



EVIDENCE-BASED
PRACTICES

KIT

Knowledge Informing Transformation

Building Your Program

Integrated Treatment for Co-Occurring Disorders



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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Building Your Program

Building Your Program is intended to help mental health and substance abuse authorities, agency administrators, and program leaders think through and develop the structure of Integrated Treatment for Co-Occurring Disorders. The first part of this booklet gives you background information about the evidence-based model. This section is followed by specific information about your role in implementing and sustaining your Integrated Treatment program. Although you will work closely together to build your program, for ease, we separated tips into two sections:

- *Tips for Mental Health and Substance Abuse Authorities; and*
- *Tips for Agency Administrators and Program Leaders.*

In preparing this information, we could think of no one better to advise you than people who have worked successfully with Integrated Treatment programs. Therefore, we based the information in this booklet on the experience of veteran program leaders and administrators.

For references, see the booklet *The Evidence*.

Integrated Treatment for Co-Occurring Disorders

This KIT is part of a series of Evidence-Based Practices KITs created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of the Integrated Treatment for Co-Occurring Disorders KIT that includes a DVD, CD-ROM, and seven booklets:

How to Use the Evidence-Based Practices KITs

Getting Started with Evidence-Based Practices

Building Your Program

Training Frontline Staff

Evaluating Your Program

The Evidence

Using Multimedia to Introduce Your EBP



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Integrated Treatment for Co-Occurring Disorders



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Building Your Program

What is Integrated Treatment for Co-Occurring Disorders?

Integrated Treatment for Co-Occurring Disorders differs from traditional approaches in several ways. First, services are organized in an integrated fashion. For example, assessments screen for both mental illness and substance use.

Practitioners in the Integrated Treatment program (called *integrated treatment specialists*) develop integrated treatment plans and treat both serious mental illnesses and substance use disorders so that consumers do not get lost, excluded, or confused going back and forth between different mental health and substance abuse programs.

Consumers receive one consistent, integrated message about substance use and mental health treatment. Second, clinical treatment is integrated. Integrated treatment specialists have knowledge of

both substance use disorders and serious mental illnesses and understand the complexity of interactions between disorders. They are trained in skills that have been found to be effective in treating consumers with co-occurring disorders.

Up to 56 percent of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime (Regier et al., 1990). Therefore, within specialty mental health and substance use clinical settings, it is the norm rather than the exception to see consumers with co-occurring disorders. Lacking recognition of the high prevalence of co-occurring disorders, agencies that develop specialty teams to treat small groups of consumers with co-occurring disorders, consequently, leave many consumers undiagnosed and untreated.



In the Integrated Treatment model, however, one or more integrated treatment specialists participate in each multidisciplinary treatment team in the agency. They cross-train other treatment team members to disseminate information and skills about treating consumers with co-occurring disorders. Working in multidisciplinary treatment teams also ensures that treatment addresses consumers' goals related to both substance use and serious mental illness.

The goal of this evidence-based practice is to support consumers in their recovery process. Recovery is not simply abstaining from substance use, controlling symptoms, or complying with mental health treatment. Instead, *recovery* means that consumers are learning

to move beyond illness so that they can pursue a personally meaningful life. Integrated treatment specialists support and empower consumers to define and achieve their individual goals.

Integrated Treatment programs are based on a core set of practice principles that form the foundation of the program (see below). A mid-level manager (called a *program leader*) with both administrative and clinical skills and authority oversees the Integrated Treatment program. The program leader supervises integrated treatment specialists and develops policies and procedures to ensure that these practice principles and other core components of the evidence-based model guide the way treatment and services are provided.

The Practice Principles

- Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders.
- Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses.
- Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages.
- Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage.
- Substance abuse counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages.
- Multiple formats for services are available, including individual, group, self-help, and family.
- Medication services are integrated and coordinated with psychosocial services.

Principle 1. Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders

Co-occurring disorders are common. Up to 56 percent of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime (Regier et al., 1990). Yet most

consumers with co-occurring disorders receive treatment from different agencies or for their mental illness or substance use disorder *only* — if they receive treatment of any kind. This kind of fragmented treatment often leads to poor outcomes. Consumers with co-occurring disorders have a better chance of recovering from both disorders when they receive mental health and substance abuse treatment in an integrated fashion from the same practitioner (an integrated treatment specialist).

Principle 2. Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses

To effectively assess and treat co-occurring disorders, integrated treatment specialists should be trained in psychopathology, assessment, and treatment strategies for both mental illnesses and substance use disorders. Mental health practitioners, therefore, should increase their knowledge about substance use disorders including the following:

- Substances that are abused by consumers;
- How these substances affect people with co-occurring disorders; and
- The short- and long-term effects of abuse and dependence.

Integrated treatment specialists should understand both mental health terminology and the language used for substance use disorders. They should understand the differences in levels of substance use and abuse and be able to provide integrated services to treat co-occurring disorders.

Principle 3. Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages

Consumers recovering from substance use disorders and serious mental illnesses go through stages, each of which marks readiness for a specific treatment. Integrated treatment specialists must assess consumers' stage of treatment and tailor services accordingly.

The Four Stages of Treatment

- Engagement
- Persuasion
- Active treatment and
- Relapse prevention

Principle 4. Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage

Motivational interventions are key to integrated treatment for co-occurring disorders. These interventions help consumers identify personal recovery goals. Typically, consumers reduce or abstain from using substances of abuse as they become motivated to reach their goals. These interventions often stimulate consumers to make a number of changes in their lives.

Motivational interventions include motivational interviewing, motivational counseling, and motivational treatment. When providing the interventions, integrated treatment specialists use specific listening and counseling skills to help consumers who are demoralized or who are not ready to pursue abstinence.

Principle 5. Substance abuse counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages

Consumers may have difficulty managing unpleasant emotions and symptoms that lead to substance use disorders. Integrated treatment specialists with skills in cognitive-behavioral counseling can help consumers stop automatic patterns of thought that lead them to abusing substances. For example, one way to help consumers change their substance use behavior is to help them identify thoughts or feelings that trigger the urge to use and then help them change these thoughts and feelings. Learning to manage negative thoughts and emotions can dramatically help consumers to stay away from substances.

Principle 6. Multiple formats for services are available, including individual, group, self-help, and family

Consumers benefit most when multiple formats are available to them at appropriate stages of treatment. For example, consumers in the persuasion stage may benefit from motivational interventions that are provided individually. Including family or other supporters in treatment is recommended because they can be a strong source of support for consumers who often have a restricted, non-substance-using social network. Also, families who receive information are better able to effectively support their relative.

Group treatment can help consumers feel less alone. Whether groups are led by professionals or peers, group treatment allows consumers to develop a peer network. Consumers with similar experiences offer support, empathy, and opportunities to socialize with nonusers, which is especially useful in the relapse prevention stage.

Principle 7. Medication services are integrated and coordinated with psychosocial services

Physicians, nurses, or other approved providers who prescribe medications should be trained to treat co-occurring disorders effectively. Medication prescribers should participate in multidisciplinary treatment team meetings. They should work closely with consumers, integrated treatment specialists, and other treatment team members to ensure that treatment for both mental illnesses and substance use disorders is provided in an integrated fashion.

Psychiatric medication should be prescribed despite active substance use. Medication prescribers should avoid prescribing potentially addictive medications to consumers with co-occurring disorders and, when appropriate, they should offer medications that may help reduce addictive behavior.

Many people who take numerous medications at various times throughout their day have difficulties following medication regimes. Providing medication services can help consumers by enhancing their motivation and offering strategies for remembering medication regimes.

How do we know that it's effective?

Researchers began to document the prevalence of co-occurring disorders in the early 1980s. As noted earlier, studies found that up to 56 percent of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime (Regier et al., 1990). Also, studies showed that compared to consumers without co-occurring disorders, consumers with co-occurring disorders relapsed more frequently and were more likely to be—

- Hospitalized;
- Violent;
- Incarcerated;
- Homeless; and
- Infected with HIV, hepatitis, and other diseases (Drake et al., 2001).

Studies also showed that consumers who received care in systems in which mental health and substance abuse treatment were separate were often excluded from services in one system and told to return when the other problem was under control. Those who received services in nonintegrated systems of care also had difficulty making sense of disparate messages about treatment and recovery. Consequently, the evidence demonstrated that consumers with co-occurring disorders in nonintegrated systems of care have poor outcomes (Drake et al., 2001).

Since the mid 1990s, eight studies support the effectiveness of Integrated Treatment for Co-Occurring Disorders. While the type and array of interventions in these programs vary, they include the critical components outlined in the Integrated Treatment Fidelity Scale. This scale's measures help agencies assess whether their Integrated Treatment program provides services in a manner that adheres to the evidence-based model.

In contrast with nonintegrated treatment, integrated treatment is associated with the following positive outcomes:

- Reduced substance use;
- Improvement in psychiatric symptoms and functioning;
- Decreased hospitalization;
- Increased housing stability;
- Fewer arrests; and
- Improved quality of life (Drake et al., 2001).

In short, consumers with co-occurring disorders fare better when provided Integrated Treatment for Co-Occurring Disorders. For more information about the effectiveness of this evidence-based model, see *The Evidence* in this KIT.

Similarly, all these studies included both males and females, with males making up the majority of participants, which is consistent with the higher prevalence of substance abuse in men than women (Mueser, Yarnold, & Bellack, 1992; Mueser et al., 2000). Special issues have been identified related to the unique needs of women with co-occurring disorders (Brunette & Drake, 1998; Brunette & Drake, 1997; Gearon & Bellack, 1999), but no evidence suggests that women with co-occurring disorders benefit less from integrated treatment.

Race and ethnicity have varied across the different studies, with most studies including a majority of Caucasian consumers but also including some African American consumers (Carmichael et al., 1998; Drake et al., 1998a; Godley et al., 1994; Jerrell & Ridgely, 1995). One study included only African American consumers and reported very positive results (Drake et al., 1997).

Research studies have also included significant numbers of consumers with housing instability and homelessness (Carmichael et al., 1998; Drake et al., 1998a; Drake et al., 1997; Meisler, Blankertz, Santos, & McKay, 1997). The evidence from these studies shows that this model is effective at improving both co-occurring disorders and housing outcomes. Presumably, the outreach component is critical to successful outcomes in work with this challenging population.

Who benefits most?

Studies show that Integrated Treatment for Co-Occurring Disorders is effective for consumers with a wide range of backgrounds. Although consumers with co-occurring disorders tend to be younger, studies include a wide range of ages, with most consumers between ages 18 and 55 (Barrowclough et al., 2001; Carmichael et al., 1998; Drake et al., 1998a; Drake, Yovetich, Bebout, Harris, & McHugo, 1997; Godley, Hoewing-Roberson, & Godley, 1994; Jerrell & Ridgely, 1995).



Where should Integrated Treatment for Co-Occurring Disorders be provided?

Integrated Treatment for Co-Occurring Disorders has been successfully implemented in a variety of settings and geographic locations. The majority of the studies have been conducted on an outpatient basis, with positive results (Barrowclough et al., 2001; Carmichael et al., 1998; Drake et al., 1998a; Drake et al., 1997; Godley et al., 1994; Jerrell & Ridgely, 1995).

Less research has examined the effectiveness of this model provided in inpatient, residential, or intensive day treatment programs. Most of the studies examining short-term, residential, or intensive day treatment (3 to 6 months) programs suffer from high dropout rates (Blankertz & Cnaan, 1994; Burnam et al., 1995; Penn & Brooks, 1999; Rahav et al., 1995).

Substance Abuse Treatment for Persons with Co-Occurring Disorders: A Treatment Improvement Protocol (TIP) 42

Similar to this KIT, TIP 42 produced by SAMHSA's Center for Substance Abuse Treatment (CSAT) is a guide for treating co-occurring mental illnesses and substance use disorders. It is an excellent complement to the Integrated Treatment KIT.

The primary audiences for TIP 42 are substance abuse treatment practitioners with varying degrees of education and experience. Secondary audiences are other professionals who work with people who have co-occurring disorders and policymakers.

TIP 42 summarizes state-of-the-art treatment of co-occurring disorders. It has chapters on terminology, assessment, and treatment strategies and gives suggestions for policy planning. Concepts, models, and strategies outlined in TIP 42 are based on definitive research, empirical support, and agreements of a consensus panel. Successful models of treatment are portrayed and specific consensus panel recommendations are cited throughout the TIP.

For example, TIP 42 presents The Quadrants of Care, developed by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD) as a conceptual framework that classifies consumers in four basic groups based on symptom severity:

- **Category I:** Less severe mental disorder/less severe substance disorder
- **Category II:** More severe mental disorder/less severe substance disorder
- **Category III:** Less severe mental disorder/more severe substance disorder
- **Category IV:** More severe mental disorder/more severe substance disorder

The quadrants are an aid to formulating treatment and a guide to improvements in systems integration of mental illness and substance abuse (pp. 28-30). Examples of their use are given throughout the TIP. The TIP offers these six guiding principles in treating consumers with co-occurring disorders (p.38):

1. Employ a recovery perspective.
2. Adopt a multi-problem viewpoint.
3. Develop a phased approach to treatment.
4. Address specific real-life problems early in treatment.
5. Plan for the consumer's cognitive and functional impairments.
6. Use support systems to maintain and extend treatment effectiveness.

More on TIP 42

TIP 42 is a valuable source of federal, state, and private funding opportunities (pp. 52-53). It presents a wide variety of funding resources, with advice on how they may best be used and how they can be combined to collaborate on initiatives. TIP 42 also addresses organizational and systems changes necessary for successful programming and financing change.

TIP 42 summarizes a variety of outpatient and residential settings for co-occurring disorders treatment and highlights promising models as well as provides a guide to evaluating outpatient programs (see Chapter 6). TIP 42 describes Assertive Community Treatment (ACT) and Intensive Case Management (ICM) and offers empirical evidence for each. Similarities and differences of ACT and ICM are detailed (p. 159). Advice to administrators who wish to implement these programs is presented on page 157 (ACT) and page 159 (ICM).

Similar to information found in *Training Frontline Staff* of the Integrated Treatment KIT, TIP 42 includes information about practice strategies including—

- Motivational interviewing
- Cognitive-behavioral therapy
- Contingency management
- Relapse prevention
- Self-help groups

It includes information about the specific needs of consumers who are homeless, those in the criminal justice system, and women. It also offers advice for helping these special populations.

While nicotine dependence is not discussed in the Integrated Treatment KIT, TIP 42 provides a brief history of nicotine dependence and steps for addressing tobacco use in substance use and mental illness treatment planning (see Chapter 8). Additionally, TIP 42 discusses specific mental disorders in the context of their treatment in substance abuse including—

- Personality disorders
- Bipolar
- Major depressive
- Schizophrenia
- Attention deficit hyperactivity disorder
- Post-traumatic stress disorder
- Eating disorders

TIP 42 includes a brief section on substance-induced disorders that describes how substances can mimic mental illness (see Chapter 9). These disorders are distinguished from independent co-occurring disorders because the psychiatric symptoms are a result of substance use.

For a copy of TIP 42 and supplemental guides for this TIP, see the CD-ROM for this KIT or visit www.ncadi.samhsa.gov.

One longer term residential program, integrated into the community with a gradual transition from the residence into the community, found very positive long-term outcomes (Brunette, Drake, Woods, & Hartnett, 2001). Shorter term, integrated inpatient treatment for co-occurring disorders may have an important role to play in stabilizing consumers, engaging them in treatment, providing education about mental illness and substance abuse interactions, and motivating them to work on their substance abuse problems (Franco, Galanter, Castaneda, & Patterson, 1995; Rosenthal, 2002). However, more research is needed.

Research has been conducted in a variety of places with positive effects including large urban areas (Barrowclough et al., 2001, Carmichael et al., 1998; Drake et al., 1997; Jerrell & Ridgely, 1995) and rural settings (Drake et al., 1998a; Godley et al., 1994). These studies show that the model is robust across a variety of geographical settings.

While the materials in this KIT are designed to help implement the model in mental health settings, the model may also be implemented in substance abuse centers. For more information on implementing Integrated Treatment for Co-Occurring Disorder in substance abuse treatment settings, see the Substance Abuse Treatment for Persons with Co-Occurring Disorders: Treatment Improvement Protocol (TIP) 42 in *The Evidence* in this KIT.

Is Integrated Treatment for Co-Occurring Disorders cost-effective?

On average, services for consumers with co-occurring disorders cost nearly twice as much as for consumers with single disorders. Compared to consumers without co-occurring disorders, consumers with co-occurring disorders are at risk for negative outcomes such as the following:

- Hospitalization;
- Violence;
- Incarceration;
- Homelessness; and
- Infectious disease (Drake et al., 2001).

Consequently, mental health and substance abuse systems spend most of their resources on high-risk populations such as consumers with co-occurring disorders (Dickey & Azeni, 1996).

Often consumers with co-occurring disorders are forced into parallel treatment settings, where substance abuse treatment is provided separately and independently of treatment for mental illness. This practice has proved to be costly, inefficient, and ineffective. In contrast, Integrated Treatment for Co-Occurring Disorders leads to dual recovery and reduces costs.

In summary, many mental health and substance abuse authorities and agencies are confronted with the challenge of meeting the needs of consumers with co-occurring disorders in an environment of limited resources. Integrated Treatment for Co-Occurring Disorders, an evidence-based practice, is one of the most effective service strategies available, demonstrating consistent, positive outcomes for this vulnerable population.

Building Your Program

Tips for Mental Health and Substance Abuse Authorities

Successfully implementing evidence-based practices requires the leadership and involvement of mental health and substance abuse authorities. This section discusses why you should be involved in implementing Integrated Treatment for Co-Occurring Disorders and the types of activities that mental health and substance abuse authorities typically undertake.

Why should you be interested in Integrated Treatment for Co-Occurring Disorders?

Up to 56 percent of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime (Regier et al., 1990). These consumers are at risk for a variety of negative outcomes, which makes them both difficult and costly to treat.

Also, consumers with co-occurring disorders are often provided treatment for their substance use disorder separately and independently from their treatment for mental illness. This practice has proved to be ineffective, both clinically and in relation to cost.

The Integrated Treatment KIT presents public mental health and substance abuse authorities with a unique opportunity to improve services for consumers with both serious mental illnesses and substance use disorders. Research has demonstrated that

Integrated Treatment for Co-Occurring Disorders has a consistent, positive impact on the lives of consumers.

The Integrated Treatment KIT provides information and guidance for implementing this evidence-based practice in a comprehensive and easy-to-use format.

Can Integrated Treatment for Co-Occurring Disorders make a difference?

Whenever new programs arise, administrators have to ask whether it is worth it to reorganize: **Is the new program really going to make a difference?**

When it comes to Integrated Treatment for Co-Occurring Disorders, extensive research shows that the answer is “**Yes.**” Most impressive is the extent to which this model has been subjected to rigorous research and the consistency of favorable findings.

Briefly stated, research shows that consumers in Integrated Treatment programs were more successful than consumers in non-integrated programs in the following areas:

- Reduced substance use;
- Improvement in psychiatric symptoms and functioning;
- Decreased hospitalization;
- Increased housing stability;
- Fewer arrests; and
- Improved quality of life (Drake et al., 2001).

In short, consumers with co-occurring disorders have high rates of recovery when provided Integrated Treatment for Co-Occurring Disorders. For more information, see *The Evidence* in this KIT.

Aren't we already doing this?

Your behavioral health system may already provide both mental health and substance abuse treatment programs. While these services share some characteristics of the evidence-based model, important distinctions exist. In Integrated Treatment programs, the same practitioner or treatment team provides both mental health and substance abuse interventions in an integrated fashion. Consumers receive one consistent, integrated message about treatment and recovery.

Integrated Treatment for Co-Occurring Disorders Is Based on These Principles

- Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders.
- Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses.
- Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages.
- Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage.
- Substance abuse counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages.
- Multiple formats for services are available, including individual, group, self-help, and family.
- Medication services are integrated and coordinated with psychosocial services.

Will Integrated Treatment for Co-Occurring Disorders work in your behavioral health system?

The evidence-based model has been adapted in diverse settings and a wide range of geographic locations. Studies show that the model is effective for consumers of different ages, genders, races, and ethnicities as well as for consumers who are homeless.

How can mental health and substance abuse authorities support Integrated Treatment for Co-Occurring Disorders?

As you read about the evidence-based model, you may think that it sounds great but unaffordable. We want to challenge that notion because other mental health systems with limited resources are implementing Integrated Treatment programs statewide. These systems have visionaries who recognized the benefits of providing this evidence-based practice and persisted in overcoming challenges.

Implementing this evidence-based model takes a consolidated effort by agency staff, mental health authorities, substance abuse authorities, consumers, and families. However, for this initiative to be successful, mental health authorities must lead and be involved in developing Integrated Treatment programs in local communities.

Be Involved in Integrated Treatment for Co-Occurring Disorders

- Step 1** **Create a vision** by clearly articulating evidence-based practice principles and goals. Designate a staff person to oversee your Integrated Treatment initiative.
- Step 2** **Form advisory groups** to build support, plan, and provide feedback for your Integrated Treatment initiative.
- Step 3** **Establish program standards** that support implementation. Make adherence to those standards part of licensing criteria.
- Step 4** **Address financial issues** and align incentives to support implementation.
- Step 5** **Develop a training structure** tailored to the needs of different stakeholders.
- Step 6** **Monitor fidelity and outcomes** to maintain and sustain program effectiveness.

Create a vision

Agencies commonly set out to implement one program, but end up with something entirely different. Sometimes these variations are intentional, but often they occur for the following reasons:

- One administration starts an initiative and another with a different vision and priorities subsequently assumes leadership.
- The model wasn't clearly understood from inception.
- The staff drifts back to doing things in a way that is more familiar and comfortable.

Articulating the vision that providing integrated treatment to help consumers recover from co-occurring disorders is essential for successfully implementing an Integrated Treatment program. Place the Integrated Treatment initiative in the context of the larger recovery paradigm. Talk about how Integrated Treatment programs help agencies fulfill their mission—assisting consumers with co-occurring disorders in their recovery process.

To ensure that your vision is clearly communicated, designate a staff person who has experience with the evidence-based model to oversee your Integrated Treatment initiative. Some mental health and substance abuse authorities designate an office and staff with whom agencies may consult throughout the process of building and sustaining their Integrated Treatment programs. Designated staff may also have oversight responsibility for Integrated Treatment programs across the state.

Form advisory groups

You can ensure that the evidence-based model is implemented appropriately if you mandate that stakeholder advisory groups guide the implementation initiative. Your Integrated Treatment program can benefit in many ways from an advisory group. Among other things, an advisory group can help you do the following:

- Build internal and external support;
- Increase program visibility; and
- Advise you about ongoing planning efforts.

Consider forming both local and state-level advisory groups. State-level advisory groups may include the following members:

- Representatives of state agencies (mental health and substance abuse authorities, Medicaid, etc.) that would be invested in the initiative
- Leadership from implementing agencies; and
- Representatives from consumer and family advocacy organizations.

Local advisory groups can serve as liaisons between the community and agencies that are implementing Integrated Treatment programs. Community stakeholders who have an interest in the success of Integrated Treatment programs include representatives of the following:

- Local consumer organizations;
- Local family organizations;
- Agency administrators;
- Local substance abuse agencies; and
- Integrated treatment specialists.

Form a partnership between your mental health and substance abuse authorities

If mental health and substance abuse authorities are separate in your region or state, inviting key representatives of both to participate in an Integrated Treatment Advisory Committee is the first step in integrating treatment between the two systems. Forming this partnership will allow you to do the following:

- Develop a common vision for integrating treatment;
- Discuss how services are currently provided, and
- Develop a unified plan to blend mental health and substance abuse treatments so that consumers need not go from one place to another to receive information and services.

Partner with other key stakeholders

Consumers, families, agency administrators, and policymakers are also critical partners to effectively plan, implement, and sustain an integrated service system for consumers with co-occurring disorders. Involve key leaders from different stakeholder groups early in the planning process. Examine the expectations and goals related to implementing the evidence-based model and make sure that stakeholders share a common vision.

Financial structures and organizational processes must be aligned at the top administrative levels to support agencies in their efforts to implement Integrated Treatment programs.

Collaborative planning may generate ideas for streamlining procedures that are related to screening, diagnosing, assessing, and treating consumers with co-occurring disorders. The development of training and evaluation structures is another area where stakeholder input is extremely valuable. It can ensure that consumers have access to treatment regardless of their point of entry into the system. For more information on the “No wrong door” approach for service planning, see the reference for TIP 42 in *The Evidence* in this KIT.

Facilitating your advisory group

From the beginning, lead your advisory groups in understanding and articulating what Integrated Treatment for Co-Occurring Disorders is and how it is going to be developed in your behavioral health care system. For training materials that you can use to help stakeholders develop a basic understanding of the evidence-based model, see *Using Multimedia to Introduce Your EBP* in this KIT.

Advisory groups should continue to meet well after your Integrated Treatment program has been established. We suggest that they meet about once a month for the first year, once every 2 months for the second year, and quarterly for the third year. By the second and third years, advisory groups may help Integrated Treatment programs sustain high fidelity by assisting with fidelity evaluations and outcomes monitoring or translating evaluation data into steps for continuous quality improvement. For more information about the role of advisory groups, see *Getting Started with EBPs* in this KIT.

Planning your Integrated Treatment initiative

With a vision firmly in place, the process of unfolding Integrated Treatment programs across the service system can begin. Carefully planning this process will help ensure a successful outcome.

Implementing Integrated Treatment programs first in pilot or demonstration sites may be useful. Working with pilot sites can help you manage problems as they arise and also give constituents the opportunity to see that the evidence-based model works. Multiple pilot sites are preferable to just one. When only one site is used, idiosyncratic things can happen that misrepresent the model.

In contrast, when programs do a system-wide “rollout,” it is difficult to adequately train all Integrated Treatment program staff. In that case, system problems, which may have been resolved easily on a smaller scale with a few Integrated Treatment programs, can cause havoc.

Establish program standards

Studies of agencies that have tried to replicate evidence-based practices have found that if agencies did not achieve positive outcomes, it was often because they failed to implement all of the components of the evidence-based model (Becker et al., 2001; Bond & Salyers, 2004; Jerrell & Ridgely, 1995; McHugo et al., 1996). As a behavioral health authority, you have the capacity to ensure that the system has incentives to implement the evidence-based model. Attention to aligning these incentives in a positive way (such as attaching financial incentives to achieving improved mental health and substance use outcomes) is vital to successfully implementing Integrated Treatment programs.

States have the authority to adopt regulations that govern services to consumers. These regulations set standards for the quality and adequacy of programs, including criteria that govern these areas:

- Screening and diagnosis;
- Referral and discharge;
- Staffing;
- Program organization and communication;
- Core service components;
- Assessment and treatment planning;
- Consumer medical records;
- Consumer rights; and
- Supervision and program evaluation.

Support implementing Integrated Treatment programs by explicitly referencing the evidence-based model in licensing standards and other program review documents (for example, grant applications, contracts, requests for proposals, and so forth). It is also important to review current administrative rules and regulations to identify any barriers to implementing programs. Work closely with agency administrators to ensure that state-level policies support high-fidelity practice.

Address financial issues

Each state is different. In many cases, while your Integrated Treatment initiative can be mounted with little or no additional appropriations, it is important to review funding streams to ensure that they support implementing the evidence-based model. Financing should correspond with services, and policymakers must ensure that Integrated Treatment programs are reimbursed at a realistic level by some combination of state mental health and substance abuse dollars, SAMHSA block grants, Medicaid, and other insurers.

For more information on federal, state, and private funding opportunities, advice on how they may best be used, and how they can be combined, see the reference for TIP 42 in *The Evidence* in this KIT.

Develop a training structure

Agencies that implement evidence-based practices are often stymied in their efforts because people misunderstand the model or because they lack information. It is important that key stakeholders (consumers, families, and other essential community members) and agency-wide staff develop a basic understanding of the evidence-based model.

We encourage you to support agency administrators in their efforts to develop a training structure for implementing the evidence-based model. The training plan should include basic training for key community stakeholders, including these:

- Consumers;
- Families;
- Mental health authorities;
- Substance abuse authorities; and
- Staff from key community organizations.

The training plan should also include basic training for staff at all levels across the agency, especially medication prescribers, and intensive training for integrated treatment specialists (staff designated to provide services to consumers with co-occurring disorders).

Choose your trainer

An intensive training plan for integrated treatment specialists may be designed in several different ways, but you must first decide who will conduct the training. Program leaders may facilitate the initial training for integrated treatment specialists by using the training tools in *Training Frontline Staff* in this KIT. Some mental health or substance abuse authorities choose to hire external trainers.

One successful strategy for training integrated treatment specialists entails having new integrated treatment specialists visit an existing, well-functioning, high-fidelity Integrated Treatment program to observe how the program works. New integrated treatment specialists will benefit most from this visit if they have a basic understanding of the evidence-based model.

Once trained, program leaders and integrated treatment specialists will be able to use the tools in *Using Multimedia to Introduce Your EBP* in this KIT to provide basic training to key stakeholders.

Offer ongoing training and consultation

Throughout the first year of your Integrated Treatment program, we encourage you to offer integrated treatment specialists intermittent booster training sessions. After the first year, consider establishing an annual statewide conference on Integrated Treatment for Co-Occurring Disorders.

Routine onsite and telephone consultation is also important, particularly for program leaders since leading an Integrated Treatment program requires a complex set of administrative and clinical skills. For example, program leaders provide direct services and supervision, which may require a shift in thinking from how services were traditionally provided. Program leaders also have administrative responsibilities such as hiring, preparing administrative reports, and developing policies and procedures.

Perhaps more important, program leaders are responsible for ensuring that the Integrated Treatment program operates with fidelity to the evidence-based model, including ensuring the quality and content of staff-consumer interactions. It is very difficult for any program leader to grasp everything that has to be learned in a brief time. Also, understanding what needs to be done and translating that understanding into action are different and equally difficult. Since the daily leadership provided by the program is essential for ensuring that the evidence-based model is faithfully carried out, supporting the program leader during early implementation is essential.

For at least the first year a new program is in operation, program leaders need someone who is experienced in the evidence-based model to provide ongoing consultation on organizational and clinical issues. Consultation ranges from integrating evidence-based practice principles into the agency's policies and procedures to case consultation.

Some states develop a few Integrated Treatment programs at a time so that staff from the first Integrated Treatment programs can help train those in newly developed programs. Generally, it takes about a year for staff to feel confident providing the evidence-based model, but this can vary depending on how much structural change is needed. Integrated treatment specialists who are not already participating in treatment team meetings or practitioners who are reluctant to accept new models can take longer to change.



It may take 2 to 3 years for an agency to become sufficiently proficient in the evidence-based model before it can assume the added responsibility of training other agencies' integrated treatment specialists. Agencies that have become training sites indicate that involving their staff in training staff from new Integrated Treatment programs reinforces the practice principles and knowledge of the evidence-based model.

Other states have established training centers or enhanced existing education and training centers that offer education, training, and ongoing consultation or supervision. A state- or county-wide coordinator who is experienced with the evidence-based model can also help new Integrated Treatment programs through ongoing contact, assessment, and troubleshooting.

Monitor fidelity and outcomes

Providing Integrated Treatment for Co-Occurring Disorders involves incorporating a new program into the service delivery system. The best way to protect your investment is to make certain that agencies actually provide services that positively affect the lives of consumers.

Programs that adhere more closely to the evidence-based model are more effective than those that do not follow the model. Adhering to the model is called *fidelity*.

The Integrated Treatment Fidelity Scale measures how well programs follow key elements of the evidence-based model. Services research tells us that the higher an agency scores on a fidelity scale, the greater the likelihood that the agency will achieve favorable consumer outcomes (Jerrell & Ridgely, 1995; McHugo et al., 1999). For this reason, it is important to monitor both fidelity and outcomes.

As a central part of the initial planning process, you must address how you will monitor the fidelity and outcomes of Integrated Treatment programs. Too many excellent initiatives had positive beginnings and enthusiastic support but floundered at the end of a year because they did not plan how they would maintain the program. Monitoring fidelity and outcomes on an ongoing basis is a good way to ensure that your Integrated Treatment programs will continue to grow and develop. For more information about monitoring fidelity and outcomes, see *Evaluating Your Program* in this KIT.

Consider developing routine supervision and evaluations of your Integrated Treatment programs. If it is not possible, use strategies (for example, rules, contracts, financial incentives, and so forth) to support fidelity and outcomes monitoring on the local level or within individual agencies.

The characteristics of a program that would have a perfect score on the Integrated Treatment Fidelity Scale are shown on the next page. For the entire Integrated Treatment Fidelity Scale, see *Evaluating Your Program* in this KIT.

Characteristics of an Integrated Treatment Program that Would Have a Perfect Score on the Integrated Treatment Fidelity Scale (see *Evaluating Your Program* for a copy of the Fidelity Scale)

Multidisciplinary team	Case managers, psychiatrists, nurses, residential staff, employment specialists, and rehabilitation specialists work collaboratively on mental health treatment teams.
Integrated treatment specialist	Integrated treatment specialists work collaboratively with the multidisciplinary treatment team, modeling co-occurring disorders treatment skills and training other staff in evidence-based practice principles and practice.
Stage-wise interventions	All services are consistent with and determined by each consumer's stage of treatment (engagement, persuasion, active treatment, relapse prevention).
Access to comprehensive services	Consumers in the Integrated Treatment program have access to comprehensive services.
Time-unlimited services	Consumers in the Integrated Treatment program are treated on a time-unlimited basis with intensity modified according to each consumer's needs.
Outreach	Integrated treatment specialists demonstrate consistently well-thought-out outreach strategies and connect consumers to community services, whenever appropriate, to keep consumers engaged in the Integrated Treatment program.
Motivational interventions	All interactions with consumers in the Integrated Treatment program are based on motivational interventions.
Substance abuse counseling	Consumers who are in the active treatment or relapse prevention stages receive substance abuse counseling that includes seven specific criteria.
Group treatment for co-occurring disorders	Consumers in the Integrated Treatment program are offered group treatment specifically designed to address both mental health and substance abuse problems.
Family interventions for co-occurring disorders	With consumers' permission, integrated treatment specialists involve consumers' families (or other supporters), provide education about co-occurring disorders, offer coping skills training and support to reduce stress in the family, and promote collaboration with the treatment team.
Alcohol and drug self-help groups	Consumers in the active treatment or relapse prevention stages attend self-help programs in the community.
Pharmacological treatment	Prescribers for consumers in the Integrated Treatment program are trained in the evidence-based model and use five specific strategies (see Fidelity Scale).
Interventions to promote health	Integrated treatment specialists promote health by encouraging consumers with co-occurring disorders to avoid high-risk behaviors and situations that can lead to infectious diseases, find safe housing, and practice proper diet and exercise.
Secondary interventions for nonresponders	The Integrated Treatment program has a protocol to identify consumers who do not respond to basic treatment for co-occurring disorders, to evaluate them, and to link them to appropriate secondary interventions.



Building Your Program

Tips for Agency Administrators and Program Leaders

Whether your agency is interested in enhancing an existing program or developing a new one, you will need a broad range of activities to successfully implement Integrated Treatment for Co-Occurring Disorders. This section outlines the range of implementation activities in which agency administrators and program leaders are often involved.

Recruit your staff

Integrated Treatment programs consist of a program leader and one or more practitioners, depending on the number of consumers that the agency plans to serve. Mental health practitioners often have not been trained to assess and treat substance use disorders, and substance abuse practitioners often have not been trained to assess and treat mental illnesses.

For this reason, many agencies simply designate practitioners who are currently on staff to receive intensive training on the evidence-based model and to serve as *integrated treatment specialists*.

Integrated treatment specialists should participate in multidisciplinary treatment teams. If your agency already has multidisciplinary treatment teams, consider designating one integrated treatment specialist to each team.



Choose a program leader

It is important to hire or designate a leader for your Integrated Treatment program. We suggest that program leaders be full-time employees whose time is completely dedicated to the Integrated Treatment program.

Program leaders are often mid-level managers who have the authority to make or suggest administrative changes within the agency. Successful program leaders have both administrative and clinical skills. As part of their administrative responsibilities, program leaders undertake the following tasks:

- Hire and train integrated treatment specialists;
- Develop program policies and procedures;
- Act as a liaison with other agency coordinators;
- Manage program referrals;
- Monitor the program's fidelity to the evidence-based model;
- Give program feedback to the integrated treatment specialists and other key stakeholders; and
- Oversee other quality control and financial responsibilities.

As part of their clinical responsibilities, program leaders undertake the following tasks:

- Provide services to consumers with co-occurring disorders;
- Provide weekly group supervision; and
- Provide individual supervision as needed.

On this page is an example of the program leader's job description. Because program leaders must have an active role in setting up the structures and processes needed to support the Integrated Treatment program, we encourage you to make the KIT available to candidates during the hiring process so that they will understand what they must do.

Sample Job Description for Program Leaders	
Overall function	<ul style="list-style-type: none"> ■ Oversees the Integrated Treatment program by supervising integrated treatment specialists and being the administrative liaison to other coordinators within the agency.
Responsibilities	<ul style="list-style-type: none"> ■ Accepts referrals and assigns integrated treatment specialists to work with consumers. ■ Supervises integrated treatment specialists weekly as a group using case examples and following evidence-based practice principles and procedures. ■ Individually supervises integrated treatment specialists as needed. ■ Acts as liaison to other department coordinators in the agency. ■ Monitors and ensures the participation of integrated treatment specialists with multidisciplinary treatment teams. ■ Provides services to small caseload.
Qualifications	<ul style="list-style-type: none"> ■ Previous experience as an integrated treatment specialist, substance abuse specialist, or mental health practitioner helping people with serious mental illnesses is desired. ■ Previous supervisory experience is desired.

Reflect your community's cultural diversity

Staff of Integrated Treatment programs should reflect the cultural diversity of the communities in which they operate. More important, integrated treatment specialists must be aware of and sensitive to cultural differences and consumer preferences. Integrated Treatment programs should include bilingual integrated treatment specialists as needed to reflect the cultural diversity of the communities in which they provide services. If bilingual staff are not available, translators should be provided as needed.

Having a balance of male and female integrated treatment specialists may also be helpful. Your Integrated Treatment program must also have resources available to allow integrated treatment specialists to work with consumers who have hearing and visual impairments.

Consider these hiring tips

Thoroughly check references for job candidates. The best predictor of work performance is likely to be candidates' performance in previous jobs, particularly jobs that required some of the same skills and personal qualities that are desirable for integrated treatment specialists. The program leader should talk to previous supervisors, ask in detail about candidates' previous work responsibilities and performance, and seek opinions about their capabilities.

Invite all candidates who are being seriously considered for employment to spend half a day or more in your Integrated Treatment program so that they can see integrated treatment specialists at work firsthand. Candidates can then better evaluate how well they might fit in and be able to make a more informed decision about taking the job.

This visit will also give integrated treatment specialists a chance to talk with and observe candidates. Ask them to offer their feedback during the hiring process. This type of screening may help you to screen out people who may not be appropriate for your Integrated Treatment program.

Build support for your program

Developing a successful Integrated Treatment program depends on the support and collaboration of a number of stakeholders. Internally, it is important that the director and staff across the agency understand and support implementing Integrated Treatment for Co-Occurring Disorders. Your program is more likely to achieve high fidelity if the agency director is informed and involved in the implementation process from the start.

It is important that the agency director take the lead in promoting the Integrated Treatment program and addressing any misconceptions. Articulate internal and public support for the Integrated Treatment program by telling key stakeholders that consumers can recover from both mental illnesses and substance use disorders. Inform key stakeholders that Integrated Treatment for Co-Occurring Disorders is linked to positive consumer outcomes and emphasize the importance of your Integrated Treatment program by demonstrating how integrated treatment helps consumers get on with life beyond illness to achieve their personal recovery goals.

Once the agency director has articulated a clear vision for implementing the evidence-based model, continue to bolster internal support for your program by giving all agency staff basic information. For more information, see *Develop a Training Plan* later in this booklet.



Form advisory committees

Forming a local advisory committee for your Integrated Treatment program is an effective way to gain key stakeholders' support for your program. Identify community stakeholders who have an interest in the success of your Integrated Treatment program to serve on your committee. Committees often include the following personnel:

- Representatives from local consumer organizations;
- Members of local family organizations;
- Representatives from local mental health authority;
- Representatives from local substance abuse authority;
- Representatives from local substance abuse and mental health agencies;
- Key agency staff; and
- Integrated treatment specialists.

To start, your mental health authority and substance abuse authority representatives or agency director should voice support for the Integrated Treatment initiative. Next, provide basic training to help advisory group members understand the evidence-based model. Once established, advisory groups may help implement your program in a variety of ways. For more information, see *Getting Started with Evidence-Based Practices* in this KIT.

Sustain support for your program

Building support for your Integrated Treatment program should be an ongoing effort. Once your program is operational, find ways to recognize and reward the achievements of integrated treatment specialists and consumers. For example, organize meetings with key stakeholders during which consumers share success stories and administrators highlight staff achievements.

Another option is to sponsor a banquet to celebrate the program's accomplishments with consumers, family members, policymakers, and agency staff members. Banquets are particularly helpful if a wide array of stakeholders (such as physicians, administrators, and key public officials) attend.

Your agency director and program leader should meet regularly to review program evaluation data, discuss roadblocks, and plan ways to improve your Integrated Treatment program.

Building support from internal staff and key community stakeholders is essential to implementing an effective Integrated Treatment program. While sharing information is important, remember to protect consumers' confidentiality when information is shared outside of the treatment team. Consumers with substance use disorders are particularly vulnerable since using and distributing illicit drugs is an illegal activity punishable by law. For this reason, they are afforded special protections under the Code of Federal Regulations. For more information about the types of information you may share and how to protect consumers' confidentiality, see: http://www.access.gpo.gov/nara/cfr/waisidx_00/42cfr2_00.html or pages 523-525 in TIP 42 in *The Evidence* in this KIT.

Agency Directors Can Lead This Effort

- Articulate clear support for the Integrated Treatment program to internal staff and key community stakeholders.
- Attend some Integrated Treatment trainings, supervision, and advisory group meetings.
- Meet monthly with the program leader to address roadblocks to providing Integrated Treatment for Co-Occurring Disorders.
- Facilitate ongoing planning and program improvement efforts.
- Engage local and state mental health and substance abuse authority representatives.

Develop effective policies and procedures

Starting a new Integrated Treatment program means developing policies and procedures that support the activities of the evidence-based model.

What Policies and Procedures Should Cover

- Screening and diagnosis
- Referral and discharge criteria
- Staffing criteria
- Program organization and communication
- Core service components
- Assessment and treatment planning criteria
- Consumer records requirements
- Consumers' rights
- Program and team member performance evaluation

Develop criteria for screening and diagnosis

When you develop criteria for screening and diagnosing co-occurring disorders, integrate the principles of the evidence-based model. The intent is to identify all who could benefit from the Integrated Treatment program. Establish explicit and routine procedures for screening and diagnosing co-occurring disorders. Screening typically occurs during intake when consumers first enter the agency. However, since co-occurring disorders can develop at any time, you should routinely re-screen all consumers. Screen all consumers for both substance use disorders and mental illnesses. Establish explicit procedures to ensure all consumers are screened for substance use and mental disorders and that both disorders are appropriately diagnosed.

Designate someone to be responsible for conducting screenings and for diagnosing mental illnesses and substance use disorders. Also, develop a system to track the results of your screening so that you can report the number of consumers who are eligible for your program as a part of your quality assurance efforts. For more information on process and outcomes monitoring, see *Evaluating Your Program* in this KIT.

To screen for substance use disorders in consumers, we recommend using the Dartmouth Assessment of Lifestyle Inventory (DALI) (Rosenberg et al., 1998). For an electronic version, instructions, and scoring, see <http://dms.dartmouth.edu/prc/instruments/DALI.pdf>.

To diagnose mental health and substance use disorders, we recommend using the Structured Clinical Interview for DSM-IV TR (SCID). For more information about the DSM-IV TR or the SCID, contact the American Psychiatric Association or see www.psych.org.

Develop referral and discharge criteria

Agencies with effective Integrated Treatment programs routinely screen consumers for both mental health and substance use disorders. Once consumers screen “positive” for both substance use and mental health disorders, they should be referred to the Integrated Treatment program.

Consumers do not have to accept that they have a mental illness or substance use disorder to be referred to the Integrated Treatment program. Integrated treatment specialists can effectively work with consumers even if they do not believe that their substance use or mental health issues are causing problems in their lives. For this reason, all consumers who are positively screened for co-occurring disorders should be referred to the program.

Develop a simple referral process. Typically, program leaders receive all referrals, review them, and pair consumers with integrated treatment specialists.

Once you have developed your referral process, integrate it into your intake procedures so that consumers who are new to your agency know that your agency has an Integrated Treatment program. Staff from your Integrated Treatment program and intake specialists should review ways to explain the program to consumers to help them make informed decisions about accepting services.

Generating referrals takes some planning and effort at first. All of the activities designed to build support for your program (described in this booklet) can also help you generate referrals. Acquaint a variety of stakeholders with your referral process including these individuals:

- All staff in your agency;
- Advisory committee members; and
- Consumers in your agency.

The key to generating referrals is to get the word out. Elicit ideas from your Integrated Treatment Advisory Group and staff for engaging consumers and increasing referrals. On the next page is a sample referral form that you may use as a basis for creating your own.

Sample: Integrated Treatment Referral Form

Consumer's name		Consumer's I.D. number	
Telephone	() -	Date of referral	/ /
Referral source		Date referral was received	/ /
Assigned to			
Date of first meeting with integrated treatment specialist	/ /	Date initial assessment was completed	/ /
Screening results			
Psychiatric and substance use diagnoses			
Medications and side effects			
Criminal history (if any)			
Any information you feel would help this person reach his or her recovery goals			



Develop discharge criteria

When you develop the discharge criteria for your Integrated Treatment program, integrate the principles from the evidence-based model. Some consumers struggle with symptoms that persist over time, so their optimal treatment and rehabilitation require a long-term commitment. For this reason, despite consumers' success in abstaining from substances, consumers are never terminated from the Integrated Treatment program unless they directly request it.

In your discharge policies and procedures, specify that services should be provided to consumers on a time-unlimited basis with intensity modified according to each consumer's needs.

Establish staffing criteria

Your policies and procedures should also specify the staffing criteria for your program. Generally, Integrated Treatment programs consist of one program leader and one or more integrated treatment specialists, depending on the number of consumers that the agency plans to serve.

Integrated treatment specialists should participate in multidisciplinary treatment teams. Assign an integrated treatment specialist to each treatment team in your agency.

Create useful job descriptions

Include clear and useful job descriptions within the staffing criteria of your policies and procedures. For job applicants, a good position description clarifies whether a particular position matches their skills and expectations:

- Develop task-specific position descriptions,
- Outline the main task categories, and
- Detail specific duties.

Clear job descriptions allow program leaders to effectively supervise new employees and also allow employees to focus on the basic elements of their jobs.

Discuss program organization and communication

Policies and procedures for your Integrated Treatment program should include criteria for how the program is organized and how integrated treatment specialists relate to one another. To be effective, integrated treatment specialists must be able to work both independently and also as team members. They should communicate regularly and provide cross-coverage for consumers. Integrated treatment specialists should also attend weekly group supervisory meetings that the program leader facilitates. These meetings give integrated treatment specialists the opportunity to discuss and problem-solve consumer cases.

Your policies should outline clear procedures for how integrated treatment specialists will communicate with multidisciplinary treatment team members. It is essential that integrated treatment specialists be part of a multidisciplinary treatment team that communicates frequently and meets weekly.

When working with treatment team members, integrated treatment specialists should model evidence-based practice treatment skills. They should also coordinate services with other team members to ensure that treatment supports dual recovery goals.

Integrated treatment specialists can work on several multidisciplinary treatment teams. However, if they work on more than two teams, they generally have to spend too much time in meetings or don't have the chance to adequately communicate with other team members.

Involve significant others

Policies and procedures for your Integrated Treatment program should encourage and facilitate involving family members and other supporters to help consumers increase their natural supports. Instruct integrated treatment specialists to ask consumers to identify a family member or other supporter whom they would like to involve in treatment.

With consumers' permission, family or other supporters may join meetings with the consumer and integrated treatment specialist, meet or talk with the integrated treatment specialist alone, or attend treatment team meetings. Family interventions should also be offered such as the following:

- Education about co-occurring disorders;
- Family support groups; and
- Family therapy.

Outline core service components

Core service components for your Integrated Treatment program should be outlined in your program policies and procedures including these components:

- Stage-wise interventions;
- Access to comprehensive services;
- Outreach to keep consumers engaged;
- Group treatment;
- Interventions to promote health; and
- A protocol to help nonresponders.

Offer stage-wise interventions

Services for co-occurring disorders are most effective when they are consistent with and determined by each consumer's stage of treatment. Policies and procedures should specify that integrated treatment specialists should assess consumers' stage of treatment every 3 months and offer interventions that are appropriate for the stage of treatment (such as motivational and cognitive-behavioral interventions).

Provide access to comprehensive services

Consumers with co-occurring disorders have a wide range of needs, such as the following:

- Developing a capacity for independent living;
- Obtaining employment or other meaningful recovery goals;
- Improving the quality of their family and social relationships; and
- Managing anxiety and other moods.

Since the recovery process occurs slowly over time in the context of making many life changes, Integrated Treatment programs must be comprehensive to be effective. Develop policies and procedures to ensure that consumers in your Integrated Treatment program have access to comprehensive services as described below:

- **Residential services** include supervised residential services, supported housing, and residential programs with onsite residential staff. Consumers with co-occurring disorders who live independently should receive counseling on their housing options, when needed.
- **Supported Employment (SE)** includes services that are focused on helping consumers find and keep competitive jobs. Abstinence should not be required to obtain these services.



- **Family Interventions** include a collaborative relationship between the treatment team, consumer, and family (or other supporters) in which basic education about co-occurring disorders, coping skills training, and support are offered to reduce stress in the family.
- **Illness Management and Recovery (IMR)** includes psychoeducation, behavioral tailoring, coping skills training, and cognitive-behavioral approaches to help consumers learn to manage their illness, find their own goals for recovery, and make informed decisions about their treatment.
- **Assertive Community Treatment (ACT)** includes a multidisciplinary team approach to treatment (consumer-to-practitioner ratios of 15:1 or lower) with 24-hour access and at least 50 percent of consumer contact occurring in the community.

Provide outreach to keep consumers engaged

Many consumers with co-occurring disorders drop out of treatment due to problems in their lives, low motivation, cognitive impairment, and hopelessness. Effective Integrated Treatment programs use assertive outreach to keep consumers engaged. For this reason, the policies and procedures for your Integrated Treatment program should specify that for all consumers in the program—and especially those in the engagement stage—integrated treatment specialists provide assertive outreach by offering practical assistance or by connecting consumers with other community services (for example, housing assistance, medical care, crisis management, legal aid) that meet their needs as a way to develop trust and a working alliance.

Offer group treatment

Integrated Treatment programs are most effective when consumers are able to access services in a variety of formats including individual treatment, group treatment, and self-help groups. Group treatment can be a powerful way for consumers with co-occurring disorders to do the following:

- Learn about themselves;
- Learn new skills;
- Find models of recovery;
- Develop new values;
- Develop social supports; and
- Have the experience of helping others.

It is also a cost-effective way of providing education and treatment. Integrated Treatment programs that follow the evidence-based model are able to engage about two-thirds of their consumers with co-occurring disorders in group interventions.

We recommend that you offer two types of treatment groups as a part of your Integrated Treatment program:

- Groups for consumers in the persuasion stage of treatment; and
- Groups for consumers in the active treatment and relapse prevention stage.

Agencies may choose to run a single group for co-occurring disorders when there are not enough consumers to attend two separate groups. The challenge in running a combined group is meeting the varied needs of all group members. Consumers in the persuasion stage of treatment need to explore the effects of substance use on their lives, while those in the active treatment stage need to learn new skills to stop using substances, to remain abstinent, and to go on with their lives.

Although in a combined group, consumers in the engagement stage have the opportunity to have peer role models who are abstinent, the disadvantage of combined groups is that issues that are relevant for consumers in the persuasion stage may not be relevant for those in active treatment, so some active treatment consumers lose interest and drop out. Ideally, you should offer groups for both stages.

We also recommend that integrated treatment specialists routinely refer consumers with co-occurring disorders to self-help groups. Self-help groups are widely available, are affordable (free), and offer many different tools and supports for recovery. Specifically, encourage consumers in the active treatment and relapse prevention stages to attend self-help groups. Self-help groups can be effective for the following:

- Any consumer who wants to go;
- Consumers who have no sober support network; and
- Consumers who like the idea of peer support rather than, or in addition to, professional supports.

To refer consumers to self-help groups, integrated treatment specialists have to get to know the types of self-help group meetings offered in your local community. Also, the evidence-based model encourages integrated treatment specialists to help consumers select a meeting by accompanying them to their first self-help group meetings, if the consumer desires. It is important to establish policies and procedures that facilitate these referrals. For more information on group treatment, see *Training Frontline Staff* in this KIT.

Provide interventions to promote health

Consumers with co-occurring disorders are at higher risk than consumers without co-occurring disorders for detrimental effects of substance use. Typical negative consequences of substance use that are the focus of interventions include the following:

- **Physical effects**—chronic illnesses, sexually transmitted diseases, blood borne illnesses;
- **Social effects**—loss of family support, victimization;
- **Self-care and independent functioning**—mental illness relapses, malnutrition, unemployment, housing instability, incarceration; and
- **Use of substances in unsafe situations**—driving while intoxicated, needle sharing for intravenous drug use.

Policies and procedures for your Integrated Treatment program should encourage integrated treatment specialists to promote health by encouraging consumers to avoid high-risk behavior and situations that can lead to infectious diseases, find safe housing, practice proper diet, and exercise.

Other interventions designed to reduce negative consequences include the following:

- Providing support to families;
- Helping consumers avoid high-risk situations for victimization;
- Encouraging consumers to pursue work; and
- Helping consumers develop friendships with non-users.

Establish policies and procedures that encourage integrated treatment specialists to provide interventions to promote health.



Outline a protocol to help nonresponders

Approximately 50 percent of consumers with co-occurring disorders respond well to basic treatment and will attain stable remissions of their substance use disorders within 2 to 3 years. The policies and procedures for your Integrated Treatment program should outline a protocol to also help those who do not respond to basic treatment, to evaluate them, and to link them with appropriate secondary (i.e., more intensive) interventions.

To identify nonresponders, we recommend assessing the progress of all consumers every 3 months. A senior clinician should reassess consumers who are not progressing and should consider them for more intensive interventions such as the following:

- Prescribing and monitoring medications that may help reduce addictive behavior (for example, clozapine, naltrexone, buprenorphine, or disulfiram);
- Offering intensive psychosocial interventions (for example, intensive family treatment, additional trauma interventions, intensive outpatient treatment such as daily group programs, or long-term residential care); or
- Providing intensive monitoring, which is usually imposed by the legal system (for example, protective payeeship, conditional discharge, or mandatory urine testing).

Outline a protocol in your policies and procedures for how you will reassess and treat those who do not respond to basic treatment.

Develop integrated assessment forms

Traditionally, substance use and mental disorders were assessed and treated separately at different points in time and often by different practitioners in different agencies. Experience and research evidence show that doing so is a mistake because assessing and treating co-occurring disorders separately is ineffective. The evidence-based model recommends conducting integrated assessments for consumers with co-occurring disorders.

In general, integrated treatment specialists conduct two types of assessments:

- Comprehensive longitudinal; and
- Contextual.

Comprehensive longitudinal assessments involve collecting information about functional status, mental health, substance use, and interactions between mental illness and substance use in a timeline. This information may need to be filled in over time, from multiple sources.

On the next page is a sample form that may be used to record this type of information.

Sample: Comprehensive Longitudinal Assessment

Date	_ / _ / _	_ / _ / _	_ / _ / _	_ / _ / _	_ / _ / _
Functional status					
Mental illness symptoms and treatment					
Substance abuse symptoms and treatment					
Interactions					



The second type of assessment, *the contextual assessment*, is similar to functional assessments for mental illness. It assesses the context of substance use and how it interacts with consumers' mental illnesses. Consider integrating the following questions on your comprehensive assessment forms to help integrated treatment specialists complete contextual assessments.

Although this information is essential for developing effective integrated treatment plans, consumers may not initially share it. Integrated treatment specialists may need to collect this information over time as they develop a strong working alliance with consumers.

We recommend that integrated treatment specialists diagram consumer responses. The diagram can help integrated treatment specialists talk with consumers about their co-occurring disorders and plan interventions that will help them meet their personal recovery goals.

On the next page is a sample form that may be used to diagram consumer responses. For more information about integrated assessments, see *Training Frontline Staff* in this KIT.

Examples of Questions Included in a Contextual Assessment

- When do you usually use alcohol?
- With whom do you usually drink? Where?
- How do you feel before you have a drink?
- What makes you think about wanting to have a drink?
- What is it like when you drink? How do you feel? What do you do?
- What do you enjoy about drinking?
- What are the down sides to drinking for you?
- What do other people think of your drinking?
- How do you feel after you have a drink?
- Have you ever tried to stop drinking?
- What are your current goals?

Specify in the policies and procedures for your Integrated Treatment program that information from the comprehensive longitudinal and contextual assessments may be used to rate

consumers' stage of change and their associated stage of treatment. Below is a sample form that may be used to capture consumers' progress through the stages of treatment over time.

Sample: Stage of Treatment Assessment Form				
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
1. Pre-engagement The consumer meets the criteria for a substance use disorder but does not have contact with the integrated treatment specialist.				
2. Engagement The consumer meets DSM criteria for Substance Abuse or Dependence but has little or irregular contact with an integrated treatment specialist.				
3. Persuasion The consumer meets DSM criteria for Substance Abuse or Dependence and has regular contact with an integrated treatment specialist, but continues to use the same amount of substances or has reduced substance use (fewer substances, smaller quantities or both) for less than 1 month.				
4. Active Treatment The consumer is engaged in treatment and has reduced or abstained from substance use for 1–6 months.				
5. Relapse Prevention The consumer is engaged in treatment and abstained from substance use for 6 months or more.				
6. In Remission or Recovery The consumer is in Sustained Full Remission (has not met DSM criteria for Substance Abuse or Dependence for 1 year or more).				

Assess cognitive impairments

Intoxication with or withdrawal from alcohol and other substances causes reversible changes in memory and concentration during the time of use

or withdrawal. Cognitive problems can persist for weeks or months and gradually clear up once a person stops using. Unfortunately, alcohol can also cause permanent changes in memory and other cognitive functions, and the only way to know if

these memory problems will get better is to observe consumers carefully during prolonged abstinence.

For this reason, when consumers with co-occurring disorders have problems with memory and concentration, we recommend using a simple test, such as the Folstein Mini Mental Status Exam (MMSE) to assess and monitor their cognitive impairment. For more information, see www.minimental.com or contact:

Psychological Assessment Resources, Inc.
16204 North Florida Avenue
Lutz, FL 33549
1-800-331-8378
(813) 968-3003

If the problems are severe (for example, score is less than 20 on the MMSE) or moderate (score is less than 25 on the MMSE) and do not improve within a month of sobriety or show improvement, refer the consumer for a neuropsychological assessment or medical evaluation to assess other problems that could be causing the impairment.

Develop integrated treatment plans

Treatment planning is a collaborative process that guides treatment. It involves working with consumers and their family members (or other supporters) to consider the assessment information, establish personal recovery goals, and specify the means by which treatment can help them reach those goals.

Initial treatment planning typically occurs over weeks or months during the assessment and engagement processes. For consumers with co-occurring disorders, the treatment plan will address both mental health and substance use and will involve building both skills and supports for recovery goals.

In the policies and procedures for your Integrated Treatment program, specify the following:

- Integrated treatment plans should be written collaboratively.
- Integrated treatment plans should cover mental illnesses and substance use disorders.
- Integrated treatment plans should be updated every 3 months.

Also, consider including that, working together, consumers and integrated treatment specialists should complete the following six steps when developing integrated treatment plans:

Steps for Developing Integrated Treatment Plans

- Step 1** Evaluate pressing needs.
- Step 2** Determine consumers' stage of treatment.
- Step 3** Select target behaviors for change.
- Step 4** Determine interventions for achieving desired goals.
- Step 5** Choose measures to evaluate the effects of your interventions.
- Step 6** Select followup times to review the plan.

On the next page is a sample integrated treatment plan. For more information about how to develop integrated treatment plans, see *Training Frontline Staff* in this KIT.

Sample: Integrated Treatment Plan

Integrated Treatment Plan	Consumer name	Initial plan date ____/____/____
	Mental illness diagnosis	Plan updated on ____/____/____
	Substance use diagnosis	
	Stage of treatment	

Problem 1	
Goal	
Targets	
Intervention	
Responsible practitioner	
Review date and evaluation measure	
Problem 2	
Goal	
Targets	
Intervention	
Responsible practitioner	
Review date and evaluation measure	
Problem 3	
Goal	
Targets	
Intervention	
Responsible practitioner	
Review date and evaluation measure	
Problem 4	
Goal	
Targets	
Intervention	
Responsible practitioner	
Review date and evaluation measure	

We strongly encourage you to adapt the referral, assessment, and treatment plan forms and incorporate them in your routine paperwork. For printable copies, see the CD-ROM for this KIT. For a more detailed discussion of the screening, diagnosis, assessment, and treatment planning process, see *Training Frontline Staff* in this KIT.

Describe how to maintain consumer records

In the policies and procedures for your Integrated Treatment program, describe how you will maintain consumers' records. You must maintain records for each consumer and safeguard them against loss, tampering, and unauthorized use. The records should be consistent with Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations) and Centers for Medicaid and Medicare Services (CMS) requirements.

If you are creating a new recordkeeping system, you will need materials to create the records (for example, binders and forms) and to store them appropriately. You also need written policies and procedures for documenting and maintaining records. People with substance use disorders are protected by the Code of Federal Regulations (CFR) under 42 CFR Part 2, *Confidentiality of Alcohol and Drug Abuse Patient Records*. To learn more about these protections, visit http://www.access.gpo.gov/nara/cfr/waisidx_00/42cfr2_00.html or see pages 525-528 in TIP 42 in *The Evidence* in this KIT. HIPAA regulations may also apply, visit www.hhs.gov/ocr/hipaa.

Make sure that integrated treatment specialists are familiar with your policies and procedures for documenting and maintaining records. Supervise them in completing the required documentation and monitor that records are properly stored and protected.

Discuss how to ensure consumers' rights

In the policies and procedures for your Integrated Treatment program, discuss how you will ensure that consumers' rights are upheld. Integrated treatment specialists should do the following:

- Be aware of the state and federal consumer rights requirements;
- Inform consumers in a meaningful way of their rights; and
- Help consumers exercise their rights.

Also, your policies and procedures should reflect the model's recovery orientation. Traditional services were developed with a biomedical approach to mental health and substance use treatment; they focus on abstinence, reducing symptoms, and preventing relapse. In contrast, the evidence-based model is based on the concept of recovery. In the recovery framework, the expectation is that consumers can live lives in which co-occurring disorders are not the driving factors. Recovery means more than "maintaining" people with co-occurring disorders in the community. Recovery-oriented services encourage consumers to define and fulfill their personal goals.

Integrated treatment specialists must believe in and be true to the recovery principles within the evidence-based model. Integrated treatment specialists should be careful not to replicate those elements of traditional services that simply emphasize abstinence, containing symptoms, and complying with medication.

The value of consumer choice in service delivery and the importance of consumer perceptions must pervade how you provide Integrated Treatment. Most practitioners have never examined their own attitudes and behaviors about consumer recovery and uncritically accept many clinical traditions without paying attention to how disempowering these practices are for consumers.

In recovery-based services, establishing a trusting relationship is critical. Interactions with consumers should be based on mutuality and respect:

- Integrated treatment specialists should be challenged to listen to, respect, and understand consumers' perspectives and take into account consumers' reasons for "noncompliance."
- Integrated treatment specialists should also focus on consumer-defined needs and preferences and accept consumer choice in service delivery.

Providing services with a recovery orientation means that integrated treatment specialists support and empower consumers to achieve their individual goals.

How Administrators and Program Leaders Can Help Provide Recovery-Oriented Services

- Clearly explain consumer rights in program policies and procedures.
- Offer training on recovery principles and consumer rights to practitioners, consumers, and families.
- Hold community forums using the multimedia tools in this KIT.
- Involve consumers in local advisory groups.

Develop procedures to evaluate program and staff performance

When properly implemented, services for co-occurring disorders are associated with a variety of positive outcomes. For example, consumers in Integrated Treatment programs are more likely to achieve these goals:

- Reduced substance use;
- Improvement in psychiatric symptoms and functioning;
- Decreased hospitalization;
- Increased housing stability;
- Fewer arrests; and
- Improved quality of life.

Evaluating the performance of your Integrated Treatment program will help you provide high-quality services to consumers and assure stakeholders of your program's effective performance. We recommend that you develop procedures to evaluate your program early using the guidelines in *Evaluating Your Program* in this KIT.

Additionally, you should develop procedures for how you will supervise and evaluate the performance of integrated treatment specialists. To a large extent, clinical supervision is the process that will determine whether Integrated Treatment staff understand and are consistently applying the evidence-based practices for treating people with co-occurring disorders or if further leadership, training and accountability is required to meet this goal.

We recommend that program leaders provide weekly group supervision to integrated treatment specialists. Group supervision should review all consumers involved in the Integrated Treatment program and problem-solve ways to help them better meet their individual goals.

Because program leaders dedicate some time to direct services, they will be familiar with all of the parts of providing Integrated Treatment for Co-Occurring Disorders. Program leaders will not just review “cases” that integrated treatment specialists present, but will also be able to actively problem-solve using evidence-based principles and techniques. Program leaders also provide individual, side-by-side supervision to achieve the following goals:

- Assess performance;
- Give feedback; and
- Model interventions.

Program leaders may schedule regular meetings with integrated treatment specialists to review specific cases. They should be regularly available to consult with integrated treatment specialists, as needed.

Some aspects of the integrated treatment specialist’s job are hard to understand without seeing them done by an experienced integrated treatment specialist. Once program leaders thoroughly understand the evidence-based model, they should take integrated treatment specialists out into the field to model aspects of the job—such as engagement or motivational interventions—and directly coach them in their work. For training tools and recommendations, see *Training Frontline Staff* in this KIT.

If the Integrated Treatment program is working with a consultant, the program leader should involve the consultant in group supervision, treatment team meetings, and group treatment. Many new Integrated Treatment programs have found that feedback from an external consultant is a crucial component for improving staff performance and the quality of their program as a whole.

Develop a training plan

Developing an Integrated Treatment program is a complex undertaking. Recruiting and retaining integrated treatment specialists who know the evidence-based model or who know how to treat consumers can be difficult. Agencies that have successfully implemented an Integrated Treatment program indicate that offering one-time training for integrated treatment specialists is not enough. Instead, you should assess the knowledge level of key stakeholders (See *Evaluating Your Program*) and develop a training plan.

Practitioners who implement evidence-based practices (EBPs) are often stymied in their efforts because people misunderstand the model or lack information. It is important that key stakeholders (consumers, families, and other essential community members) and agency-wide staff develop a basic understanding of Integrated Treatment for Co-Occurring Disorders.

What Should Your Training Plan Include?

- Basic training for staff at all levels across the agency
- Basic training for medication prescribers
- Basic training for key stakeholders, including consumers, families, mental health and substance abuse authorities, and members of key community organizations
- Intensive training for integrated treatment specialists

This training will build support for your Integrated Treatment program. Your staff will find that they are better able to generate referrals for their program, engage consumers, and provide effective treatment. Since effective treatment depends on integrating mental health and substance abuse treatment, it is important for all members of the treatment team to have a basic understanding of the evidence-based model. Additionally, we suggest that you offer basic training to medication prescribers. Research shows that psychotropic medications are effective in treating serious mental illness, including consumers who have active substance use disorders. Access to such medications, including antipsychotics, mood stabilizers, and antidepressants, is critical to effectively treating serious mental illness.

Physicians or nurses who prescribe medications should be trained in the evidence-based model and work with consumers, integrated treatment specialists, and other team members to increase adherence to psychiatric medications, decrease the use of potentially addictive medications such as benzodiazepines, and offer medications such as clozapine, disulfiram, or naltrexone that may help reduce addictive behavior. Medication prescribers should be able to use the following strategies:

- Prescribe psychiatric medications despite active substance use;
- Work closely with consumers and the treatment team;
- Focus on increasing adherence to psychiatric medication;
- Avoid prescribing medications that may be addictive; and
- Prescribe medications that help reduce addictive behavior.

In addition to these internal basic training activities, consider organizing routine educational meetings for consumers, families, or other key stakeholders in the community where consumers who have received services through Integrated Treatment programs share their experiences. These key stakeholders may hold misconceptions about the goals of the Integrated Treatment program. For example, they may believe that consumers must be abstinent to participate. It is important to correct false beliefs before they impede implementing the evidence-based model.

Next, consider how you will offer the staff of your Integrated Treatment program intensive training to allow them to learn and master the evidence-based model. We suggest organizing a group training series that includes at least five half-day sessions. The Integrated Treatment KIT includes *Training Frontline Staff*, which gives integrated treatment specialists in-depth information about the evidence-based model and skills for providing effective services to consumers with co-occurring disorders. Program leaders may facilitate a structured group training using these materials.

Once integrated treatment specialists have a basic understanding of the model, we recommend that they visit an existing, well-functioning, high-fidelity Integrated Treatment program to observe how integrated treatment specialists work with consumers, interact with one another, and collaborate in multidisciplinary treatment teams. Once trained, program leaders and integrated treatment specialists will also be able to use the basic training materials found in the KIT to conduct routine community workshops and in-service seminars. For materials to support basic training, see *Using Multimedia to Introduce Your EBP*. You will find these resources:

- An introductory PowerPoint presentation;
- A sample brochure in both English and Spanish; and
- The introductory video.

Hire an external consultant and trainer

Establishing the initial processes that must be in place to provide quality services requires great attention to detail. Consequently, during the first 1 to 2 years after forming a new Integrated Treatment program, many agencies have found it helpful to work with an experienced external consultant and trainer. Consultants and program leaders often work together over the 2 years to ensure that the Integrated Treatment program is structured appropriately. They integrate evidence-based practice principles into the agency's policies and tailor procedures to meet local needs.

Once the Integrated Treatment program has been launched, it is important that you do not allow integrated treatment specialists to revert to older and more familiar ways of doing things. External consultants and trainers who are experienced in running Integrated Treatment programs can provide ongoing technical assistance, side-by-side supervision, and periodic booster training sessions. This type of assistance, along with ongoing evaluation of fidelity and outcomes, has been found to be critical in reducing the chance that integrated treatment specialists return to old habits.

Select a location for your Integrated Treatment program

Although integrated treatment specialists will reach out to consumers in the community, they will also meet with consumers in your agency. For this reason, it is important for integrated treatment specialists to have a place to meet with consumers and to have access to a desk, a phone, and voice mail. Additionally, access to a cell phone for outreach work can increase safety and improve communication.

Office space should not be separate from the rest of the treatment team. Ideally, the offices should be intermingled and the space consistent with how space is allotted for other team members. Touching base in the hall and lunchroom with other treatment team members facilitates ongoing communication that supports the goals of Integrated Treatment for Co-Occurring Disorders.

Mental health agencies that implement Integrated Treatment programs will increase the amount of substance use laboratory screening they do as well as associated expenses. Explore the least expensive and most efficient ways of doing this. Many agencies acquire their own testing equipment.



Review your program budget and revenue sources

It is important for you to understand the budget for your Integrated Treatment program and revenue sources so that you can actively participate in the budgeting process, make informed management decisions, and understand where collateral revenue sources are most needed.

In some mental health systems, programs receive a fixed rate for each consumer who receives services. In other systems, programs are only reimbursed based on the specific services provided. In that case, you should be familiar with how services must be tracked to capture billing from various funding streams. You will also need to know the billing process and billing codes.

Financing mechanisms for Integrated Treatment programs vary from agency to agency. Administrators use federal, state, and private funding opportunities to fund Integrated Treatment programs.

Financial barriers can slow implementation. Be aware that over time the mission and activities of programs can become defined by the funding that supports them. Know the principles of the evidence-based model and be vigilant that funding opportunities support the model rather than shape and corrode it. Consult with agencies and system administrators who have been successful in this area for useful ideas and strategies. For more information, see the reference for TIP 42 in *The Evidence* in this KIT.

In summary, building an effective, well-functioning Integrated Treatment program is a developmental process. We encourage you to periodically revisit the information in this KIT throughout the first year after you start your new program. We believe that these materials will take on a new meaning as the process of implementing an Integrated Treatment program evolves.

