

---

## *BEST PRACTICES*

---

### What Is Integration? Part I

Kenneth Minkoff, MD

#### *WHAT IS INTEGRATION?*

Increased recognition of the importance of providing appropriate services to individuals and families with co-occurring mental health and substance use disorders has led to widespread recommendations to promote “integration” of mental health and substance abuse systems, services, and treatment as a mechanism to achieve this goal. While this is a logical recommendation, and one that is generally supported by an increasing volume of research (cf SAMHSA’s Integrated Dual Disorder Treatment Toolkit (ref) and Treatment Improvement Protocol #42 on Substance Abuse Treatment for Individuals with Co-occurring Disorders (ref)), the use of the term “integration” is often associated with lack of precision regarding the meaning of the concept, and in an area already associated with considerable conceptual difficulty, this lack of precision may result in further confusion. This issue was raised in the previous edition of this column, and was deferred to this edition for further discussion.

One source of confusion is that the term “integration” may vary with reference to what is being “integrated.” For example, integration may be

---

Kenneth Minkoff, MD, is Clinical Assistant Professor of Psychiatry, Harvard University, and Senior Systems Consultant, Zialogic, Acton, MA (E-mail: Kminkov@aol.com).

Journal of Dual Diagnosis, Vol. 2(4) 2006  
Available online at <http://jdd.haworthpress.com>  
© 2006 by The Haworth Press, Inc. All rights reserved.  
doi:10.1300/J374v02n04\_11

applied not only to mental health and substance abuse services, but to various combinations of either or both types of behavioral health services with medical services, correctional services, child welfare services, developmental disability services and so on. The SAMHSA Co-occurring Disorder Center of Excellence (COCE) has defined behavioral health integration as follows:

As applied to behavioral health service delivery, integration refers to 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, and so on. As used . . . (by COCE), integration refers to strategies for combining mental health and substance abuse services to address the needs of individuals with COD.

For the purpose of this column as well, we will maintain a focus on the integration of mental health and substance abuse, but as will be seen, it is often difficult if not impossible to avoid overlapping discussion of integration with other domains.

Second, "integration" may refer to many different things, all of which may have relationships with one another, but are not inherently equivalent. Without clarity about which type of "integration" is being discussed, there may be an erroneous assumption that all the types of "integration" are interchangeable.

A third source of confusion is that there has not been a well-established consensus on the definitions of *any* type of integration, so that even when there is clarity about the type of integration, there may still be confusion about what is being described, and the indicators that "integration" has been achieved or is present. During the past year, both CSAT (in TIP 42) and The SAMHSA COCE have begun to provide initial efforts at establishing consensus on defining various concepts in relation to "integration." However, the process of understanding what these concepts mean is by no means complete; rather, it is a work in progress. The purpose of this column will be to delineate the basic elements of a conceptual framework for "integration" in behavioral health, and then apply that conceptual framework to the major "types of integration" (regarding mental health and substance abuse), in order to assist the reader to have a basic conceptualization with which to approach the emerging volume of literature on "dual diagnosis" services. This

discussion will take place in several parts. This first column (Part I) will focus on defining the conceptual framework, and applying that framework to a discussion of systems, and services broadly defined. The second part will apply the framework to programs and clinical practice, both treatment and interventions. The third part will apply the framework to clinical relationships, clinician scopes of practice, and clinical competencies.

### ***Conceptual Framework for Behavioral Health Integration***

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.* According to Cline (2005), integration refers to those activities at the level of any behavioral health organization (state system, mental health system, county, agency, program) that organize both the structure of the organization and the functional processes of the organization so that mental health and substance abuse “components” are interwoven in a coherent manner in order to accomplish the organization’s mission for its total population of individuals and families with mental health and/or substance disorders

Within this framework, integration is distinct from “parallel” services or functions in which mental health and substance components or services are “co-located” within the organization, or provide care in tandem to the client, but without the interwoven fabric between them and the provision of integrated interface within each component.

Similarly, in this framework, integration is distinct from “blending.” Integration means, by contrast, that recognizable interventions for both mental health conditions and substance conditions are provided at the client/family interface, and at the system level recognizable components are organized to provide substance and mental health services or programs. Integration does not mean that the independent identity and value of each component is lost; rather each type of component or service is a valuable element in the interwoven fabric of care.

Now, let us apply this framework to various types of integration.

### ***Types of Integration***

Integration is a term that may be variously applied to the following elements of service delivery:

- Integrated Systems or Systems Integration
- Integrated Services or Services Integration
- Integrated Program or Program Integration
- Integrated Treatment
- Integrated Interventions
- Integrated Treatment Relationships or Integrated Treaters
- Integrated Clinical Competency or Scope of Practice.

In the next two editions of this column, we will look at each of these elements in turn. In this edition, we will look at integration in relation to systems and services. In Part II, we will look at integrated programs, treatment, clinical practice, and interventions, and in Part III, integrated relationships, clinician competencies, and scopes of practice

### ***Systems Integration***

What is a system? For the purpose of this discussion, system refers to any organizational entity or structure (or combination of entities and structures) that is responsible for providing a particular set of services to a defined population.

Within this general definition, systems can be defined and described at many levels in relation to their responsibility for the population of individuals and families with co-occurring mental health and substance use disorders. For example, a "state" behavioral health system would have "responsibility" for the provision of services to individuals with co-occurring disorders in that state. Usually, there is an implication that this relates to the so-called "public" system, but increasingly there is overlap between public and private funding streams, managed care organizations, and providers, and the state may have responsibility for not only direct provision or funding of services, but of establishing standards and overseeing quality or provider and clinician performance. In addition, the "population" to be served may be present in specific behavioral health settings, but also may be present in "collaborative systems" such as correctional settings, primary health care settings, school

settings, and so on, with varying degrees to which behavioral health services are specifically provided in those settings. Further, any “system” is likely to have multiple subsystems, each of which can be considered a “system” in its own right. For example, a “state” behavioral health system may have adult and children subsystems, mental health and substance abuse subsystems, medicaid and non-medicaid subsystems, provider networks and complex agency subsystems, and a variety of county and regional subsystems. Describing integration in any system has to address the issue of integration in all the various collaborative systems and subsystems that apply to the total population of concern.

In addition to the above, a “system” is much more than an organizational chart listing its component parts. Systems include all elements of “infrastructure” that organize the functioning of that system by describing system policies, procedures, and processes that determine how the system functions within each of its component subsystems, and how the different components function in relationship to each other. These policies and processes in behavioral health systems relate to every element of each component of the system, from mission statement and values, to administration and oversight, quality management and advocacy, funding mechanisms, requirements, and certification standards, intersystem and interprogram care coordination, collaboration, and referral, program design, licensure, and monitoring, clinical practice requirements and guidelines, and clinician credentialing, competencies, supervision, and workforce development.

Finally, systems have to be defined in relationship to the outcomes they are designed to produce. COCE has defined systems integration (and integrated systems) in relationship to their capability to produce services integration and integrated services (COCE, 2005). Consequently, evaluation of the outcome of any of the structure or process elements of systems integration has to be connected to that capability.

Based on the above discussion, we can use the conceptual framework for integration to define systems integration as consisting of two interrelated elements:

1. Systems integration involves developing the capacity of the system to deliver appropriately integrated services at every client/family interface. According to COCE, this involves the process by which individual systems (and their subsystems) or collaborating systems organize themselves to implement services integration to clients and families with COD as a routine practice that is sup-

ported by system infrastructure and is a core function of system design (ref)

2. Systems integration also involves developing organizational structures and functional processes to interweave all the mental health and substance components of the system into a coherent whole that meets the diverse needs of the total population for which the system is responsible.

In this definition, systems integration is a “process,” and the integrated system would be the “outcome” of this process.

Within this framework, let us briefly discuss some of the key elements that are often confusing when discussing systems integration or integrated systems.

1. Systems integration as defined here is distinct from “administrative integration” of behavioral health subsystems. That is, many state and county systems are merging administrative subunits responsible for mental health and substance abuse services in order to achieve “an integrated system.” It cannot be stated strongly enough that an administrative merger or “administrative integration” does not equate to or automatically result in systems or services integration. In fact, in some systems, the confusion associated with the merger process itself may impede collaborative processes to effect systems integration between cooperating administrative subunits. Consequently, administrative integration is a potential strategy for systems integration, and is neither a requirement, nor an outcome in itself. It must be recognized, as well, that there are a number of state systems (e.g., Arizona) that have achieved substantial progress in systems integration through structured and organized collaboration between distinct mental health and substance abuse departments, while there are several states with “administratively integrated” behavioral health departments in which mental health and substance abuse subsystems continue to operate in parallel.
2. Systems integration always must include the two components of universal services integration to meet the needs of each individual client and family, and interwoven components organized to meet the needs of the total population. It is insufficient to say that certain components (subsystems, programs, clinicians) have no capacity to appropriately address the needs of individuals with co-morbidity who are presenting for service or who are in their

caseloads. It is also insufficient for a system to organize a very nice array of dual diagnosis programming in mental health and substance settings but to have the whole system be “dis-integrated” so that significant populations do not have their needs met and/or fall through the cracks between the existing system components. In addition, a key element of systems integration is the ability of each component of the system to recognize its partnership with the other components, to have specific instructions for mutual collaboration and support, in order to facilitate the success of all the other programs in working with their populations of clients, and to ensure that no client or family is lost between them. Finally, behavioral health delivery systems at any level (e.g., state, county, etc.) must also attend to interweaving services provided (or providing integrated services to populations that may be ineffectively served) in “non-behavioral health” settings, such as schools, shelters, and jails.

3. Systems integration as defined here is also distinct from “funding integration” or “blended funding.” The issue of how services are funded is one of many infrastructure issues that must be addressed during the process of systems integration. All systems are likely to have multiple sources of funding including funding streams that are both flexible and categorical, and, because of the high prevalence of co-morbidity, will need to figure out mechanisms for providing integrated services with any single funding stream, as well as mechanisms for combining or “braiding” funding streams when appropriate.
4. Systems integration further must be distinguished from collaboration procedures such as “interagency referral agreements.” These may be components of systems integration, but in and of themselves collaborative referrals do not accomplish the goal of integrated services as a core system function. In fact, in relation to the “mutual support and collaboration” described in paragraph 2, interagency referral agreements alone often may lead to clients bouncing around the system to receive services in multiple domains, rather than receiving integrated services wherever they already are.
5. Systems integration is always related to a population, not to a particular program or practice. Some systems equate systems integration to the implementation of a particular program or practice such as the SAMHSA IDDT toolkit. However, because systems integration relates to the entire population, and to services provided in

- all settings, systems integration efforts always must address a wide range of program settings, clinical practices, and clinicians.
6. No one yet knows how to tell if systems integration has been achieved. The state of the art of evaluating the process and outcome of systems integration in behavioral healthcare is still in its infancy. Much has been learned in the children's system from studying Children's System of Care implementation efforts since the 1980s, but these efforts (which started with a focus primarily on mental health needs) are only now beginning to specifically attend to the needs of children and families with co-occurring mental health and substance use disorders. Further, development and evaluation of models for integrated system design and evaluation of those models has only emerged within the last decade. TIP 42 (ref) cites the Comprehensive Continuous Integrated System of Care (CCISC) (Minkoff & Cline, 2004, 2005) as one such model that is in the process of implementation in a large number of state and substate systems, but with no formal evaluation studies yet published. CCISC is a conceptual model for defining core capacity to deliver integrated services within each system component ("dual diagnosis capability") as well as creating a framework for how each component works collaboratively to identify and meet the continuous and comprehensive needs of the entire population. CCISC is currently being utilized as a framework for organizing statewide or regional systems integration projects in over 30 states and four Canadian provinces.

### ***Services Integration***

As defined by COCE, "services integration refers to the process of merging previously separate clinical services into a seamless and harmonious framework of practices for clients with co-occurring disorders (COD). In contrast, systems integration pertains to the development of educational, fiscal, and regulatory infrastructures within States and sub-state entities that support integrated services for COD" (COCE, 2005: Services Integration position paper).

More specifically, services integration is defined by COCE as the following:

Any process by which mental health and substance abuse services are appropriately integrated or combined at the level of the individual client with COD. Integrated services can be provided by an



individual clinician, a clinical team that assumes responsibility for providing integrated services to the client, or an organized program that provides appropriately integrated services by all clinicians or teams to all clients. (COCEf).

In accordance with the above conceptual framework, services integration also includes two interrelated components:

- First, services integration must relate to the extent to which integrated services of any type (screening, assessment, interventions, treatment, and programs) are provided in any setting to any client or family in the context of a treatment relationship.
- Second, services integration refers to the interweaving of the component services at any level in order to provide an appropriate array of services to the target population. Such interweaving must be supported by the “system” in which the services integration is being designed.

As with systems integration, services integration is a process as well, and integrated services are the outcome of the process.

Within this framework, let us discuss some specific issues that may require clarification related to services integration. These will be somewhat analogous to the issues identified in the discussion of systems integration.

1. The process of services integration is intended to refer to “services” in the broadest possible sense, as noted above. This can include screening, assessment, interventions, treatment strategies, and programs. Services can be provided by individual clinicians, clinical teams, organized programs, collaborative relationships between clinicians, programs, or agencies, and so on. In addition, services integration can be varyingly applied to anything ranging from the activities of an entire system to produce the outcome of universal screening and access to integrated assessment and other services, to the activities of a team of clinicians (or even a single clinician) to integrate multiple service inputs or interventions for an individual client. Similarly, the outcome of this process is termed “integrated services,” and as implied in the paragraph above, is intended to refer to services in the broadest possible sense: integrated relationships with individual providers or clinical teams, integrating various interventions in a person-centered treatment plan, integrating the activities of multiple agencies or

service providers at the level of the client, and integrating multiple services within a particular “integrated” program.

2. Services integration is not equivalent to “administrative integration” of service components. As described above, combining (as an example) outpatient substance abuse clinic and mental health clinic services under a single administrative structure does not result in services integration. Services integration in this instance refers to the capacity of each component of the clinic to offer appropriately matched integrated services to its clientele, and to the array of services offered by each component clinic to be interwoven to meet the needs of the entire clinic population.
3. Services integration is not equivalent to “co-location” of services in the same physical setting. As with administrative integration, co-location may facilitate services integration, but is neither necessary nor sufficient for achieving it. Many program settings have co-located services in the same building with no communication or coordination between them, let alone integration. Other agencies or programs may have services operating in different locations with high levels of services integration.
4. Services integration does not require “blended” or “braided” funding. It is often assumed that if a client receives “integrated services” that mental health dollars must pay for the mental health component, and substance abuse dollars must pay for the substance abuse component. As noted above, this is not true. Each single type of funding can support integrated services within its appropriate mission.
5. Services integration does not require a specific type of “integrated program” or an “integrated team.” Having mental health and substance abuse clinicians working together on the same team to provide services to a single client or family will certainly facilitate the provision of integrated services, but again is neither necessary nor sufficient. The experience of integrated services has to be ultimately defined from the perspective of the consumer, not from the perspective of any particular structure or program model. For example, a consumer can receive mental health and substance abuse services from an Assertive Community Treatment team that has both mental health and substance specialists on the team, or an addiction treatment program that has both mental health and substance abuse clinicians on staff, but those services may not be experienced as integrated if the separate clinicians do not actually function as an integrated team in relation to the consumer. Conversely, the same consumer can experience integrated services

from providers in multiple settings if those providers have the capacity to collaborate in an organized manner as a functional team and to assure that the consumer receives integrated and consistent messages from all of them. When this is successful, it can be termed: “collaborative provision of integrated services.”

6. No one yet knows how to reliably determine for any client/family or system whether services integration has been achieved. In this regard, the most important element in defining “integrated services” is the concept of client-centered services for both mental health and substance issues that are both properly matched and integrated at the level of the individual client or family. There are some “tools” that can be used to evaluate whether the services provided by a particular program is providing to its clientele are effectively integrated. [e.g., the IDDT Fidelity Scale (SAMHSA IDDT Toolkit)], but all such tools are limited in the extent to which they have been widely evaluated in relation to all types of services provided to all populations. In addition, services integration must address not just the fact of integration, but whether that which is being integrated is clinically appropriate and well matched for the client. For example, a seriously mentally ill consumer with co-occurring substance use disorder who is in the pre-contemplation stage of change for substance use would not benefit from receiving supposedly “integrated services” in a program that required commitment to abstinence as a feature of success. In short, integrating the wrong services would not constitute “integrated services.” According to COCE, the optimal integrated service design meets the stage-specific clinical needs of people with COD with a treatment team that coordinates all pertinent aspects of care, and ensures that care is accessible, especially to clients with serious disorders (SAMHSA, 2002). The design typically involves a range of services including provisions for case management, motivational enhancement therapy, addiction counseling, relapse prevention, and psychosocial rehabilitation, as well as for integrating medication for both addictions and mental illnesses (Ziedonis, 2004).

### ***Program Integration or Integrated Program***

The issue of program integration or integrated program development, as well as the provision of integrated treatment and integrated interventions, will be discussed in more detail in Part II of this discussion. For

the purpose of this column, however, we can begin to illustrate the application of the discussion of systems and services to the development of programs and treatment interventions, as follows.

A program is an “organized system” designed to deliver a particular array of services to a particular client population with defined needs. Integration at the program level, according to the conceptual framework of this column, always involves two elements:

- The capacity of each client or family in the program to receive appropriately matched integrated services within the context of the program’s mission or function.
- The ability of the program to organize all the mental health and substance abuse “service components” (e.g., individual clinicians, particular clinical tools or practices) into a coherent whole that is interwoven to meet the needs of the total population of clients served in that program.

This framework will begin to allow us to evaluate how different types of programs can become “integrated programs,” and how the concepts of “dual diagnosis capability” (as discussed in the previous column), “dual diagnosis enhancement,” and specific evidence-based integrated program models all fit together in relation to this concept.

### CONCLUSION

This column had defined a basic conceptual framework for behavioral health care integration, and applied this framework to systems and services integration, as well as a beginning discussion of integrated programs. Further editions of this column will explore the application of this conceptual framework for integration more in depth in relation to integrated programs, as well as with regard to integrated treatment, integrated interventions, and various elements of integrated clinical practice and clinician competency.

### REFERENCES

- Center for Substance Abuse Treatment. (2005). *Substance abuse treatment for persons with co-occurring disorders*. Treatment Improvement Protocol (TIP) Series No. 42 (DHHS Pub. No. SMA 05-39920). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Cline, CA (2005). Personal communication.

- Co-occurring Disorder Center of Excellence (COCE) (2005): Overview Paper on Services Integration. [www.coce.org](http://www.coce.org).
- Minkoff, K., Cline, C.A. (2004). Changing the world: The design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. *Psychiatric Clinics of North America*, 27(4):727-743.
- Minkoff K, Cline, CA (2005). Developing welcoming systems of care for individuals with co-occurring disorders: The role of the Comprehensive Continuous Integrated System of Care model. *Journal of Dual Diagnosis*, 1(1):63-89.
- Substance Abuse and Mental Health Services Administration. (2002). *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration (2004). *Integrated Dual Disorder Toolkit*, Rockville, MD: Substance Abuse and Mental Health Services Administration. [www.samhsa.gov](http://www.samhsa.gov)
- Ziedonis, D.M. (2004). Integrated treatment of co-occurring mental illness and addiction: Clinical intervention, program, and system perspectives. *CNS Spectrums*, 9(12) 892-904.

Received: 02/08/06  
Accepted: 02/08/06