# Recommendations for Integrated Systems and Services for People With Co-occurring Mental Health and Substance Use Conditions

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People with co-occurring mental and substance use disorders experience poor outcomes and incur high costs in multiple domains. Efforts to develop and disseminate evidence-based integrated programs for people with such co-occurring disorders began to wane in the past decade as efforts shifted toward integrating primary health care. Several recent trends underscore the need to refocus efforts on providing integrated care for people with both mental and substance use disorders. The authors summarize what is known about integrated care for people with these co-occurring disorders and recommend advancing implementation and research on integration and improving outcomes with existing resources.

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People with co-occurring mental and substance use disorders were recognized in the 1980s as experiencing poor outcomes and high costs in multiple health and human service domains (1). This recognition prompted the development of evidence-based integrated programs for adults with serious mental illness (2) and other populations (3–5). In 2006, the Substance Abuse and Mental Health Services Administration (SAMHSA) created the Co-Occurring Center of Excellence to improve integrated services for people with co-occurring disorders nationally (6) and funded 19 Co-Occurring State Incentive Grants. Almost all states receiving these grants used program-level implementation tool kits (7–9), with a study of one state reporting an association between improvement in "co-occurring capability" (i.e., capability of a program to treat people with co-occurring disorders) and improved health outcomes and reduced medical costs (10).

During the early 2010s, the focus on care integration for co-occurring mental and substance use disorders waned as efforts turned to primary health–behavioral health integration. Many systems merged mental health and substance use treatments administratively, leading to the mistaken impression that services for co-occurring disorders had been integrated. Emergence of the opioid epidemic, recognition of pervasive trauma among those with substance use disorder, increased need for co-occurring services in other settings (e.g., criminal justice and child welfare), and expectation of co-occurring disorder care integration in Certified Community Behavioral Health Clinics (CCBHCs) (11) underscore the need for continued improvement in integrating mental health and substance use treatment systems and services.

## REGAINING MOMENTUM TODAY

Continued improvement in services and systems for co-occurring mental and substance use disorders can build on what is already known about both services and implementation. A recent review (12) observed that interventions for substance use disorder that benefit people in the general population should be adapted to benefit also those with co-occurring mental and substance use disorders. These interventions may vary in intensity and duration and can be provided in multiple settings. Useful services may include integrated screening and assessment, integrated teamwork over time, integrated stage-matched interventions, integrated skill building, access to medications for both disorders, and integrated recovery support (13–15). Although integrated treatment ensures that mental and substance misuse services are available in the same setting and coherently delivered, the authors of the aforementioned review found that "while encouraging, results of trials . . . are equivocal, [and often] hampered by poor experimental design." The authors also reported varying study methodologies, interventions, and outcome measures and noted a lack of accommodation to variations in "readiness to change, severity and type of illness and substance use" (12). Research methods that address implementation of integration clearly need to be enhanced.

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Nonetheless, action is needed to apply what is likely to help improve integration. Integrated care embodies "no wrong door," can improve access, person-centeredness, and equity and also increases the availability of treatment for both mental health and substance use conditions for this large, heterogeneous, and high-risk population. Consequently, because of anticipated high prevalence of co-occurring mental and substance use disorders in mental health settings (e.g., prevalence of substance use disorder among people with serious mental illness) and substance use disorder settings (e.g., prevalence of mood and anxiety disorders among people with opioid use disorder), programs and providers routinely need integrated skills and practice supports to help existing populations with co-occurring disorders. However, implementation of integrated services requires focused attention by system leaders. A recent technical assistance brief (13) and systematic review of the organization of community health services for people with co-occurring disorders (14) summarized evidence-based pharmacological and psychosocial interventions that likely are effective for people with co-occurring mental and substance use disorders, while noting that much more is needed to update implementation guidance for practitioners, programs, funders, and state systems.

## IMPLEMENTATION OF INTEGRATED SYSTEMS AND SERVICES

Implementation of integrated services is facilitated when improvement efforts in co-occurring capability and workforce competency at the provider level are aligned with funding instructions, regulatory guidance, and provision of technical assistance from funders and regulators (13–15). However, part of the system can make progress on implementation when other partners are not yet engaged. Results from previous studies using implementation tool kits have indicated that progress in integrated service delivery can be embedded in any process, program, professional, or team providing care and in any policy, procedure, or payment instruction governing any single funding stream (7–10).

Efforts in CCBHCs, for example, illustrate both opportunities and challenges of implementation. CCBHCs are expected to provide comprehensive services for people with co-occurring mental and substance use disorders by providing or coordinating mental health and substance use treatment and providing medication treatment for addiction. In the first year, 84% of CCBHCs offered medication to treat people with addiction, compared with only 36% of programs nationwide (11). However, although CCBHCs reported an increase in the number of people receiving addiction treatment, no metrics or tools are available that delineate progress in delivering integrated co-occurring disorder treatment within either mental health or addiction services provided by CCBHCs.

Broader implementation of integrated services for co-occurring mental and substance use disorders may therefore benefit from efforts by state and local systems, in partnership with providers, employing strategies that previously have successfully aligned funding instructions and regulatory guidance with use of practice improvement tools and strategies by providers. Next steps for both systems and providers are described in the following.

## SUGGESTED NEXT STEPS FOR SYSTEMS

### Vision

Changes at the systems level begin with establishing the goal—universal availability of appropriately matched integrated co-occurring mental and substance use disorder services in all settings—that is communicated to all service providers.

### State and Local Change Process

A sustained state-level steering committee should be identified that has an empowered leadership from all relevant state agencies and broad stakeholder involvement, including the state Medicaid agency and other funders, to support changes that improve treatment for co-occurring disorders. If possible, these committees should be replicated at the level of key intermediaries (e.g., counties). These committees support integrated treatment through activities such as developing a charter that details a shared vision, objectives, and implementation steps; identifying and ameliorating barriers to providing integrated care (e.g., through revised policies and processes); and organizing learning collaboratives and technical assistance for providers using tool kits to implement care for people with co-occurring disorders.

### Align Performance Improvement Standards with Implementation of Co-Occurring Disorder Care Integration

Systems should require data collection, provider credentialing, quality improvement activities, performance incentives, and billing instructions to support routine measurement and development of capable care for people with co-occurring disorders within each single funding stream and service code.

### Policy Guidance for Best Practices

Internal state and local policies need to be improved. This effort includes ensuring all program descriptions at all regulatory levels include the expectation that the programs will remove access barriers to care and provide appropriate integrated interventions for persons with co-occurring disorders.

### Clarify Billing Instructions

Billing instructions and codes should undergo review to ensure that appropriate services for co-occurring disorders can be provided and billed within each individual funding stream. This review should include instructions regarding progress note and treatment plan documentation.

### Support Program Collaboration

Mechanisms need to be identified for reimbursing and reinforcing cross-consultation services in which people who are treated in addiction settings receive onsite services provided by practitioners from mental health agencies, and people treated in mental health settings receive onsite services provided by practitioners from addiction treatment agencies.

### Evaluate and Measure Program- and System-Level Progress

Changes take time, so it is important to develop strategies for ongoing evaluation and improvement of integrated care. This effort includes defining program-level improvement measures, such as incremental changes in delivery of integrated treatment assessed with tools that measure a program's co-occurring capability. It also requires defining outcome measures that emphasize continuing small steps of progress across multiple disorders, including stage of change for any issue (e.g., moving from not at all considering a change in behavior [i.e., precontemplation] to considering and working through ambivalence about change [i.e., contemplation]) and harm reduction (e.g., reduced substance use).

### Involve Partner Systems

Partner systems (e.g., justice systems, primary health, housing, and child protective services and other social service systems) can also support integrated screening and intervention as routine care for people with co-occurring mental and substance use disorders and their families. More research is needed on implementation strategies for integrated services in partner systems (12–15), with one recent review noting that the "level of organization of integration of care seems to not have moved beyond very basic recommendations" (15), but those strategies that have been effective should still be employed.

## SUGGESTED NEXT STEPS FOR BEHAVIORAL HEALTH PROVIDERS

With or without state- or county-level system efforts, provider agencies and programs can take steps to improve treatment of patients with co-occurring disorders. A recent systematic review of treatment guidelines indicated that much is known that can be implemented, even though there are still "certain important aspects . . . essential for treatment planning . . . [that are] not addressed by any guideline, including the specifics of a concurrent disorder framework, the 'matching' of treatment needs, and the evaluation or 'staging' of the severity" (15).

### Quality Improvement Self-Assessment

Providers can use formal tools (7–9) to establish strengths and areas for improvement in providing integrated services for co-occurring disorder treatment. Results from such analyses can help guide ongoing quality improvement efforts, particularly with identified champions leading the change.

### Training and Technical Assistance

Ideally, providers can access training and technical assistance to support evidence-based integrated treatment; some states have created formal centers of excellence or funded intermediary organizations to provide training and technical assistance that support implementation of integrated treatment for co-occurring mental and substance use disorders.

### Implementation Practice Support

Planning for a workforce that is competent in treating patients with co-occurring mental and substance use disorders should prompt agency leaders, program supervisors, and staff to move beyond "training alone" to offer ongoing practice supports on the job, including structured supervision, changes to workflows, electronic health record redesign (e.g., to include stage-matched treatment, which are interventions appropriate for a person's stage of change for each disorder or issue), and other integrated practice cues.

### Core Competencies

Training sessions to improve competencies in treating people with co-occurring mental and substance use disorders can be incorporated into onboarding of new staff, performance reviews, job descriptions, and certifications (e.g., for peer specialists).

### Integrated Screening, Assessment, and Intervention

Routine integrated screening and assessment will help ensure that the prevalence of co-occurring disorders is measured and reported in all settings, including partner systems. Importantly, in addition to providing stage-matched treatment, programs should routinely provide medications—and medication skills training—for all behavioral health conditions, either through direct provision of psychopharmacology or proactive collaboration between mental health and addiction treatment programs (13, 14).

## REINVEST NATIONALLY IN TECHNICAL ASSISTANCE AND RESEARCH ON INTEGRATED TREATMENT IMPLEMENTATION

People with co-occurring mental and substance use disorders have urgent needs, and many are dying without receiving needed services. It is time for a national reprioritization of investment in consultation, training, technical assistance, and research on implementation of integrated systems and services for the "expected" population with co-occurring needs. In the meantime, systems and programs should use improvement strategies already shown to be potentially effective. Our hope is

that our recommendations allow systems, funders, and individual providers to use existing resources to immediately begin making sustainable improvements in services that result in better outcomes for people with co-occurring disorders.

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