
BEST PRACTICES

What Is Integration? Part III

Kenneth Minkoff, MD

INTEGRATED CLINICIANS AND CLINICAL TEAMS

A mental health case manager is assigned to a young woman with schizoaffective disorder and cocaine dependence. He is wondering if he should be talking with her about her cocaine use, or just telling her not to use, or referring her to addiction treatment whether or not she wants to go.

An addiction counselor is assigned to a middle aged man with alcohol dependence and major depression. He wishes he could find a psychotherapist to talk to the man about his depression, but the man does not want to discuss this with anyone but him.

An addiction counselor and a mental health case manager are assigned to the same team. How should they work with individuals with co-occurring disorders? Should the addiction counselor discuss the addiction and the mental health case manager discuss the mental health, or should they both discuss both problems?

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

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All of these clinicians have experienced little guidance and direction in understanding their roles and scopes of practice in working with individuals or families with co-occurring disorders.

Previous editions of this column (Minkoff, 2006b, 2007) have addressed the concept of “integration” as applied to mental health and substance abuse, described a broad conceptualization of the definition of integration (Minkoff, 2006b), and then applied that conceptualization to understanding “systems integration” and system level “services integration” (Minkoff, 2006b), and to understanding “integrated programs” and “integrated interventions” within those programs (Minkoff, 2007). The purpose of this column is to extend that conceptualization to a discussion of “integrated clinicians and clinical teams” and “integrated competencies and scopes of practice.”

For the sake of convenience, the definitions of integration and integrated programs in the previous column will be re-stated:

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

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:

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. (Minkoff, 2006b)

At the program level (Minkoff, 2007):

An integrated program is an organized program structure (that may be either Dual Diagnosis Capable or Dual Diagnosis Enhanced) “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.

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. (Minkoff, 2007)

This approach has been commonly summarized as follows:

One team, one plan, for one person (CSAT, 2005a)

Consequently, “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.”*

Let us now consider the implications of this conceptualization (particularly the second bullet in the above paragraph) for workforce development issues related to clinician competency and scope of practice at both the system level and the program level.

N.B. In many systems, the term “clinician” only applies to individuals with licenses. For the sake of this discussion, however, the

term “clinician” will be used to describe anyone who has clinical contact with clients or families.

Historically, and to a great degree currently, behavioral health workforce development has not been based on the recognition that co-occurring disorders are an “expectation” in both the adult population and the child and family population. (Consider the high prevalence of co-occurring families in which one member has one kind of disorder like a child with an emotional disturbance and another member has another kind of disorder like a family member or caregiver with a substance use disorder.). As a result, all levels of workforce development, beginning with core professional training, and extending to scopes of practice, core competencies, and job descriptions—for both licensed and unlicensed or paraprofessional clinical staff (like case managers, residential aides, and so on) and, in some cases, even peer support workers—have been designed on the assumption that each clinician will be either a “mental health clinician” or a “substance abuse clinician” but not both. In this regard, dramatically few mental health training programs (e.g., psychology and social work training) have any required course work in substance use disorders. Similarly, addiction counselor training programs often have no required course work in mental illness. A recent survey of state credentialing requirements for substance abuse counselors found that only six states had any requirement of even minimal core competency or training in mental health (CSAT, 2005b), even though some basic mental health competencies have been included in the most recently updated version of Center for Substance Abuse Treatment TAP 21 (2006), which defines 123 recommended competencies (attitudes, knowledge, and skills) for addiction counselors.

Reinforcing this lack of “integration” of training and competency expectations, scopes of practice developed by professional licensure boards generally provide few, if any, instructions for how to work with a co-occurring disordered client or family. In most states, licensure boards operate outside the state public behavioral health authority, and therefore define scopes of practice that may not match the real experience of clinicians in public behavioral health settings. It is common, for example, for the scope of practice for licensed substance counselors to state that they are permitted (and expected) to “screen and appropriately refer” individuals with mental health issues and disorders, without any direction or permission for having a discussion with that client that integrates attention to the co-occurring mental health issues into the content of the substance abuse treatment. Certain substance abuse licensing

boards have introduced specialized co-occurring disorder credentials, but have not provided clear instructions to those counselors with “ordinary” credentials regarding their scope of practice. In fact, because substance counselors are not generally permitted to independently establish a mental health diagnosis, most counselors have no specific instruction or clear permission to document a mental health diagnosis that has already been established, even though they can easily document established medical diagnoses. Similarly, even though mental health clinicians are more likely to be able to establish a substance abuse diagnosis, mental health licensing boards will frequently have language stating that individual professionals should only practice within their level of expertise and training, and may offer specialized certificates or credentials in substance abuse treatment, without clarifying what the “average” clinician can and should be doing to integrate attention to substance use issues within his or her usual practice to address mental health issues. This reinforces the impression that co-occurring disorder competency is only the province of a few specialized clinicians with either special credentials or dual licenses.

This traditional concept of “parallel” clinicians with “parallel” competencies and scopes of practice has informed the original design of evidence based integrated treatment programs. For example, in the original conceptual framework that measures fidelity for Integrated Dual Disorder Treatment (Drake et al, 2001; CMHS, 2002), the description of the program model is a clinical team of mental health practitioners (many of whom may be unlicensed case managers) that is required to have “one substance abuse counselor” or “dual diagnosis specialist” who provides “substance abuse assessments” and “substance abuse counseling” on the multidisciplinary team. In the General Organization Index, there is reference to “training” and “supervision” in the EBP, but not a clear description of the expected competencies and scopes of practice for different team members. Similarly, research on other types of addiction programs will frequently describe the composition of the multidisciplinary team of mental health and addiction clinicians, without necessarily clearly specifying the integrated competencies, job description, and scope of practice of each clinician within the team.

In real world functioning of integrated teams or programs, however, it is clear that all clinicians do need to become integrated clinicians themselves. In order for the team to provide integrated treatment, it is insufficient that the client experiences parallel messages from practitioners within the team, such as “I am your mental health case manager, you need to speak with the substance counselor about your substance

abuse issues” OR “I am a substance counselor, you need to discuss mental health symptoms with the psychiatrist.” In integrated services, the implication is that ALL the team members have the ability to function as integrated clinicians in relationship to their clients, and that team members with higher levels of expertise in any area help and support those with less expertise in that area to function in an integrated role. Thus, within the context of “specialized integrated programs,” it has quickly become recognized that all clinical staff at any level of licensure or training (even residential aides on the overnight shift) need to have some basic integrated competency, job description, and scope of practice that is consistent with the overall mission of the program, and that is consonant with their level of training and experience, as it applies to their role.

Further, as it has become increasingly recognized that because co-occurring disorders are an expectation, ALL programs (not just specialized co-occurring disorder programs) need to begin to make progress toward becoming “integrated” dual diagnosis capable programs (Minkoff, 2006a, 2007), it has also become increasingly clear that all clinical staff in those programs are likely to have co-occurring clients and/or families in their caseloads, and therefore need to have core competencies, job descriptions, and scopes of practice that support their capacity to function as integrated clinicians and members of integrated teams.

Consequently, in order to be an “integrated clinician” it is not necessary to have two licenses or two degrees or to be an expert in both disorders. In fact, it is not necessary to be an “expert” in either disorder. In order to be an integrated clinician, any staff person must recognize that in the context of his role (whatever that is) his job is to make clinical relationships with individuals who have multiple problems (including commonly both mental health and substance abuse problems) and engage with those individuals in a manner that is welcoming, empathic, integrated, person centered, and hopeful, in order to help that person identify their problems and goals, make decisions about addressing any and all of their problems to achieve their goals, receive and understand recommendations for each problem (from “more expert” clinicians), and develop the skills and supports to follow those recommendations consistently over time, including the ability to figure out over time how to fit together recommendations for multiple simultaneous problems that may not easily fit together. Thus, if the clinician can understand the recommendations just a little bit better than the client, he or she can be helpful to the client in figuring this out, and helping the client to learn helpful skills, rather than leaving the client to figure out how to put

together disconnected parallel recommendations for multiple problems or disorders.

This conceptualization begins to create the recognition that over time, just as all programs need to become integrated “dual diagnosis capable” programs, all clinicians need to become integrated “dual diagnosis competent” clinicians. This allows us to create a definition of “integrated clinician” and “integrated clinical team”:

An integrated clinician is any clinician, regardless of licensure, who within the context of his or her job description, licensure (if any), training, and expertise is able to provide properly designed and appropriately matched integrated mental health and substance abuse interventions to the clients and/or families in his or her “caseload.”

An integrated clinical team is one in which the respective expertise of each member of the team is interwoven, so that all the team members help each other to function as integrated clinicians, and the team as a whole is experienced by the client or family as providing “integrated interventions” to help the client and/or family address both mental health and substance abuse disorders, along with, frequently, other problems as well.

How is this operationalized? It has to be understood that being an integrated clinician does not mean that clinicians can just do anything they want, or that they do not require training and competency development strategies. In fact, it is more important when clinicians are addressing the needs of complex individuals or families in any program that they get MORE instructions and guidance, not less, and that they are very specifically trained, supported, and supervised to learn how to implement these instructions in their actual jobs and programs, rather than, as so often happens, being trained in a “vacuum” by attending a course or a conference, with no clear message about translating this back into practice. In fact, one of the strong recommendations of the nationally recognized Annapolis Coalition for behavioral health workforce development (2007), addressing the gap between how behavioral health clinicians are “trained” and the competencies that are required for them to be successful with the clients and families they encounter in real world programs, is that not only are they routinely trained to be able to deliver integrated services, but that the training is connected to program level activities to support on the job competency development.

Several recent publications have begun to provide more guidance on how to universalize the competencies and scopes of practice for integrated clinicians. TIP 42, for example (CSAT, 2005a), provided a delineation and description of basic, intermediate, and advanced competencies for all clinicians within any program or system. Minkoff and Cline, based on work with focused groups of public sector behavioral health clinicians in New Mexico (Cline and Minkoff, 2002), have published guidelines for the scope of practice of singly trained addiction counselors (Minkoff and Cline, 2003) and singly trained mental health or rehabilitation counselors (Minkoff and Cline, 2006c). The scopes of practice provide a recommended description of what a singly trained clinician could do, and should have permission to do, without requiring another license or a specialized credential. Examples of the recommended scope of practice activities include:

1. Convey a welcoming, empathic attitude, supporting a philosophy of dual recovery
2. Screen for co-morbidity, including trauma history
3. Assess for acute mental health/detoxification risk, and know how to get the person to safety
4. Obtain assessment of the co-morbid condition, either one that has already been done, or, if needed, a new one.
5. Be aware of—and understand—the diagnosis and treatment plan for each problem (at least as well as the client understands them)
6. Support treatment adherence, including medication compliance, 12 step attendance, etc.
7. Identify stage of change for each problem
8. Provide individual and group interventions for education and motivational enhancement, to help clients move through stages of change.
9. Provide specific skills training to reduce substance use and/or manage mental health symptoms or mental illness (e.g., help clients learn how to say no a dealer; help clients to take medication exactly as prescribed)
10. Help client manage feelings and mental health symptoms without using substances
11. Help client advocate with other providers regarding mental health treatment needs
12. Help client advocate with other providers regarding substance abuse/dependence treatment needs
13. Collaborate with other providers so that client receives an integrated message.

14. Educate client about the appropriateness of taking psychiatric medications and participating in mental health treatment while attending 12 step recovery programs and participating in other addiction treatment support systems, and vice versa.
15. Modify (simplify) skills training for any problem to accommodate a client's cognitive or emotional learning impairment or disability, regardless of cause.
16. Promote dual recovery meeting attendance, when appropriate for the client, and such meetings are available.

This type of instruction does not immediately create a *requirement* for every clinician to have the competency to do ALL of these things, but it does clarify what clinicians can learn how to do within their individual license or scope of practice, as appropriate to their job, program, and caseload.

Note that all “integrated clinicians” are not the same. They have different levels of training, different clinical backgrounds, work with different types of clients, and work in different settings. Some practice independently (with access to consultation when needed), and some work in teams. However, the capacity to provide integrated interventions within a definable scope of practice, in this framework, is an option (and in fact likely to be a necessity) for all. Further, the specific instructions for practice, for any clinician in any program, can be written into job descriptions, human resource evaluations, and competency development, supervision, and training plans in any agency.

Here are some examples of integrated clinician activity, in accordance with the above definitions:

- A case manager working in a dual diagnosis capable outpatient program with mentally ill adults welcomes clients on her caseload who have co-occurring substance use issues, identifies stage of change, and facilitates small steps of movement through stages of change, such as by helping the pre-contemplative client to discuss substances more openly and less defensively, to review the positive and negative aspects of substances in relation to his goals, and to begin to “contemplate” whether or not he should consider a change.
- A substance abuse counselor working in a dual diagnosis capable intensive outpatient addiction treatment program welcomes clients in his caseload who have co-occurring mood and anxiety disorders, helps them to identify and discuss the symptoms of their al-

ready diagnosed disorder, and supports them developing strategies to manage those symptoms consistently while receiving addiction treatment, including learning how to take medicine exactly as prescribed even when one's friends want to borrow it, learning what to do if asked about medication in an AA meeting, and so on.

- A licensed social worker in a school based outreach program for seriously emotionally disturbed adolescents, welcomes her clients to discuss openly their substance abuse related choices and decisions, connects these decisions to peer and family issues, and to the clients' own goals, and helps the client figure out whether or not to make a change, and how to make a change. If the client has severe enough substance use disorder that he or she requires and becomes willing to attend some type of formal substance abuse programming, the social worker maintains a relationship, helps the client figure out how to succeed in the program, collaborates with program staff, and provides integrated continuity of care.
- A residential aide in an addiction treatment program, who works on the overnight shift, welcomes the presence of clients who have co-occurring disorders and who are on medication. He is consistent that the client is in a process of achieving dual recovery, needs to take medicine as prescribed, is supportive if the client is displaying symptoms, and has clear instructions regarding who and how to call for help if he has questions about the client's behavior and does not know how to respond.

These examples illustrate the wide range of circumstances in which integrated clinical activity can be provided by clinicians of all different backgrounds.

CONCLUSION

This column concludes the three-part series on: What is Integration? This series has addressed systems integration, services integration, integrated programs, and integrated interventions in previous columns. The purpose of this column was to extend the conceptualization of integration to the concept of integrated clinicians and integrated competencies and scopes of practice. The goal of this discussion is to create more detailed understanding of how to support workforce development activities that reinforce routine access to integrated relationships with individual clinicians and clinical teams that will support the dual recovery

of the individuals and families with co-occurring disorders who are consistently presenting at every door of our service system. Hopefully, the three columns taken together will provide a comprehensive overview of how to conceptualize integration at all levels throughout the system of care.

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