

Services Integration

Richard N. Rosenthal, MD
COCE Senior Fellow
Professor of Clinical Psychiatry,
Columbia University
Chairman, Dept. Psychiatry,
St. Luke's Roosevelt Hospital Center, NY

Services Integration

- Services integration refers to both:
 - ◆ The process of merging previously separate clinical services into a seamless and harmonious framework of practices at the level of the individual
 - ◆ The delivery of integrated treatment for clients with co-occurring disorders (COD) utilizing various techniques

Services Integration

- Services integration for COD can be defined as the process of providing of two or more interrelated services to specific clients within a primary treatment relationship or service setting (CSAT, 2005).
- Integration can range from single-provider efforts to comprehensive program integration.
- Complete services integration requires a consideration of, and response to, the needs, problems, and issues across services for persons with co-occurring disorders (COD).

Definition: Services Integration

- **Any process by which mental health and substance abuse services are appropriately integrated at the client level for an individual with COD.**
- **Integrated services can be provided by:**
 - ◆ **Individual or team in one or more settings that collaborates in collective responsibility for a client and assumes responsibility for integrated services**
 - ◆ **Organized program with a structure specifically designed to facilitate delivery of integrated services by all clinicians or teams to all clients**

Services Integration

- **Co-location of mental health and substance abuse programs or clinicians may facilitate the provision of integrated services, but is neither necessary, nor sufficient for services integration.**

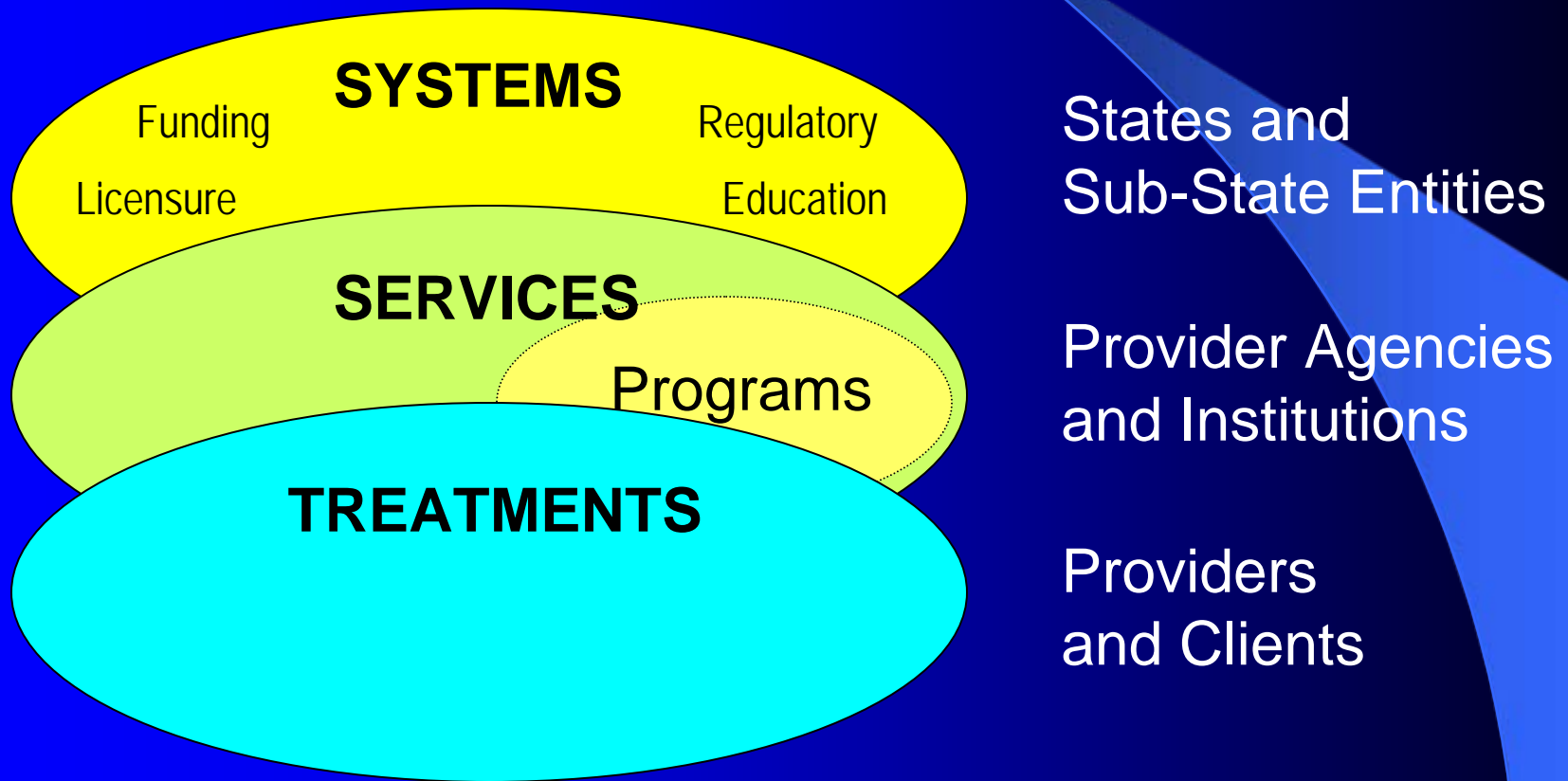
Services Integration

- Complete implementation merges previously separate medical and psychosocial services such as:
 - ◆ **medication management**
 - ◆ **case management**
 - ◆ **rehabilitation services**
 - ◆ **addiction counseling**
 - ◆ **psychotherapy**
- into a set of harmonious, internally consistent clinical practices that appear seamless from the client's perspective.

Who Provides Services Integration?

- Services Integration may include integrated clinical treatment by an individual treatment provider or clinical team, or COD program development by a particular treatment program.

Processes at Different Levels of Organization



Contrasting Systems Integration

- Systems Integration facilitates an integrated response to client needs through the development of educational, fiscal, and regulatory infrastructures within States and sub-state entities that support integrated services for COD.
- Systems integration = infrastructure integration, e.g., deals with
 - ◆ **Clinician education**
 - ◆ **Licensure of clinicians and programs**
 - ◆ **Service settings**
 - ◆ **Funding sources**

Contrasting Systems Integration

- Systems level above Services level
- Includes States and sub-state entities such as cities, counties, tribes and tribal organizations
- Processes connecting these entities with respect to integration for COD are:
 - ◆ **Interagency cooperation, coordination, and communication at the local and State levels**
 - ◆ **Negotiated fiscal co-responsibility**
 - ◆ **Shared certification and licensure**
 - ◆ **Workforce development including pre-service and continuing education**

Processes at Different Levels of Organization

- Services Integration: all relevant clinical processes that touch clients directly.
 - ◆ **Providers & practices: screening, assessment, treatment, the programs they work in, and organizations and institutions that sustain them.**
- Program Integration: services integration implemented by agency or institution to enable clinicians to provide integrated COD treatment. An integrated program is organized to provide specific services to a particular group of clients in a deliberate way.

Processes at Different Levels of Organization

- Treatment Integration, a component of integrated services, is at the next level down, where the provider acts with specific skills to achieve service goals.
 - ◆ **Emphasis on the moment of provider/client interaction.**
 - ◆ **Integrated treatment is a Service Integration activity, like integrated screening or assessment**
 - ◆ **Integrated treatment occurs**
 - Across agencies
 - Within a program
 - In an individual provider's office (CSAT, 2005).

Why Integrate Services?

- Strong literature base supports the need for the integration of services provided to COD clients (CSAT, 2005).
- Need is generally based on:
 - ◆ High community rates of COD (Regier et al., 1990; Kessler et al., 1994; Grant et al., 2004),
 - ◆ Negative impact of each untreated disorder on recovery from the other (Rosenthal & Westreich, 1999),
 - ◆ Most treatment settings unprepared to effectively manage both substance use and mental disorders (SAMHSA, 2002).

Why Integrate Services?

- Most research evidence has focused on need for, and effects of, services integration for severe substance use and mental disorders (e.g., Drake et al., 2001).
- Less work has been done investigating services integration for those with severe addiction problems and less severe co-occurring mental disorders, e.g., Quadrant III

How Do You Know?

- A “bottom-up” approach: comprehensive client assessment documents need for integrated services.
- Determining current diagnoses and corresponding impairments usually sufficient to reveal need for additional core services within traditional provider settings.

COD Treatment Capacity

- Current programs can be classified as having basic, intermediate, or advanced capacity for COD treatment, with the highest level being full integration of addiction, mental health, and related services (CSAT, 2005).
- There is a wide range of models that fall into the label of “integrated treatment” and “integrated programs” and the classification of these subtypes is an area of future work.

Role of Integration

- Available research for the severely mentally ill in combination with documents based on consensus-based practices (SAMHSA 2005), support the principle that, provided that proper attention is paid to severity and type of disorder, services integration can play an important role in providing appropriate and effective treatment to persons with COD (SAMHSA, 2002).

Optimal Design of Integrated Services

- Meets stage-specific needs of COD clients
- The treatment team
 - ◆ Coordinates all pertinent aspects of care
 - ◆ Ensures care is accessible
 - ◆ Especially for clients with serious disorders

Optimal Design of Integrated Services

- Involves a range of services
 - ◆ Provisions for integrating medication for addictions and mental illnesses
 - ◆ Case management, including ACT or ICM
 - ◆ Motivational interviewing
 - ◆ Individual or group addiction counseling
 - ◆ COD-adapted evidence-based therapies
 - cognitive-behavioral therapy
 - relapse prevention
 - contingency management
 - ◆ 12-step recovery meetings, including dual recovery mutual self-help meetings
 - ◆ psychosocial rehabilitation (CSAT 2005, Ziedonis, 2004).

Integration Strategies: Incremental

- Most services not initially designed for COD-specific service needs
- Integration usually requires new services
- Advantage: strategy enables programs to build on current knowledge, skills, and strengths while expanding gradually (SAMHSA, 2003a).
- Approach allows facilities and providers to simplify and change licensing and certification requirements for treating COD in the context of different licensing and certification standards.

Other COD Integration Strategies

- Referral networks (no wrong door)
- Physical and temporal proximity
 - ◆ services provided by the same clinician or in the same setting
- Care coordination
 - ◆ services provided by a team of providers from different service arenas who take joint responsibility for the client.

Principles of Care That Facilitate Services Integration

- Consensus viewpoint:
 - ◆ Respect for the individual
 - ◆ Engagement of the most difficult to reach
 - ◆ Belief in the human capacity for change
 - ◆ Provision of culturally competent services (e.g., appropriate for age, sexuality, and gender, and reflective of community diversity)
 - ◆ Recognition of the importance of community, family, and peers to the recovery process

Integration Success or Failure

- Depends on:
 - ◆ Quality of leadership
 - ◆ Development of shared values
 - ◆ Staff access to (and funds for) training
 - ◆ Funding for treatment
 - ◆ Administrative support
 - ◆ Common assessment tools
 - ◆ Capacity for changes in licensure and certification
 - ◆ Broad stakeholder involvement
- The systemic benefits can be demonstrated at program, clinician, and client levels.

Characteristics Impeding Services Integration

- Inadequate leadership
- Rigid, bureaucratic restraints
- Lack of trained staff
- Insufficient collegial support
- Change-resistant culture
- Demoralized staff (Corrigan et al., 2001).
- “Top-down” strategic decisions guided more by power structures, ingrained routines, and established resource configurations than by evidence or consensus (Rosenheck, 2001).

Vital Steps to Transform Services, Including Services Integration

- Develop effective leadership styles that prioritize organizational values: “no wrong door”, a recovery perspective, and adopting a multi-problem viewpoint (CSAT, 2005).
- Remove barriers, e.g.: inadequate funding, cohorted disciplines, antiquated program requirements, disparate meeting times, “standard” assessment forms without appropriate addiction and mental health screening
- Support and promote staff development

Vital Steps to Transform Services, Including Services Integration

- Allow staff to take appropriate 'risks', such as:
 - ◆ Asking about substance history in MH clients, mental health history in CD clients;
 - ◆ Challenging mental disorder diagnoses given to clients who have long-term SUD;
 - ◆ Challenging use of addictive anti-anxiety or sleep medications.

Vital Steps to Transform Services, Including Services Integration

- Establish new relationships, such as AA/NA for mental health staff; with psychiatrists and other mental health clinicians for addictions treatment staff
- Encourage decisions that are driven by current scientific evidence or through consensus derived by reasonable inquiry (Garvin & Roberto, 2001)
- Support and implement technology transfer as evidence-based practices are validated

Management and Fiscal Structures That Impede Services Integration

- Lack of funds for cross-training
- Lack of funds to support delivery of co-occurring services
- Lack of incentives for clinicians to cross-train
- Outdated policies that do not support COD treatment
- Fiscal restraints that impede the treatment of more severe disorders (SAMHSA, 2002).

Management and Fiscal Structures That Facilitate Integrative Process

- **An integrated organizational chart**
- **Shared assessment tools**
- **Integrated funding streams**
- **Integrated policy manuals (NASMHPD/NASADAD, 1998).**
- **Investigate general regulatory guidelines for a service's funding stream**
- **Generate specific guidelines and instructions for providing and documenting appropriately matched integrated treatment within the context of the already funded service (Minkoff & Cline, 2004).**

Outcomes Expected From Services Integration: Program Level

- **Common values and principles develop**
 - ◆ When mental health and substance abuse programs are administratively and locally unified, or
 - ◆ When internal capacity to treat COD is increased (SAMHSA, 2003a, SAMHSA 2005).
- **Multi-problem view of clients**
- **Clear description of treatment population**
- **Specific program COD services and levels of care to be provided are identified.**
- **Services that are to be coordinated with other agencies are identified.**

Outcomes Expected From Services Integration: Practice Level

- **Clinicians have been trained in:**
 - ◆ **Case management**
 - ◆ **Psychopathology**
 - ◆ **Integrated screening and assessment**
 - ◆ **Generating an integrated treatment plan**
 - ◆ **Treatment strategies for mental and substance use disorders**
- **Case management skills facilitate engagement into medical, housing and vocational services (McLellan et al., 1998).**
- **SUD treatment tailored for SMI clients, and stage-wise, motivational counseling offered in the context of an alliance-building and supportive therapeutic relationship (CSAT, 2005; Winston et al., 2004).**

Outcomes Expected From Services Integration: Client Level

- **Addiction settings- Clients receiving integrated services**
 - ◆ **More likely to complete treatment**
 - ◆ **Better outcomes (McLellan et al., 1997).**
- **With clinically, philosophically, and environmentally integrated services, severe COD clients**
 - ◆ **Better engaged in treatment (Hellerstein et al., 1995)**
 - ◆ **Better outcomes, e.g., increased abstinence or reduced psychotic symptoms (Barrowclough et al., 2001; Drake et al., 1997, 2001; Jerrell and Ridgely, 1995).**

Citations: See Notes

Integration

- **A range of processes for combining different types of services provided by different agencies or systems to deliver care to clients with complex problems.**
- **“Integration” may describe combining primary health care and behavioral health care, incorporating behavioral health into criminal justice settings, etc..**
- **Integration refers here to strategies for combining mental health and substance abuse services to address the needs of individuals with co-occurring disorders.**