SAMHSA's Co-Occurring Center for Excellence (COCE)

Services Integration:

Technical Assistance (TA) Report for the Co-Occurring State Incentive Grants (COSIGs)

September 14, 2005
Updated June 2008

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Background

Introduction

- This report was prepared as part of a group process involving SAMHSA's Co-Occurring Center for Excellence (COCE) and the Co-Occurring State Incentive Grants (COSIGs) from 2003-2005.
- The content of this report is intended as an introduction to the topic of services integration, rather than an exhaustive review.
- This report is adapted from a presentation delivered to the COSIG workgroup by Richard N. Rosenthal, MD, COCE Senior Fellow, on 5/19/2005. It was updated in January 2008 for posting to the COCE Web.
- The SAMHSA Federal Project Officer for COCE is Charlene Le Fauve, Ph.D. (CSAT)

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Purpose and Utility of the Services Integration Report

Purpose:

- To provide a practical guide on the implementation of mental health and substance abuse services integration.

Utility:

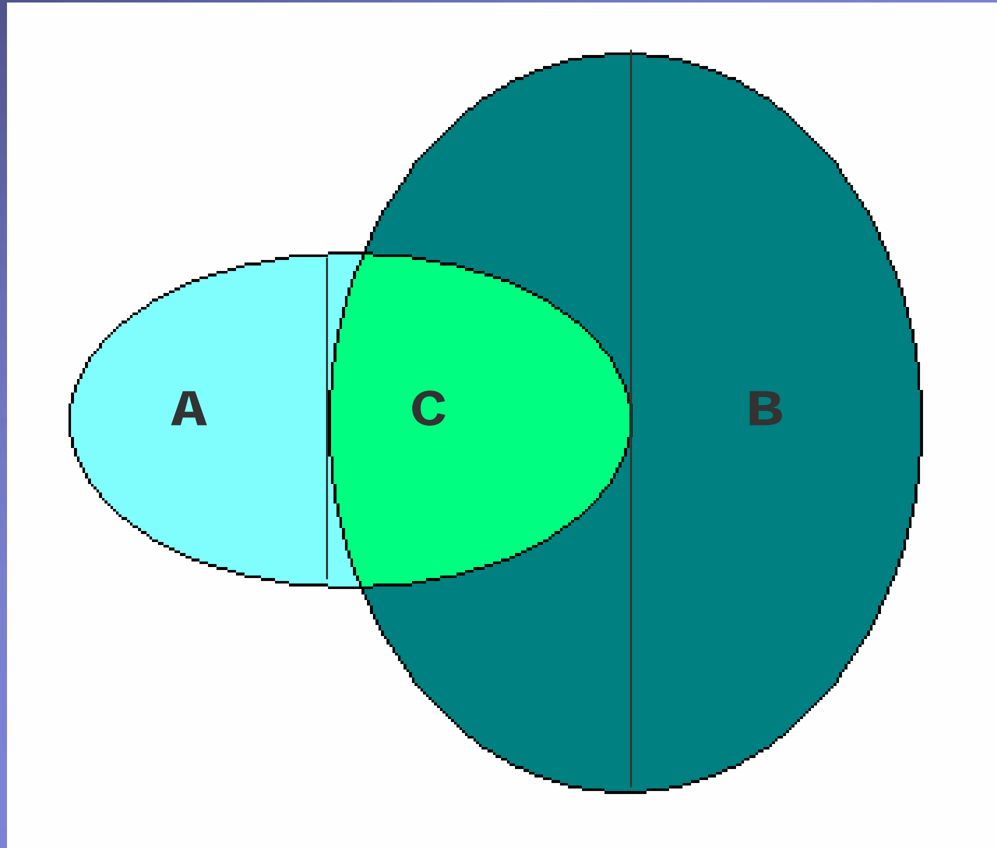
- PowerPoint format allows the report to be used in multiple settings and with multiple target groups.
- The report can be partitioned where particular components are needed.
- The report was updated in January 2008 and will continue to be updated periodically to ensure that the information remains accurate over time and available to a broader audience via the COCE Web site.

SAMHSA's Definition of Co-Occurring Disorders (COD)

- The term refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have co-occurring disorders have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs (CSAT, 2006)

Co-Occurring Mental and Substance Use Disorders

Mental Disorders (A)



Substance Use Disorders (B)

Co-Occurring Disorders (C)

Source: *Adapted from Osher, F.C. (1996)*

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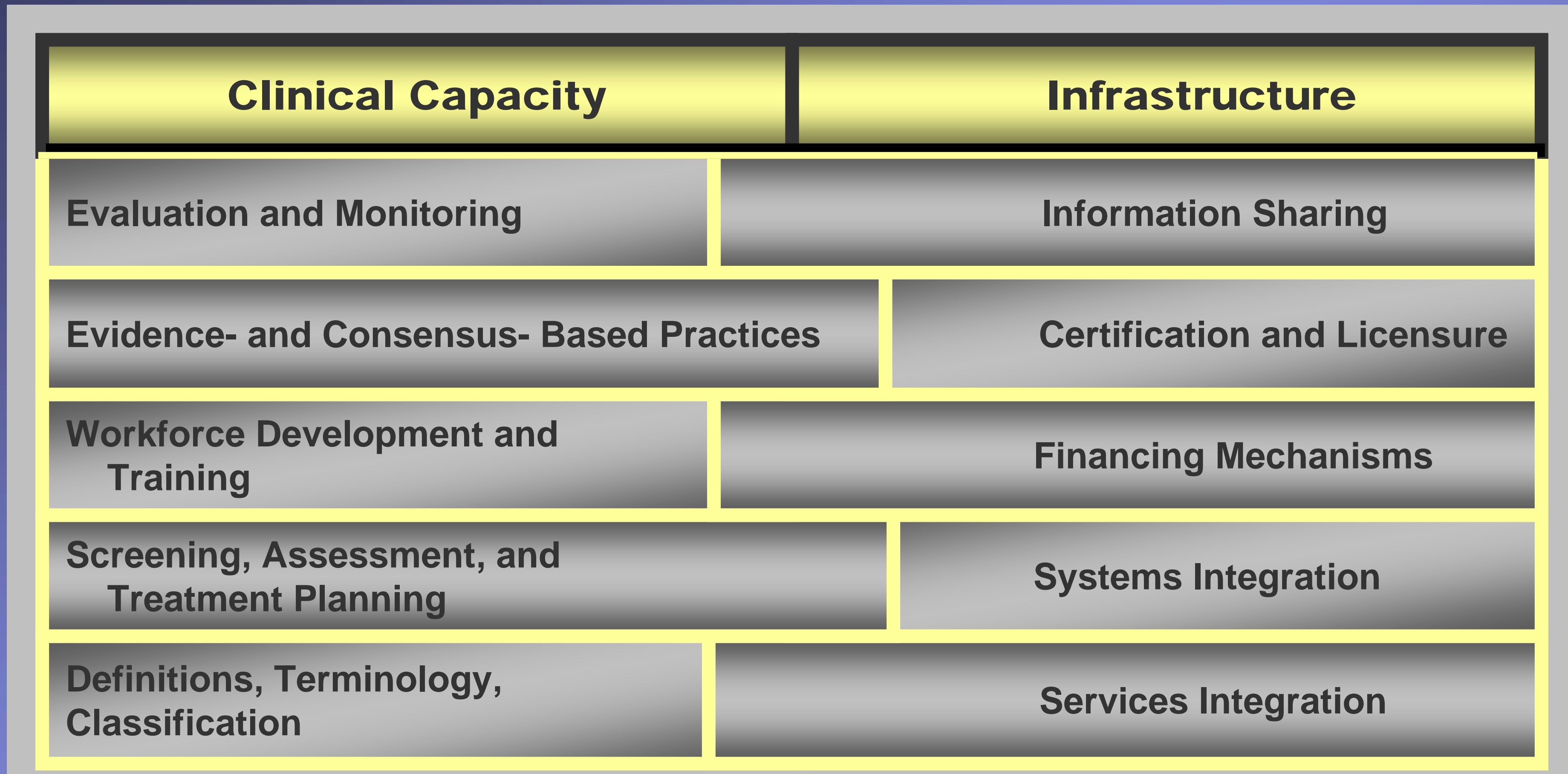
Building Blocks for Constructing a Co-Occurring Treatment System



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The Evolving Meaning of Integrated Treatment

- The concept of integrated treatment for persons with co-occurring disorders (COD), as originally articulated by a series of articles in *New Directions for Mental Health Services* (Minkoff & Drake, 1991), emphasized the need for correspondence between the treatment models for mental health and substance abuse treatment in a residential setting.
- The model stressed the importance of well coordinated, stage-wise treatment phases (i.e., engagement, persuasion, active treatment, relapse prevention) of mental and substance use disorders (Osher & Kofoed, 1989).
- Dual recovery treatment goals were emphasized, as well as the need to use effective treatment strategies from both the mental health and the substance abuse treatment fields.

The Evolving Meaning of Integrated Treatment (cont'd)

- In the literature of the field of COD, integrated treatment recognizes the need for a unified treatment approach to meet the substance abuse, mental health, and related needs of a client, and is the clinically preferred model of treatment (CSAT, 2005).
- Services integration is one of the best mechanisms for reducing stigma related to both substance use and mental health disorders based on the "contact" that occurs with the disorders across disciplines (Corrigan & Gelb, 2006; Corrigan, et al. 2005; Ay et al. 2006).
- Integrated treatment has continued to evolve, and several treatment models have been described:
  - Integrated dual disorder treatment (IDDT), assertive community treatment (ACT), and modified therapeutic community treatment (MTC).

Services Integration

Definition & Features

Services Integration: Definition

- ***Any process by which mental health and substance abuse services are appropriately integrated or combined at either the level of direct contact with the individual client with COD or between providers or programs serving those individuals (CSAT, 2007).***
  - **Complete services integration requires a consideration of, and response to, the needs, problems, and issues across services for persons with COD.**

Who Provides Services Integration?

- Individual clinician
- Clinical team that assumes responsibility for providing integrated services to the client
- Program that provides appropriately integrated services across clinicians or teams to all clients

CSAT 2007

Services Integration: Organizational Configurations

- Integrated services may be implemented using a wide range of staffing configurations and organizational formats that meet the overall goals of integrated screening, assessment, treatment planning, treatment provision, and continuing care (CSAT, 2007).

Ways of Achieving Integrated Treatment

Differing mechanisms can be used to achieve integration. For example:

- One clinician delivers a variety of needed services.
- Two or more clinicians work together to provide needed services.
- A clinician may consult with other specialties and then integrate that consultation into the care provided.
- A clinician may coordinate a variety of efforts in an individualized treatment plan that integrates the needed services. For example, if someone with housing needs was not accepted at certain facilities, the clinician might work with a State-level community housing program to find the transitional or supported housing the client needs.
- One program can provide integrated care.
- Multiple agencies can join together to create a program that will serve a specific population. For example, a mental health center, a local housing authority, a foundation, a county government funding agency, a substance abuse treatment program, and a neighborhood association could join together to establish a treatment center to serve women with children with COD.

CSAT 2005

Why Integrate Services?

- A strong literature base supports the need for the integration of services provided to COD clients (IOM 2006; CSAT, 2005).
- Need is generally based on:
  - High rates of COD in community samples (National Comorbidity Study [NCS]; National Epidemiologic Study on Alcohol and Related Conditions [NESARC]; National Survey on Drug Use and Health [NSDUH]) and in treatment samples (e.g. Sacks et al. 1997; Compton et al. 2000; Watkins et al. 2004).
  - Negative impact of each untreated disorder on recovery from the other (Grella et al. 2006; Drake et al. 1998; Office of Surgeon General, 1999).
  - Most treatment settings are unprepared to effectively manage both substance use and mental disorders (SAMHSA, 2002).

Why Integrate Services? (continued)

- Available research for the severely mentally ill (e.g., Drake et al. 2001), in combination with documents based on consensus-based practices (CSAT, 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).
- 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: see COCE Assessment TA Report for more information on the Quadrant model).

Integrated Interventions: Definition

- *Specific treatment strategies or therapeutic techniques in which interventions for both disorders are combined in a single session or interaction, or in a series of interactions or multiple sessions (CSAT, 2005).*

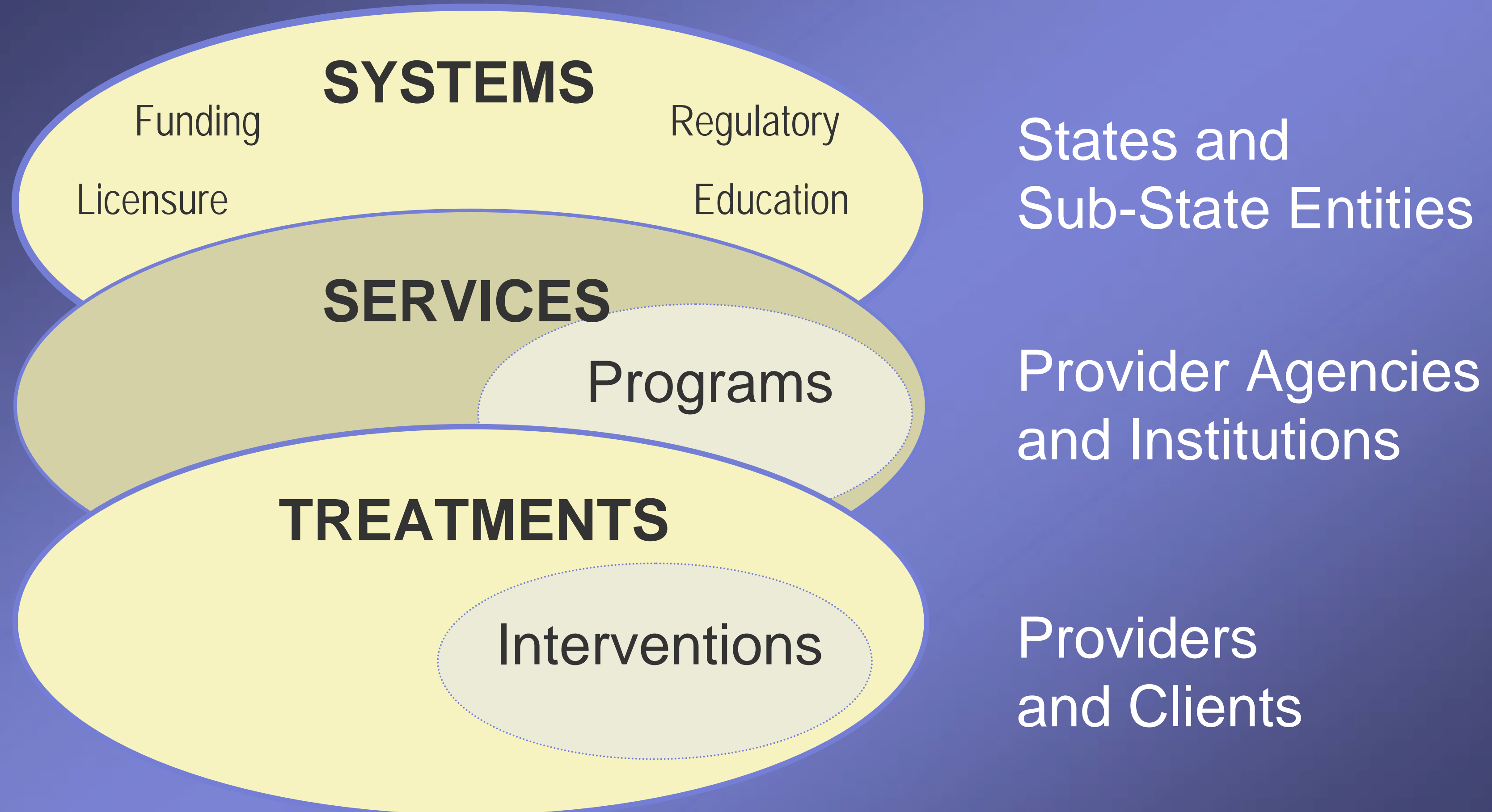
Integrated Interventions *(Continued)*

- **Integrated interventions can include a wide range of techniques, including:**
  - Integrated screening and assessment processes;
  - Dual recovery mutual self-help meetings;
  - Dual recovery groups (in which recovery skills for both disorders are discussed);
  - Motivational enhancement interventions (individual or group) that address issues related to both mental health and substance abuse or dependence problems;
  - Group interventions for persons with the triple diagnosis of mental disorder, substance use disorder, and trauma, or which are designed to meet the needs of persons with COD and a shared problem such as homelessness or criminality; and
  - Combined psychopharmacological interventions, in which an individual receives medication designed to reduce cravings for substances as well as medication for a mental disorder.
- **Integrated interventions can be part of a single program or can be used in multiple program settings: homelessness; primary care; perinatal; adolescent; HIV/AIDS; geriatric; and criminal justice.**

CSAT 2005

Processes at Different Levels of Organization

Processes at Different Levels of Organization



There are multiple processes that influence services integration across these levels of organization

Adapted from Rosenthal, 2005 (Presentation to COSIG Workgroup)

Integrated Systems

- A model for bringing the mental health and substance abuse treatment systems (and other systems, potentially) into an integrated planning process.
- The entire system is organized in ways consistent with the assumption that COD is highly prevalent and requires specialized interventions.
- This includes system-level policies and financing, the design of all programs, clinical practices throughout the system, and basic clinical competencies for all clinicians.

CSAT 2005

Systems Integration: Definition

- *The process by which individual systems or collaborating systems organize themselves to implement services integration to clients with co-occurring disorders and their families (CSAT, 2007).*

Contrasting Services and Systems Integration

- Systems integration can facilitate services integration if designed to support integrated treatment and programs.
- Services integration can occur, to some degree, in the absence of systems integration (i.e., pilot programs, etc.) but may be limited in impact and difficult to sustain.
- Providing integrated treatment to the client is fundamental – without this outcome, integrated programs and systems integration have no purpose.

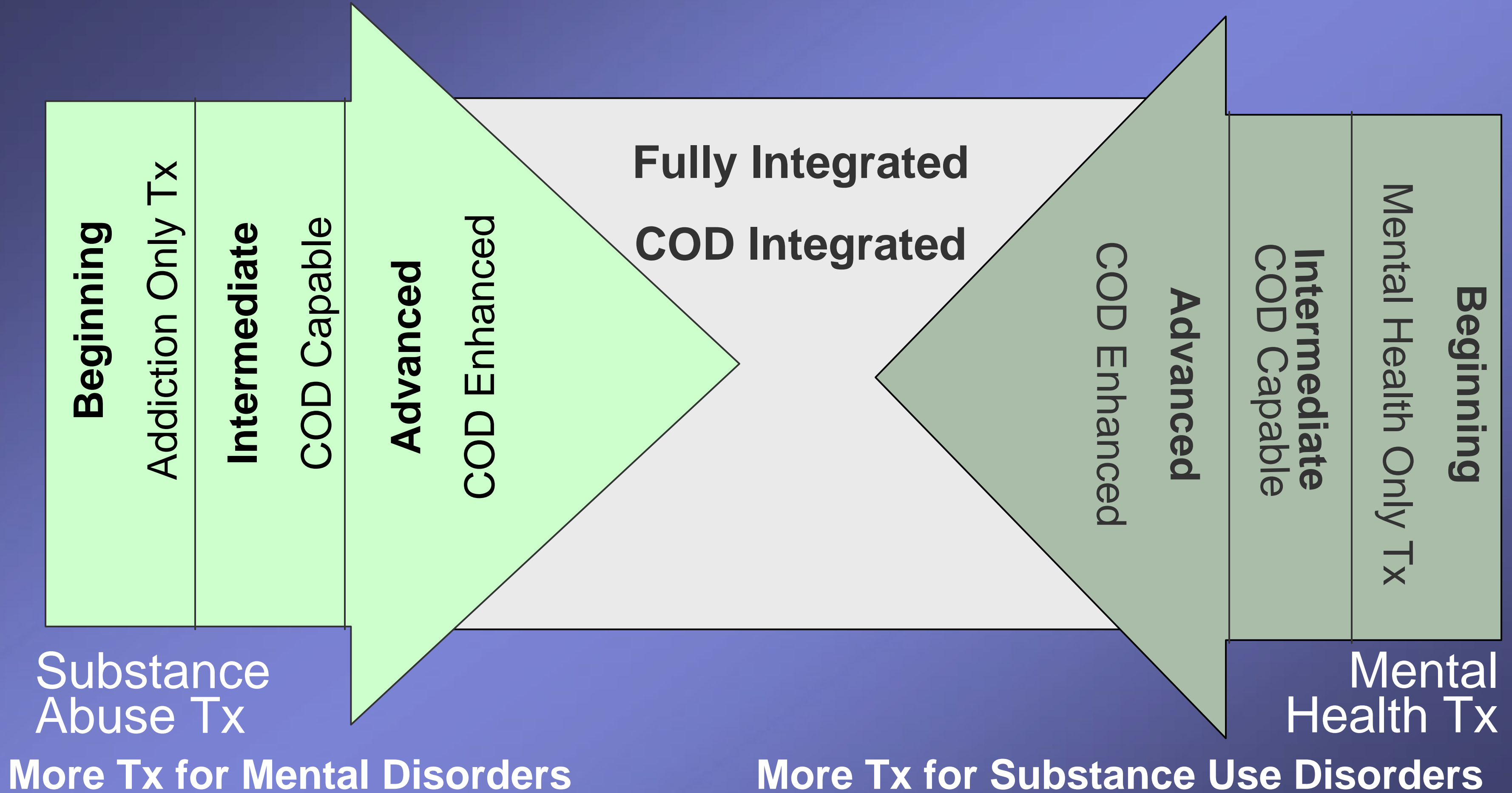
CSAT 2007

Levels of Program Capacity

COD Program Capacity

- Current programs can be classified as having addiction or mental health only services, basic capability to address co-occurring disorders, or enhanced capability to provide integrated services in staffing, services, and program content (ASAM 2001).
- A number of models fall under the headings of “integrated treatment” and “integrated programs,” and the classification of these subtypes is an area of future study.

Levels of Program Capacity in COD



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Services Integration

Implementation Strategies and Issues

Integration Strategies: Incremental Implementation

- Most services are not initially designed for COD-specific service needs.
- Integration usually requires new services which are more easily introduced over time.
- Enables programs to build on current knowledge, skills, and strengths while expanding gradually.
- Allows facilities and providers to simplify and change licensing and certification requirements for treating COD in the context of different licensing and certification standards.

SAMHSA 2003

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

CSAT 2007

Principles of Care That Facilitate Services Integration

- Consensus viewpoint:
  - Respect for the individual
  - Engagement of those 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

Management and Fiscal Structures and Activities That Facilitate the Integration Process

- An integrated organizational chart, identifying senior staff that can plan for integration
- Shared assessment tools
- Integrated funding streams
- Integrated policy manuals (NASMHPD/NASADAD 1999)
- General regulatory guidelines for a service's funding stream
- Specific guidelines and instructions for providing and documenting appropriately matched integrated treatment within the context of the already-funded service (Minkoff and Cline 2004)

Management and Fiscal Structures That Impede Services Integration

- Lack of funds for cross-training
- A real or perceived 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)

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 benefits can be demonstrated at the client, practice, and program levels (see slides 40-42).

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 substance abuse and mental health screening.
- Support and promote staff development.

Vital Steps to Transform Services, Including Services Integration *(Continued)*

- Allow staff to take appropriate 'risks,' such as:
  - Asking about substance use history in mental health treatment clients, and mental health history in substance abuse treatment clients
  - Asking about how to differentiate mental health and substance use disorders and symptoms
  - Asking about the appropriateness of the use of medications for clients based on co-occurring diagnoses

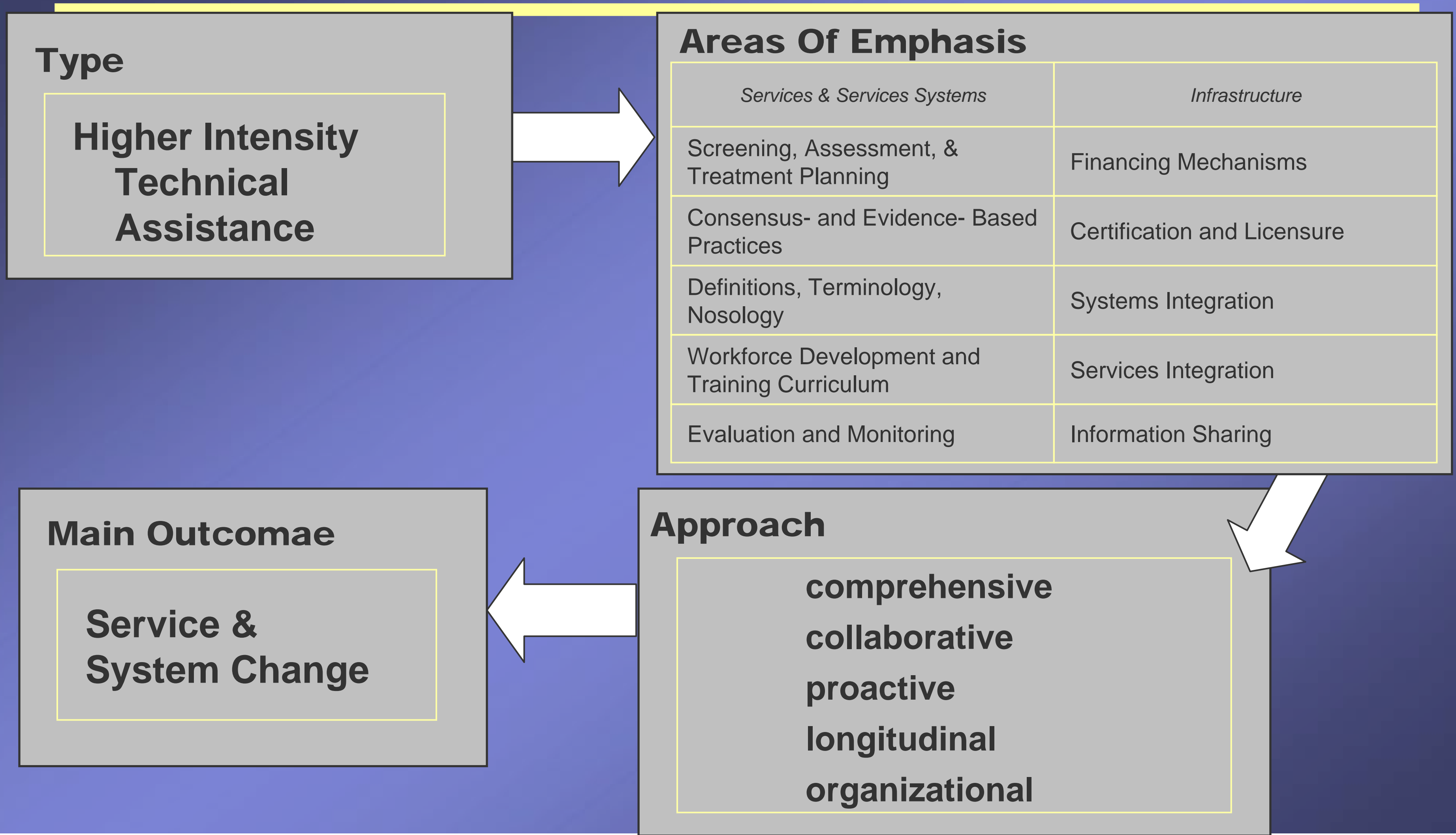
Vital Steps to Transform Services, Including Services Integration *(Continued)*

- Establish new relationships, such as AA/NA for mental health staff, or with psychiatrists and other mental health clinicians for substance abuse treatment staff.
- Encourage decisions that are driven by current scientific evidence or through consensus derived by reasonable inquiry (Garvin and Roberto 2001).
- Support and implement technology transfer as evidence-based practices are validated (Johnson et al. 2005). For example, support supervision as a valued activity both clinically and administratively (Ducharme et al. 2005).

Services Integration

Expected Outcomes

Service & System Change
Co-Occurring Center for Excellence (COCE)



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Outcomes Expected From Services Integration: Client Level

- Clients receiving integrated services in mental health and substance abuse treatment settings
  - Are more likely to stay in treatment (Watkins et al. 2005; Bartels et al. 2004)
  - Achieve better outcomes (Morrissey et al. 2005; Holdcraft & Comtois 2002; McLellan et al. 1997)
- With clinically, philosophically, and environmentally integrated services, clients with serious mental disorders and co-occurring substance use:
  - Are better engaged in treatment (Hellerstein et al. 1995)
  - Achieve better outcomes, e.g., increased abstinence or reduced psychotic symptoms (Barrowclough et al. 2001; Drake et al. 1997, 2001; Jerrell & Ridgely 1995; Brunette & Mueser 2006)

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 health and substance use disorders
- Case management skills facilitate engagement into medical, housing, and vocational services (McLellan et al. 1998)
- Substance abuse 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: 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, 2003; CSAT, 2005)
- Multi-problem view of clients
- Clear description of treatment population
- Specific programmatic COD services and levels of care to be provided are identified
- Services that are to be coordinated with other agencies are identified

Research Literature on Treatment Integration

Summary Findings from Literature Reviews
(For technical findings from the research, see Appendix A)

- Integrated treatment may be regarded as a research-based practice for those with severe mental disorders that co-occur with substance use disorders, based on the weight of evidentiary support catalogued in several literature reviews (Drake et al. in press; Barrowclough et al. 2006; Donald et al. 2005).
- Additional research is needed to establish the effectiveness of integrated treatment approaches for clients being served in substance abuse treatment settings who have mild to moderate co-occurring mental disorders (Back et al. 2006).

Recommendations

- The TIP 42 Consensus Panel and SAMHSA's COCE support and encourage the development of a unified substance abuse and mental health approach to COD.
- Both bodies recognize that system integration is difficult to achieve, but that the need for improved COD services in substance abuse treatment agencies is sufficiently urgent to warrant the effort.
- It is recommended that, at this stage, the emphasis be placed on assisting the substance abuse treatment system in the development of increased internal capability to effectively treat individuals with COD.
- A parallel effort should be undertaken in the mental health system, with the two systems continuing to work cooperatively on services to individual clients.

CSAT 2005a. TIP 42.

Appendix A

Quantitative and Descriptive Reviews of the Literature

Quantitative Reviews of the Literature

- As part of Cochrane Collaboration reviews, Jeffery and colleagues (2000) included six randomized, controlled trials published in the 1990's in which a substance abuse treatment program administered within the context of standard psychiatric care was compared with standard psychiatric care alone.
- None of the mental health or substance use measures in the primary studies were considered adequate for synthesis.
- Problems identified included the use of scales with unknown validity which had not been peer reviewed, and outcome data that were too badly skewed.
- There were several limitations in this synthesis, such as the restriction to only one of the many contexts in which people with co-occurring disorders are found.

Quantitative Reviews of the Literature (cont'd)

- Dumaine (2003) included 15 studies published in the 1990's in which a psychosocial intervention for clients with COD was evaluated relative to a control or comparison group.
- Only six of these studies used an experimental design, and substantial attrition (>40%) was common.
- Positive effects modest in size (Cohen's $d = .13 - .35$) were found for a variety of combinations of setting and psychosocial intervention approach.
- There were a number of limitations in this meta-analysis, the most important being the absence of information on effect size heterogeneity and the analytic methods used to pool effect sizes.

Descriptive Reviews of the Literature

- In a review of 45 studies (22 experimental, 23 quasi-experimental) of non-specific and specific interventions for persons with co-occurring substance use disorders and severe mental disorders, Drake and colleagues (2008) found a likelihood that at least three types of integrated interventions for substance use disorder are effective for dual diagnosis clients: group counseling, contingency management, and long-term residential treatment.
- These three types of interventions had significant positive effects on a variety of other outcomes, which was also the case for those interventions not effective for substance use outcomes. For example, case management typically extended time in the community, while legal interventions (e.g., jail diversion and release programs mandating treatment) generally improved treatment participation.
- In this review, the category of "case management" included both assertive community treatment and intensive case management, while "residential treatment" included the modified therapeutic community.

Descriptive Reviews of the Literature (cont'd)

- A recent systematic qualitative review by Donald and colleagues (2005) summarized ten randomized, controlled trials of integrated care for COD, mostly published in the late 1990's and early 2000's.
- Integrated treatment was compared with either standard or parallel treatment. The significance of findings for psychiatric symptoms and substance use were summarized, with most not significant and only a few favoring integrated treatment.
- Limitations of this review include the fact that conclusions were based on individual studies with typically small sample sizes, evidence from integrated treatment models was excluded, and a large amount of evidence from studies employing quasi-experimental designs was not considered.

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