiction clinic in which all staff have core competencies in addressing co-occurring issues within the context of their existing programming, and in which there are mechanisms that ensure organized teamwork through regularly planned and structured consultation and collaboration between clinic staff and other treaters for every client.

As long as each client with multiple problems is welcomed comfortably and experiences "one team, one plan, for one person," within the context of the service that the client is requesting, then the program could be defined as integrated.

CONCLUSION

The purpose of this column was to extend the conceptualization of integration as applied to systems integration and services integration in the previous column, to the concept of integrated programs and integrated interventions. In doing so, an alternative way of defining and understanding "integration" at the level of client centered service has been proposed, based on the ability of ANY program to create structures and processes that ensure that each client with co-occurring disorders receives the integrated interventions that are needed in the context of that program. This conceptualization may broaden our capacity to provide integrated programming widely throughout any system of care to all the clients and families who need it.

The next column will extend this discussion further, by examining the definitions of integrated clinician, integrated clinical teams, and integrated clinical competencies and scopes of practice.

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