The show will be filmed in a panel format, with free discussion between the show host and other panelists. This discussion guide is not to be considered a script. The information and resources provided in this discussion guide are provided to assist panelists in show preparation. The questions identified in each panel section will be asked by the show host. Panelists will respond to questions asked by the host, and they will also comment and add to information presented by other panelists in a discussion format. Panelists will bring their own keen anecdotal experiences to the show in addition to discussing ongoing research in the field.

Show Description. Many efforts are underway to build a behavioral health system that enables Americans to find effective treatments and services in their communities for mental and/or substance use disorders. Historically, the mental health and substance use service systems had been separate, and not well coordinated. Increased collaboration between the mental and substance use treatment systems has been key to the improvement of services overall. Panelists will discuss some of the challenges with integration at the federal, state, and local levels and discuss the benefits and successful outcomes when integration is pursued. This show will explore the integrated mental and substance use disorder services and recovery oriented systems of care currently adopted in some states. In addition, panelists will discuss the findings and recommendations of the 2016 Surgeon General’s report, Facing Addiction In America: The Surgeon General’s Report on Alcohol, Drugs, and Health.

Panel 1: The Challenge: Improving Recovery-Oriented Service Integration and Coordination

Key Questions:
1. What are some of the key reasons why mental health and substance use systems of care have pursued integration? What do well-integrated systems look like?
2. What are the factors or characteristics that facilitate the integration of these systems?
3. What are some of the challenges faced by systems when attempting to integrate care? How can systems overcome these challenges?
4. What are the potential benefits of integrating the mental health and substance use systems of care for clients?
5. Why is it particularly important to integrate mental health and substance use systems of care when providing services for justice-involved individuals, people who are homeless, and veterans and members of the military?
6. What are some reasons providers are striving to go further and integrate behavioral health into overall healthcare systems?

What are some of the key reasons why mental health and substance use systems of care have pursued integration? What do well-integrated systems look like?


- A growing body of research demonstrates that integrated services produce better outcomes for individuals with co-occurring disorders (COD), particularly those with more serious or complex conditions.
- The goal of integration is always the same—identifying and managing both disorders and the interaction between them. Moreover, the objective of all forms of integration is to support integrated treatment for the individual client. Integration that does not result in changes in services at the client level serves no useful purpose.


- The need for integrated services for persons with [co-occurring disorders] is apparent in the high community rates of [co-occurring disorders], the negative impact of one untreated disorder on recovery from the other, and the fact that most treatment settings are unprepared to effectively manage both substance use and mental disorders.
- A core set of benefits of services integration to programs, clinicians, and consumers can be identified:
  - Improved client outcomes
  - Improved adherence to treatment plans where both [substance use disorder] and mental illness interventions are supported
  - Improved efficiency because consumers do not have to shuffle between providers and clinicians do not have to make referrals and maintain communications among providers
- Additional benefits to consumers include
- Better integrated information rather than conflicting advice from several sources
- Improved access to services through “one-stop shopping”

**Additional benefits to programs and clinicians include**
- Opportunities for agency and professional growth
- Workforce development
- Less frustration and increased job satisfaction

**Additional benefits to consumers include**
- Better integrated information rather than conflicting advice from several sources
- Improved access to services through “one-stop shopping”


**What are the factors or characteristics that facilitate the integration of these systems?**


- Systems integration is not dependent on any specific organizational structure. In general, systems integration is facilitated by organizational structures that support an integrated planning process and is complicated by organizational structures that impede such processes
- Seven organizational processes that may support systems integration:
  - Committed leadership
  - Integrated system planning and implementation
  - Value-driven, evidence-based priorities
  - Shared vision and integrated philosophy
  - Dissemination of evidence-based technology to define clinical practice and program design
  - True partnership among all levels of the system
  - Data-driven, incentivized, and interactive performance improvement processes

**What are some of the challenges faced by systems when attempting to integrate care? How can systems overcome these challenges?**


- Despite progress as outlined above, major questions and challenges remain in considering treatment for co-occurring disorders
  - Delivering services to people in the [mental health] MH system.
    - A key question is how much service intensity is required for [integrated dual disorder treatment] IDDT to be effective. Related to this is whether the more intensive service model should be targeted narrowly to those with the most severe and chronic disorders, or expanded more broadly to those served by the public MH system, for whom there is
less evidence of the model’s effectiveness. Less intensive integrated service models might be equally effective and less costly for some people.

- A particular gap is the lack of evidence-based interventions and treatment models for people with severe mental illnesses and mild-to-moderate [substance use disorder].
  - Delivering services to people in the [substance use disorder] treatment system

- Financing barriers continue to limit access to public MH services, since state MH resources are targeted to those with severe mental disorders and the Medicaid-eligible. [Substance use disorder] is no longer a reason for disability [Supplemental Service Income] (SSI) and associated Medicaid eligibility, and many of those in the [substance use disorder] treatment system are not eligible for Temporary Assistance for Needy Families (TANF) and associated Medicaid because they do not have dependent children.

- Licensing and credentialing standards in most states also prevent [substance use disorder (SUD)] treatment providers from delivering MH services. And coordination of treatment between different [SUD] and MH treatment providers is hampered by privacy protections and the absence of routine processes for coordinating parallel or sequential care for co-occurring disorders. In addition, the development of evidence-based services for co-occurring disorders for those who receive care through the [substance use disorder] treatment system has been limited.


- [Substance use disorder] counselors in most States cannot treat mental disorders included in the DSM-IV-TR or prescribe medications for these disorders.
- Some issues associated with clients with mental disorders may be less familiar to [substance use disorder] treatment providers.
- [Substance use disorder] treatment staff may also need to become more comfortable responding to key issues in recovery from mental disorders, such as the key role of medications and the importance of accepting partial recovery as a legitimate treatment goal for persons with severe mental health problems.
- Some issues associated with clients with [substance use disorder] may be less familiar to mental health professionals.
- Mental health staff may also need to become more comfortable responding to such [substance use disorder] recovery issues as denial, working with a coerced client, abstinence, enabling, relapse, and peer counseling.
- Mental health providers may find that reimbursement rates for [substance use disorder] services are below rates for mental health services requiring comparable effort.


- From the perspective of programs and clinicians, implementation of integrated services involves many of the same challenges as any other form of organizational change and development. These may include the need to
  - Identify and respond to gaps in workforce competencies, certifications, and licensure
  - Proactively address staff concerns related to changes in roles and responsibilities
  - Institute modifications in record keeping to accommodate [co-occurring mental health and substance use disorders] COD
  - Modify facilities to meet additional needs (e.g., space for individual or group counseling)
- Revise staffing patterns and work schedules
- Reconcile differences in confidentiality regulations, policies, and practices between [substance use disorder] and mental health

**What are the potential benefits of integrating the mental health and substance use systems of care for clients?**


- Current best practices indicate that integration of mental health and [substance use disorder] services can lead to better outcomes for clients with co-occurring disorders, including fewer hospitalizations.


- Epidemiological studies find that psychiatric disorders, including mental disorders and substance use disorders, are common among adults and highly comorbid. Integrated treatment refers to the focus of treatment on two or more conditions and to the use of multiple treatments such as the combination of psychotherapy and pharmacotherapy. Integrated treatment for comorbidity has been found to be consistently superior compared to treatment of individual disorders with separate treatment plans.


- Combining strategies from the fields of psychiatry and [substance use disorder] treatment can lower the relapse rate among rehab graduates, reduce the number of suicide attempts and foster long-term abstinence.
- Integrated recovery plans are designed to overcome the negative side effects of mental health disorders, such as a reduced attention span, a low level of motivation, and a fear of socializing with others.
- Medication therapy is more effective when [a] pharmacological plan addresses [the patient’s mental disorder as well as his or her substance use disorder].
- In co-occurring disorders treatment, the traditional hesitations about prescribing psychotherapeutic medications are no longer an issue.
- Group therapy for people with co-occurring disorders offers a stronger support network for individuals who are struggling with mental illness as well as [substance use disorder].
- Treating [substance use disorder] and a mental health disorder at the same time helps rehab clients address their unique relapse triggers, such as depression, mood swings or panic attacks.


- Research evidence supports the claim that services integration leads to better client outcomes. [For example, clients receiving integrated services in [substance use disorder] treatment settings are more likely to complete treatment and have better posttreatment outcomes.]
- For clients with severe [co-occurring disorders] COD, integrated services have been shown to increase engagement in treatment and days of abstinence and reduce psychotic symptoms.

**Why is it particularly important to integrate mental health and substance use systems of care when providing services for justice-involved individuals, people who are homeless, and veterans and members of the military?**
According to a 2006 Bureau of Justice Statistics report, approximately 74% of state prisoners, 63% of federal prisoners and 76% of jail inmates met the criteria for a mental disorder. An estimated 42% of state prisoners and 49% of jail inmates met the criteria for both a mental and substance use disorder.

Co-occurring disorders, such as post-traumatic stress disorder (PTSD) and substance use, are prevalent among veterans and the military community. According to the Veterans Affairs Department (VA), approximately one-third of veterans seeking treatment for substance use disorders also met the criteria for PTSD. Veterans and service members benefit from integrated care for mental and substance use disorders. However, some veterans may not seek medical treatment for one of many reasons, including a fear of being treated differently. To promote wellness among veterans, service members, and their families, practitioners are encouraged to collaborate with other organizations to develop a training plan in effective integrated care techniques.

People with mental and substance use disorders may die decades earlier than the average person—mostly from untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease that are aggravated by poor health habits such as inadequate physical activity, poor nutrition, smoking, and substance misuse. Barriers to primary care—coupled with challenges in navigating complex healthcare systems—have been a major obstacle to care. At the same time, primary care settings have become the gateway to the behavioral health system, and primary care providers need support and resources to screen and treat individuals with behavioral and general healthcare needs. Integrating mental health, substance use disorder, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.

Systems outside of substance use disorder treatment and mental health may also participate in systems integration efforts, as when persons with co-occurring disorders COD are recruited into...
treatment from homeless shelters, emergency rooms, the criminal justice system, and so on, or when COD treatment services are located in homeless, healthcare, or correctional settings.

Panel 2: Standing Together: Integrating the Mental Health and Substance Use Systems of Care

Key Questions:
1. What are some of the key principles that behavioral healthcare systems need to apply when integrating care for mental and substance use disorders?
2. What are some strategies being adopted by healthcare systems in order to assist with the service delivery integration for behavioral health care services?
3. What changes need to be adopted by the behavioral health workforce to adapt to the integration of mental and substance use disorder into primary care? How can we best assist in this workforce transformation?
4. Which states have taken the lead in the integration of behavioral health disciplines and are there replicable models for other states to consider?
5. Are there available models for integrated care systems in non-traditional settings, such as the criminal justice system? What are those models and where do they exist?
6. Are there any challenges outlined by the 2016 Surgeon General’s report, Facing Addiction In America: The Surgeon General’s Report on Alcohol, Drugs, and Health related to systems integration? And, what are some of the recommendations made by the report in this regard?

What are some of the key principles that behavioral healthcare systems need to apply when integrating care for mental and substance use disorders?


- Principle 1: Co-occurring disorders [COD] are to be expected in all behavioral health settings, and system planning must address the need to serve people with COD in all policies, regulations, funding mechanisms, and programming.
- Principle 2: An integrated system of mental health and [substance use disorder] services that emphasizes continuity and quality is in the best interest of consumers, providers, programs, funders, and systems.
- Principle 3: The integrated system of care must be accessible from multiple points of entry (i.e., no wrong door) and be perceived as caring and accepting by the consumer.
- Principle 4: The system of care for COD should not be limited to a single “correct” model or approach.
- Principle 5: The system of care must reflect the importance of the partnership between science and service, and support both the application of evidence- and consensus-based practices for persons with COD and evaluation of the efforts of existing programs and services.
- Principle 6: Behavioral health systems must collaborate with professionals in primary care, human services, housing, criminal justice, education, and related fields in order to meet the complex needs of persons with COD.
- Principle 7: Co-occurring disorders must be expected when evaluating any person, and clinical services should incorporate this assumption into all screening, assessment, and treatment planning.
• Principle 8: Within the treatment context, both co-occurring disorders are considered primary.
• Principle 9: Empathy, respect, and belief in the individual’s capacity for recovery are fundamental provider attitudes.
• Principle 10: Treatment should be individualized to accommodate the specific needs, personal goals, and cultural perspectives of unique individuals in different stages of change.
• Principle 11: The special needs of children and adolescents must be explicitly recognized and addressed in all phases of assessment, treatment planning, and service delivery.
• Principle 12: The contribution of the community to the course of recovery for consumers with COD and the contribution of consumers with COD to the community must be explicitly recognized in program policy, treatment planning, and consumer advocacy.


• For patients with dual disorders, engagement in the treatment process is essential, although the techniques used will depend upon the nature, severity, and disability caused by an individual’s dual disorders.
• To treat patients with dual disorders, it is critical to develop continuity between treatment programs and treatment components, as well as treatment continuity over time.
• Programs should be designed to: 1) engage clients, 2) accommodate various levels of severity and disability, 3) accommodate various levels of motivation and compliance, and 4) accommodate patients in different phases of treatment.
• Dual disorder programs that provide stabilization to patients with acute needs should have the capability to:
  o Identify medical, psychiatric, and [substance] use disorders
  o Treat a range of illness severity
  o Provide drug detoxification, psychiatric medications, and other biopsychosocial levels of treatment
  o Provide a range of intensities of service.

What are some strategies being adopted by healthcare systems in order to assist with the service delivery integration for behavioral health care services?


• In order to guide systems integration efforts for [co-occurring disorders], [researchers] have developed the Comprehensive, Continuous Integrated System of Care (CCISC) model and its associated “Twelve Step Program of Implementation.”
• Other examples of models that are intended to facilitate the development of integrated systems of care … incorporate comprehensive local planning; comprehensive screening, assessment, and referral arrangements; and managed care strategies.


  o [This website provides evidence, examples, and models supporting primary and behavioral health care integration. Many tools are provided for health care systems looking to integrated care.]
What changes need to be adopted by the behavioral health workforce to adapt to the integration of mental and substance use disorder into primary care? How can we best assist in this workforce transformation?


- Clinicians and organizations providing mental and substance use health care can promote patient-centered care by 1) endorsing and supporting decision making by mental and substance use health care consumers as the default policy in their practices, 2) providing decision-making support to all such patients, including those coerced into care, and 3) supporting illness self-management practices for all consumers and formal self-management programs for individuals with chronic illnesses.
- Strengthening this infrastructure requires 1) a more coordinated strategy for filling gaps in the evidence base, 2) better dissemination of evidence to clinicians, 3) improved diagnostic and assessment strategies, 4) a stronger infrastructure for measuring and reporting quality, and 5) support for quality improvement practices at the locus of care.
- Because co-occurring disorders are expected in substance use and mental health treatment systems, the report recommends that whenever a patient is seen with a mental or substance use condition, the clinician should automatically screen for the other. Clinicians also should preplan their responses, i.e., treatment or referral, and whenever referral is planned, formal prearrangements with referral providers should be established.

Which states have taken the lead in the integration of behavioral health disciplines and are there replicable models for other states to consider?


- Staged interventions: Effective programs incorporate, implicitly or explicitly, the concept of stages of treatment.
- Assertive outreach: Many clients with a dual diagnosis have difficulty linking with services and participating in treatment. Effective programs engage clients and members of their support systems by providing assertive outreach, usually through some combination of intensive case management and meetings in the client’s residence.
- Motivational interventions: Most dual diagnosis clients have little readiness for abstinence-oriented treatment. Many also lack motivation to manage psychiatric illness and to pursue employment or other functional goals. Effective programs therefore incorporate motivational interventions that are designed to help clients become ready for more definitive interventions aimed at illness self-management.
- Counseling: Once clients are motivated to manage their own illnesses, they need to develop skills and supports to control symptoms and to pursue an abstinent lifestyle. Effective programs provide some form of counseling that promotes cognitive and behavioral skills at this stage.
- Social support interventions: In addition to helping clients build skills for managing their illness and pursuing goals, effective programs focus on strengthening the immediate social environment to help them modify their behavior.
• Long-term perspective: Effective programs recognize that recovery tends to occur over months or years in the community. People with severe mental illness and [substance use disorder] do not usually develop stability and functional improvements quickly, even in intensive treatment programs, unless they enter treatment at an advanced stage.

• Comprehensiveness: Learning to lead a symptom-free, abstinent lifestyle that is satisfying and sustainable often requires transforming many aspects of one’s life—for example, habits, stress management, friends, activities, and housing.


• The implementation of a complex multilayered systems integration model requires an organized approach, incorporating principles of strategic planning and continuous quality improvement in an incremental process. All layers of the system (system, agency or program, clinical practice and policy, clinician competency and training) and all components of the system, regardless of the system’s size or complexity, must interact.


• Most simply stated, the vision is to create a welcoming, person-centered, recovery oriented, culturally competent, trauma-informed, co-occurring capable system that is created through stakeholder partnerships reflecting the spirit and capacity of our shared values to serve consumers of the public [substance use disorder treatment and mental health] system. This vision holds the promise of creating, dynamic, enduring, and interrelated systems that:
  o Welcome individuals with complex needs into hopeful, caring and integrated relationships,
  o Support recovery through empowered partnerships focused on individualized goals,
  o Organize all staff to deliver effectively matched services in every setting to help individuals with complex needs achieve their recovery goals.

• For more information contact: Mark Lowis, LMSW at Lowism@michigan.gov.


• The Co-Occurring Disorders Initiative [Connecticut’s model for integrated services] is a state- and federally funded initiative designed to integrate services for adults with mental health and substance use disorders. A $4 million federal grant, called the Co-Occurring State Incentive Grant (COSIG), is being used to focus on three main goals: 1) statewide implementation of standardized screening and integrated assessments, 2) service coordination, network building, and integrated models of treatment, and 3) data-based decision making and data-informed program development for this population.

• For more information contact: Julienne Giard at julienne.giard@po.state.ct.us.


• The Illinois Co-occurring Center for Excellence (ICOCE) provides consultation, technical assistance, training, and research throughout the Midwest. The central role of ICOCE is to foster the use of evidence-based models of treatment and recovery for co-occurring substance use and other disorders.

• For more information contact: Randi Tolliver, Ph.D. at rtolliver@heartlandalliance.org
Are there available models for integrated care systems in non-traditional settings, such as the criminal justice system? What are those models and where do they exist?


- It is not the use of specific treatment techniques that make a treatment integrated, but the selection and blending of these techniques by the provider and the manner in which they are presented to the consumer that defines integration.

- [It should be noted that in the context of opioid use disorder there is an urgent need for adoption of medication assisted treatment within criminal justice. Failure to provide it is associated with disruption of successful treatment and misses the opportunity to provide evidence-based, effective therapy. In both cases potentially resulting in death.]

- When an individual with [co-occurring disorders] COD is also under correctional supervision, the coordination of [evidence-based practices] EBPs within each discipline is required to achieve positive outcomes. The appropriate application of coercion within treatment and supervision is one of the adaptations to COD integrated services required to work with justice-involved persons. [Some evidence-based models include the modified therapeutic community, Integrated Dual Disorder Treatment, and Assertive Community Treatment.]


- Innovative police responses to persons with [co-occurring disorders] COD illustrate a recognition, engagement, and referral approach. During the last 10 years, police-based specialized responses, most notably the Crisis Intervention Team, have been implemented across the country. In these models, police receive intensive training to recognize and engage persons with COD, with the goal of increasing access to treatment and support services and diversion from criminal justice settings.

- Problem-solving courts, such as drug courts and mental health courts, have been developed as a response to the growing influx of persons with COD in the court system.

- Jails are attempting to improve screening procedures for COD with the use of standardized instruments administered by correctional staff.

- Central to the process of outreach and engagement is the establishment of a “helping relationship.” Core characteristics of this relationship include mutual trust and respect, tolerance and flexibility, patience and realism, and being helpful in the eyes of the consumer.

Are there any challenges outlined by the 2016 Surgeon General’s report, Facing Addiction In America: The Surgeon General’s Report on Alcohol, Drugs, and Health, related to systems integration? And, what are some of the recommendations made by the report in this regard?


- An integrated system of prevention, early intervention, treatment, and recovery that can address the full spectrum of substance use-related health problems is a logical and necessary shift that our society must make to prevent substance misuse and its consequences and meet the needs of individuals with
It is clear that integrating substance use disorder services with mainstream health care is beneficial for individuals and communities and that health reform is encouraging this trend. However, several key challenges must be addressed if integration is to be fully successful. Specifically:

- The substance use disorder treatment system is underprepared to support care coordination;
- The primary care system has been slow to implement MAT [medication-assisted treatment] as well as prevention, early identification, and other evidence-based recommendations;
- The existing health care workforce is already understaffed and often lacks the necessary training and education to address substance use disorders; and
- The need to protect patient confidentiality creates hurdles for sharing of information.

[The report recommended several actions for healthcare systems. One recommendation was to promote effective integration of prevention and treatment services.]

- Effective integration of behavioral health and general health care is essential for identifying patients in need of treatment, engaging them in the appropriate level of care, and ensuring ongoing monitoring of patients with substance use disorders to reduce their risk of relapse.
- Implementation of systems to support this type of integration requires care and foresight and should include educating and training the relevant workforces; developing new workflows to support universal screening, appropriate follow-up, coordination of care across providers, and ongoing recovery management; and linking patients and families to available support services.
- Quality measurement and improvement processes should also be incorporated to ensure that the services provided are effectively addressing the needs of the patient population and improving outcomes.

[Another recommendation was to work with payors to develop and implement comprehensive billing models.]

- Consideration of how payors can develop and implement comprehensive billing models is crucial to enabling health care systems to sustainably implement integrated services to address substance use disorders.
- Coverage policies will need to be updated to support implementation of prevention measures, screening, brief counseling, and recovery support services within the general health care system, and to support coordination of care between specialty substance use disorder treatment programs, mental health organizations, and the general health care system.

Panel 3: Supporting Change: How System Leaders, Provider Organizations, Professionals, and Individuals Seeking Treatment Can Help Integrate Systems of Care

Key Questions:
1. Why is leadership critical in efforts to integrate the mental health and substance use systems of care? And, where must the leadership come from: policy, program, health departments, financing, accreditation, clinical licensing, and training at all levels, or, all of the above?

2. What are some approaches and strategies that provider organizations can implement when working to integrate care?

3. How can behavioral health professionals facilitate the integration of mental health and substance use systems of care?

4. How can primary care professionals facilitate the integration of behavioral health into their practices?

5. What is the concept of “no wrong door,” and what is the impact on individuals seeking treatment when systems implement this idea?

6. Can the individuals in need of services play a role in helping systems to adapt to the need for integrated services? How can they, or should they, carry out this role while still trying to get services?

Why is leadership critical in efforts to integrate the mental health and substance use systems of care? And, where must the leadership come from: policy, program, health departments, financing, accreditation, clinical licensing, and training at all levels, or, all of the above?


- Systems change must be supported, designed, and consistently advanced by the key influence leaders in an organization. In SAMHSA, agency leadership has consistently articulated the system vision described earlier, and made significant policy decisions in a thoughtful, strategic manner to consistently advance the implementation of that vision.


- Leadership is well known to be a critical factor in the success of any major change initiative or quality improvement effort and an essential feature of successful programs in care coordination.
- Effective leadership in part models the behaviors that are expected at the clinical care level. For example, in The Robert Wood Johnson Foundation’s *Initiative on Depression in Primary Care*, leadership was one of six component interventions to overcome barriers to the delivery of effective care for depression in primary care settings.

What are some approaches and strategies that provider organizations can implement when working to integrate care?


- Commonly used system-level strategies include building a consensus around the vision for integrated services and then conjointly planning; specifying a model; implementing structural, regulatory, and
reimbursement changes; establishing contracting mechanisms; defining standards; and funding demonstration programs and training initiatives.

- At the level of the mental health clinic or program leadership, the fundamental task is to begin recognizing and treating [substance use disorder] rather than ignoring it or using it as a criterion for exclusion.
- [Leadership should consider specifically including the use of pharmacotherapy in the management of opioid use and alcohol use disorders.]
- After consensus-building activities to prepare for change, staff need training and supervision to learn new skills, and they must receive reinforcement for acquiring and using these skills effectively.


- At the treatment level, interventions that have their own evidence to support them as [evidence-based practices] EBPs are frequently a part of a comprehensive and integrated response to persons with [co-occurring disorders] COD. These interventions include:
  - Psychopharmacological Interventions (e.g., desipramine and bupropion for people with cocaine dependence and depression)
  - Motivational Interventions (e.g., motivational enhancement therapy)
  - Behavioral Interventions (e.g., contingency management)
- At the program level, the following models have an evidence base for producing positive clinical outcomes for persons with COD:
  - Modified Therapeutic Communities
  - Integrated Dual Disorders Treatment
  - Assertive Community Treatment

**How can behavioral health professionals facilitate the integration of mental health and substance use systems of care?**


- Clear articulation of these principles and wide consensus among stakeholders regarding their importance are key steps toward setting the context for services integration.
- Organizations that articulate client-centered values, remove barriers, and allow staff to take appropriate risks and establish new relationships are vital for transforming services, including services integration.
- Workforce development is key to setting the context for services integration. Clinicians will profit from training in integrated screening, assessment, and treatment strategies for both mental and substance use disorders.

**How can primary care professionals facilitate the integration of behavioral health into their practices?**


- Another strategy would be to incorporate specialty [substance use disorder treatment] and mental health services into general medical settings such as primary care. This approach could potentially reach far more patients in less stigmatized health care settings.
• Accrediting bodies, purchasers, and Federal and State agencies can greatly facilitate integration of services by implementing certain overarching strategies, identified by the [Institute of Medicine] IOM Committee.

What is the concept of “no wrong door,” and what is the impact on individuals seeking treatment when systems implement this idea?


• “No wrong door” refers to formal recognition by a service system that individuals with [co-occurring disorders] COD may enter [the system at] a range of community service sites.

• [The Center for Substance Abuse Treatment’s] CSAT’s “no wrong door” policy states that effective systems must ensure that an individual needing treatment will be identified and assessed and will receive treatment, either directly or through appropriate referral, no matter where he or she enters the realm of services.


• An approach to service organization that provides individuals with or links them to appropriate service interventions regardless of where they enter the system of care. This principle commits all service agencies to respond to the individual’s stated and assessed needs through either direct service or a linkage to appropriate programs, as opposed to sending the person from one agency to another.

Can the individuals in need of services play a role in helping systems to adapt to the need for integrated services? How can they, or should they, carry out this role while still trying to get services?


• Consumer engagement is important for the success of all models of health care delivery.

• Ensuring the presence of an active consumer voice is especially important for vulnerable populations with specialized needs—such as people with disabilities and frail elders. As new models for delivering care are implemented by organizations that may not have previous experience with these populations, consumer engagement is an important way for early identification of promising practices to expand and potential problems to correct.

• The consumer voice is necessary to: provide the consumer perspective on major strategic decisions, give feedback on the way current services are experienced by consumers, [and] raise new issues of concern to consumers.

• This issue brief outlines a framework for thinking about the best practices that are needed to ensure a meaningful consumer voice in new care delivery models. [These include:]
  1. Involvement in Multiple, Active Ways
  2. Inclusion at the Highest Feasible Level of Governance
  3. A Representative Recruitment Process
  4. Dedicated Resources
  5. Address Barriers to Participation
  6. Evaluation and Monitoring
Panel 4: Resources on Integrated Care: Information for Individuals Seeking Treatment, Families, Providers, and Systems

Key Questions:
1. What are some resources available for individuals seeking treatment and their families about integrated care systems? And, how can they find appropriate treatment and successfully navigate these systems?
2. What are some resources for practitioners who want to better understand integrated care and how it promotes recovery?
3. What resources are available to provider organizations to help them integrate care?
4. What are some resources for the leaders of systems looking to integrate care?
5. What are some resources to help behavioral healthcare systems integrate care?
6. What resources are available to help primary care systems integrate behavioral health care?

What are some resources available for individuals seeking treatment and their families about integrated care systems? And, how can they find appropriate treatment and successfully navigate these systems?


- [This website describes co-occurring disorders.]


- [This website offers research-based information on co-occurring disorders.]


- [This website offers] a confidential and anonymous source of information for persons seeking treatment facilities in the United States or U.S. Territories for [substance use disorder] and/or mental health problems.


- [This website offers information on mental health and a treatment locator.]

What are some resources for practitioners who want to better understand integrated care and how it promotes recovery?


- [The SAMHSA-HRSA Center for Integrated Health Solutions offers information and resources for practitioners, administrators, and policy makers.] CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and
substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS provides training and technical assistance to community behavioral health organizations, community health centers, and other primary care and behavioral health organizations.


- [This document] recaps a meeting on co-occurring disorders. [It] addresses a whole-person focus, consumers’ collaboration with providers, stigma and discrimination, training and education, funding, and recommendations to improve service delivery.


- [This resource] provides [substance use disorder] treatment providers with updated information on co-occurring substance use and mental disorders and advances in treatment for people with co-occurring disorders. [It] discusses terminology, assessment, and treatment strategies and models.


- [This resource] provides practice principles about integrated treatment for co-occurring disorders, an approach that helps people recover by offering mental health and [substance use disorder] services at the same time and in one setting. [It] offers suggestions from successful programs.

What resources are available to provider organizations to help them integrate care?


- [This resource] outlines 12 overarching principles for working with persons who have co-occurring disorders of [substance use disorder] and mental illness. [It] discusses principles that are grounded in evidence-based practices for systems of care and individual treatment providers.


- [This resource] discusses evidence-based practices (EBPs) and their role in the treatment of co-occurring disorders. [It] addresses criteria for evidence-based practices, examples of EPBs for co-occurring disorders, and issues to consider in the use of evidence-based practices.

• [This resource] gives an overview of integrated screening, assessment, and treatment planning for persons with co-occurring disorders of [substance use disorder] and mental illness. [It] discusses staffing, protocols, methods, systems issues, financing, and client-centered services.


• [This presentation describes how treatment for mental and substance use disorders can be integrated in practice.]


• [This on-demand webinar] is a skill-based training program that will help [substance use disorder] counselors improve their ability to assist clients who have co-occurring disorders, within their scope of practice.

What are some resources for the leaders of systems looking to integrate care?


• [This article discusses strategic elements in achieving system transformation to support widespread availability of integrated services in any system for any population.]


• [This article discusses challenges and strategies for integrated care.]


• [This article discusses issues related to integrated care for adolescents.]


• [This article discusses issues related to integrated care for adults.]

What are some resources to help behavioral healthcare systems integrate care?

• [This resource] explains how [substance use disorder] and mental health treatment providers, administrators, and policymakers can use epidemiological studies of co-occurring disorders. [It] describes major national studies related to dual diagnosis and gives technical details about them.


• [This resource] explains how systems integration supports integrated mental health and [substance use disorder] services for persons with co-occurring disorders. [It] describes financing, evaluation, helpful organizational structures, and examples of systems integration for dual diagnosis.


• [This resource] defines services integration and explains how it is used to meet the [treatment] needs of persons with co-occurring disorders. [It] addresses the benefits, challenges, potential outcomes, design, and implementation of services integration.

What resources are available to help primary care systems integrate behavioral health care?


• [This fact sheet aids primary care providers in identifying and helping patients with co-occurring disorders. [It discusses warning signs and screening tests, patients with CODs and HIV, and a Quadrant of Care Model for treatment.]

Source: Substance Abuse and Mental Health Services Administration and Human Resources and Services Administration Center for Integrated Health Solutions. Accessed September 21, 2016.

• [This website offers information and tools to help providers and systems integrate primary and behavioral health care.]

A link check was run on all the external websites listed in the discussion guide to identify and fix any broken links as of 11/14/16. However, we acknowledge that URLs change frequently and may require ongoing link checks for accuracy. Last updated: 11/14/16.