


Integration of mental health and addictions: Where we have been, why we went there and where are we headed?

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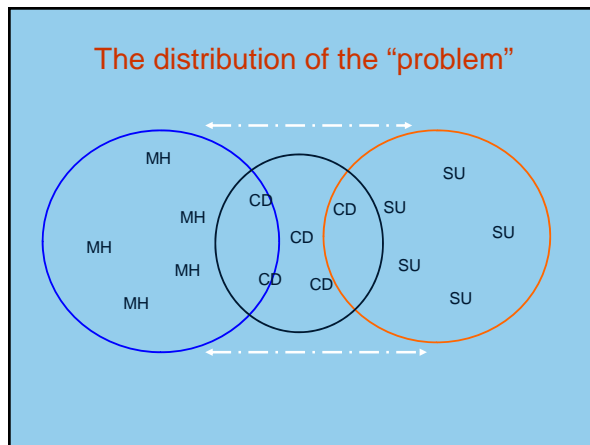
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- It's a story that can be told largely through images but first some definitional things to mention

Work proceeds on CD but there remain a lot of fuzzy edges to our definitions of mental health, addictions and co-occurring disorders?

- Mental health**
 - DSM-IV, Severe mental illness
 - Less severe/moderate? Personality disorders?
 - Mental health promotion (wellness)?
- Addiction**
 - DSM IV, dependence and abuse
 - Problem gambling, tobacco, behavioural addiction?
 - Moderate-low risk use?
- Co-occurring disorders**
 - DSM IV (current or lifetime; cross-sectional or longitudinal)
 - Fuzzy edges: other addictive disorders, moderate to high risk



The fundamental need at a health systems level

The personal and clinical experience of co-occurring disorders

Let's not forget some "silos" do have a function. It is how things move in and out of them that is important.

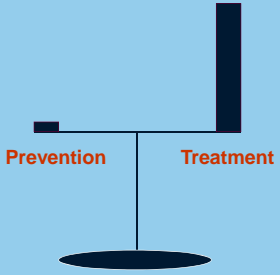


With respect to the integration of mental health and addictions.....



The train has clearly left the station!

And the focus of attention remains on



Prevention Treatment

Where we have been and what led us there?

- Canadian Best Practices report, 1999-2001.
- As in other countries that developed similar documents, the arguments for better integration of mental health and addiction services were based largely on the concurrent disorder "issue" and the following rationale >>>>

The logic chain supporting integration...

1. **Overlap** is extremely high (rule rather than exception)
2. **Impact** of Co-occurring Disorders (CD) is high
3. CD contributes to **help-seeking** and **costs** of health and social services
4. People with CD have **unsatisfactory treatment and support** experience
5. Many **challenges accessing** required services: policy, financing, competency and attitudinal barriers
6. **Integrated services** are more effective than non-integrated services
7. **System supports** are needed for sustainable integrated services
8. Administrative and governance **mergers** are needed for **some** system supports

Although not discussed at the time..

- Some integration efforts in Canada predated the CD issue (Manitoba).
- It remains a matter of speculation what other forces may have been at play (and continue to exert pressure for integration):
 - Increased efficiency/less management?
 - More competitive positioning for resources?
 - Inter-disciplinary issues of power and world view (e.g., medical/non-medical)?
 - Leveling the playing field (e.g., wages, credentialing; workforce mobility)?
 - Other factors?

The ensuing years – 2001 to the present

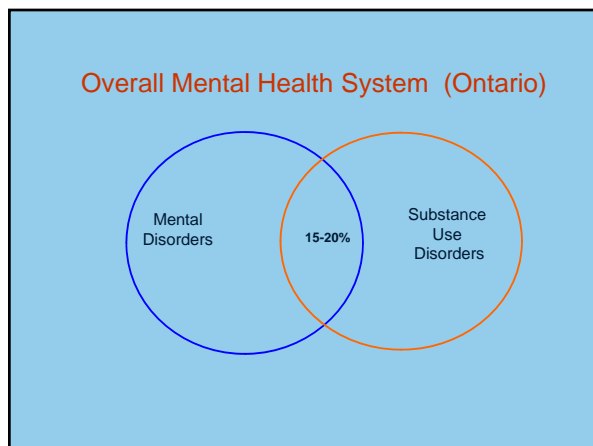
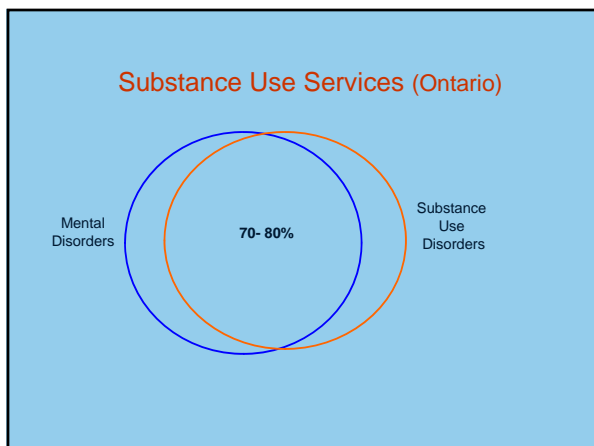
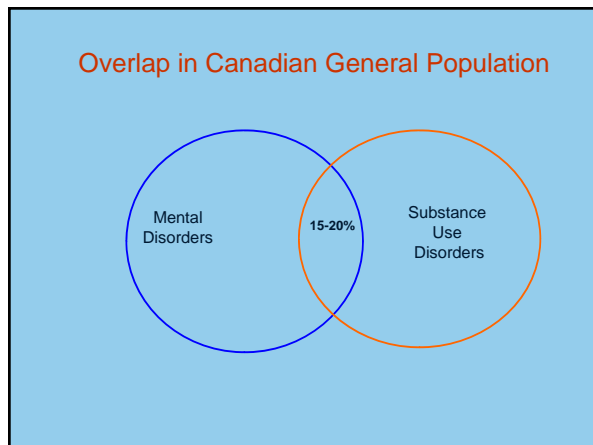
- Much more attention to **youth** →
- Research **confirming and expanding upon key findings** in the Canadian context
- Heavy emphasis on **knowledge translation** – getting the research into policy and practice, in particular, screening and assessment protocols
- But also more open **questioning** of the reflexive “movement” towards integration and the strength of this chain of logic

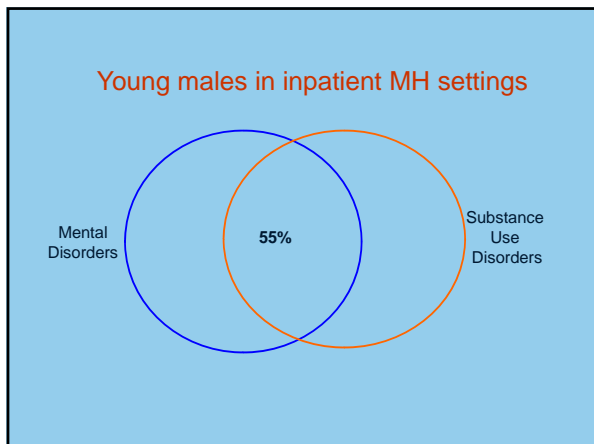
Special issues --- children, adolescents and “youth” generally

- Co-occurring disorders – **all of the above apply**
- **Life course perspective** demands attention be given to “early” years –
 - Mental health and substance use problems typically **persist** over time
 - Mental health problems are **risk factors** for later substance abuse and vice versa
 - **Common risk factors** behind each (e.g., social determinants, family, some genetic risk for particular disorder combinations)
- **Early recognition and treatment** reduces long term treatment trajectory (outcome, cost)

The Canadian Epidemiological Picture

- Just what is the degree of overlap in the Canadian context?
 - **general population**
 - **addiction services**
 - **mental health services**
 - **where does problem gambling fit in?**
- What is the relationship to help-seeking and satisfaction with services?
- What are the needs of clients in the mental health system and do those with co-occurring disorders stand out?





- ### So in the mental health system it depends critically on **sub-population**
- Young people 16-24
 - Inpatient 55%
 - Outpatient 29%
 - Community 22%
 - By diagnosis
 - Inpatient personality disorders 42%
 - Inpatient schizophrenia 30%

What is the relationship between co-occurring disorders, help-seeking and satisfaction with services?

- ### Help-seeking....
- 9.4% of Canadians sought help (formal and informal) for mental health or addiction concerns (2001 data)
 - 13.6% of those with substance dependence
 - 44.1% of those with a mood or anxiety disorder
 - 50.6% of those with a co-occurring disorder
 - Most common source of help
 - General practitioners and about one-third of those who use general practitioners ONLY used their GP
 - Satisfaction with services
 - Most reported positive experiences but level of dissatisfaction was highest among those with co-occurring disorders
 - Unmet need (self-reported)
 - Highest for those with co-occurring disorders (about 50% compared to 13% of those with substance dependence but no mental disorder)

Profile of Needs among People with Co-occurring Disorders in the Ontario Mental Health System

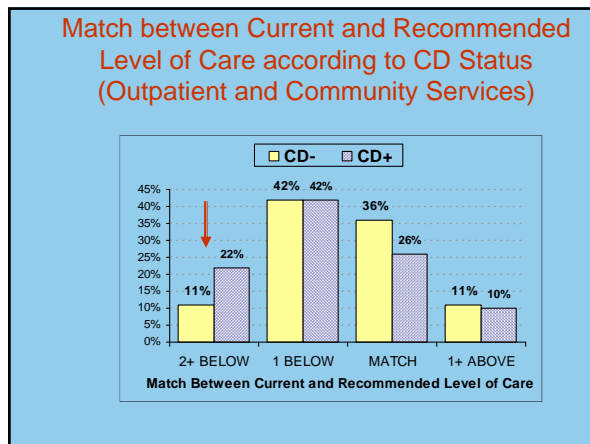
Needs of People with Co-occurring Disorders in the Ontario Mental Health System

	Specialty Inpatient	Specialty Outpatient	Community
Antisocial	X	X	X
Legal Problems	X	X	X
Suicide/Danger to self	X	X	X
Violence/Danger to others		X	X
Interpersonal Problems		X	X
Family Problems	X	X	
Self-Care/Basic Needs			X
Personal Resources			X
Overall Problem Severity		X	X

(X = those with CD have higher needs than people with mental disorders but no substance use disorder)

Then taking the **FULL** needs profile one step further...

- Behavioural, legal, health, cognitive, psychosocial, family, self-care.....
- Now what if we take this profile one step further and determine what level of service people **REQUIRE** based on their needs profile
- Then we can compare what they require with what they actually received
- i.e. we can conduct a system-wide **gap analysis** organized by the person's status with respect to co-occurring disorders



Predictors of the mismatch

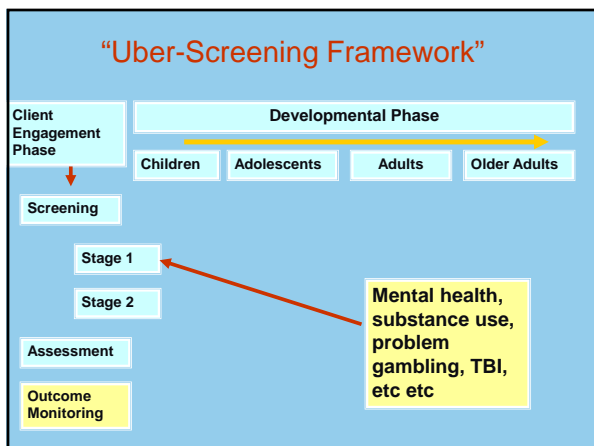
- Young age
- Personality disorders

Not predictive of a mismatch

- Gender and other demographic
- Other diagnoses

Translating research to practice

- Validation of **screening tools** (and research syntheses) to support better/earlier identification of mental health and substance use concerns/disorders
 - screening tools appear to be a key point of entry to engage clinicians, service providers and funders/policy makers
- **Adults, children and adolescents** →
- Expressed need is high among service providers but there is still a need for research-based strategy to encourage and sustain uptake (Communities-or-Practice; other collaborative network-based approaches, approaches based on Diffusion of Innovation theory)



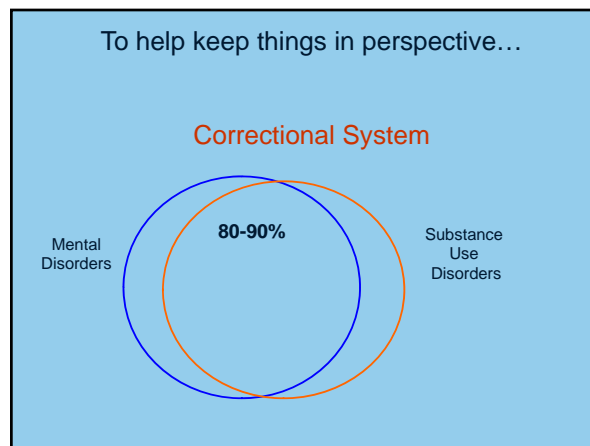
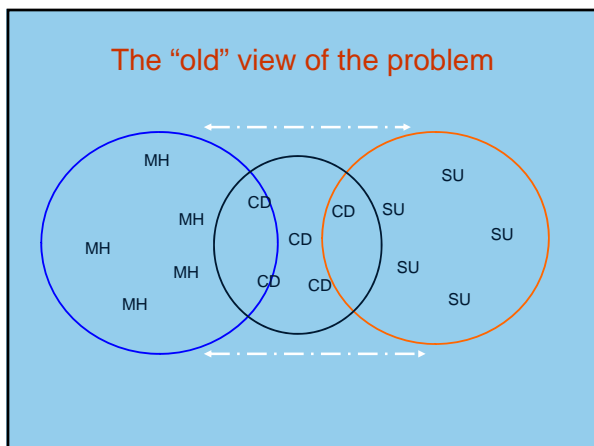
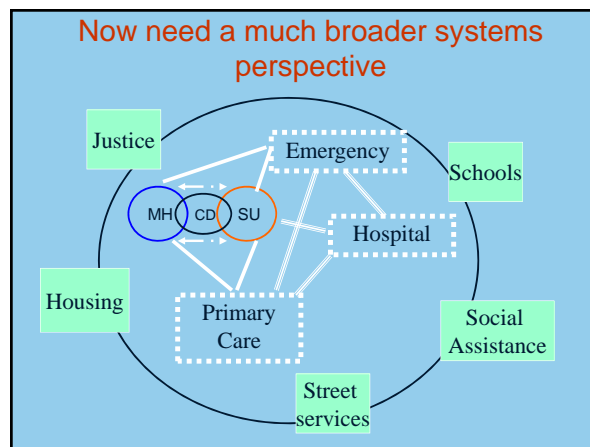
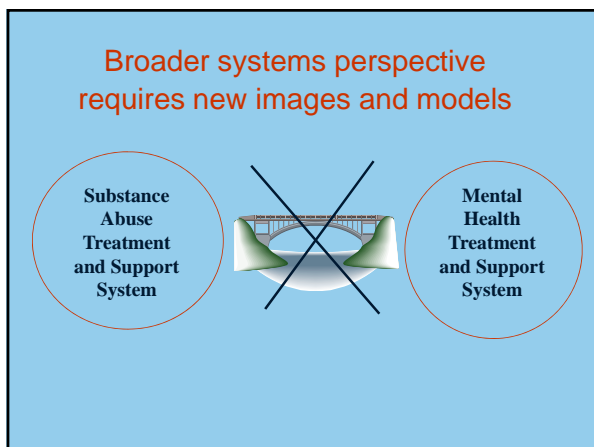
Questioning the original logic chain supporting integration

1. Just how high is the overlap?
2. Have we adequately considered overlap with other health problems/illnesses?
3. How strong is the evidence for integrated services?
4. How strong is the evidence for system supports including organizational mergers?

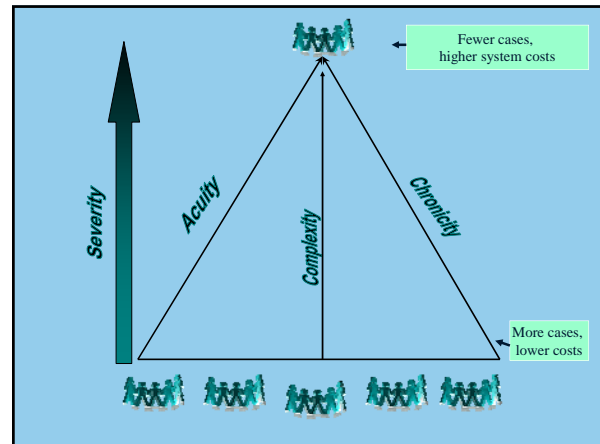
Rationale based on CD Revisited

1. Overlap is high	Depends. 15-20% at population level – Higher at clinical level but again depends where you look.
2. Impact is high	← Probably depends on severity and sub-population
3. Help seeking and costs	
4. Poor treatment experience	
5. Challenges with access	← Graduated integration
6. Integrated care more effective	
7. System supports needed to support integrated services	← Needs to be strategic, value-add and attentive to risks and benefits beyond CD
8. Administrative/governance mergers needed to ensure system supports are in place	

So where are we headed with the integration issue?

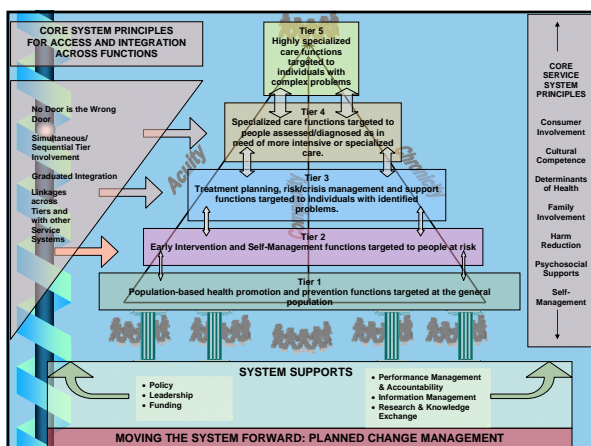
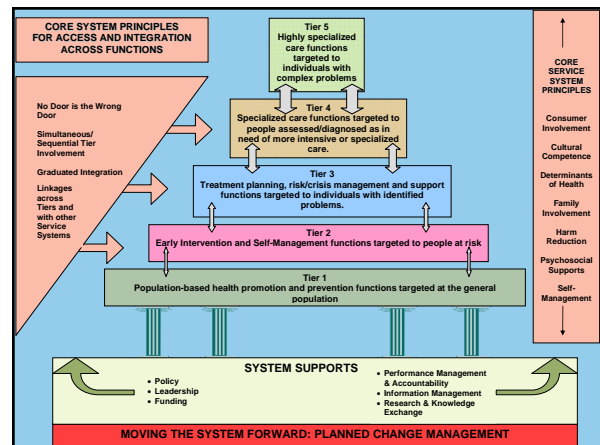


- And a new perspective on the continuum of severity underlying “co-occurring disorders”



- And a new “**tiered framework**” that overlays an integrated system of services and supports to this “**population health pyramid**”
 - Prevention and health promotion (*general population*)
 - Early intervention and self-management (*at risk*)
 - Treatment planning, crisis intervention etc (*identified problems*)
 - Specialized care and support functions (*higher need*)
 - Highly specialized care functions (*most complex needs*)

PLUS - the system-wide principles and system supports required to really make these tiered work as a system



In the context of this framework what do we mean by “Integration”?

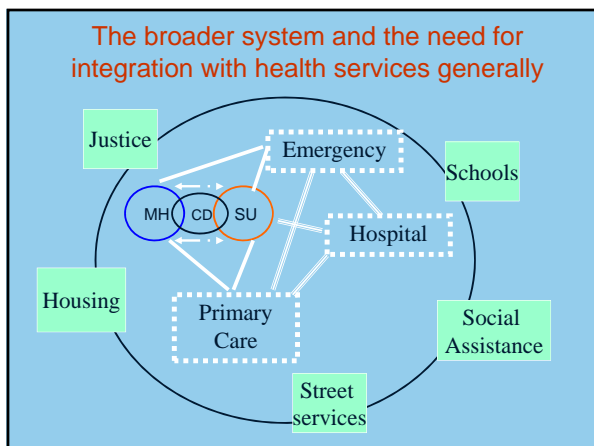
- **Service Level Integration (small-world)**
 - Clinical and psychosocial services and supports with shared philosophy and treatment messages, coherent and shared treatment and support plan
 - A. **Co-located**, single team/single site model
 - B. **Collaborative model** – multiple providers including community partners, cross-training

- **System Level Integration (big-world)**
 - Structures and processes required to fund, administer and support the services level, including:
 - Policy
 - Human resources
 - Leadership and governance
 - Funding
 - Performance management and accountability
 - Information management
 - Research and knowledge exchange

How is integration achieved and sustained?

- How is integration achieved and sustained?
- **Bottom-up (small world)** – e.g., community development, local integrated networks, communities-of-practice, network theory, emergence theory/complexity science,
 - **Top-down (big world)** – health policy and administration
 - Not an “either/or” -- Introduces the million dollar question: “Under what conditions are some key “top-down” measures critical to the success of “bottom up” initiatives?”

- What’s been happening (post-2001 Best Practices report on CD)?
- **Services integration (small world)**
 - Several examples of new CD programs and partnerships
 - But provincially and nationally it’s largely undocumented
 - CAMH capacity building – tremendous effort with its own integration trajectory
 - **Systems integration (big world)**
 - Essentially undocumented but changes are more obvious
 - Health Authorities- planning, policy, accountability agreements
 - Provincial - Ministerial department mergers/policy development
 - CAMH
 - Alberta Health Services Board- AADAC and Mental Health Services
 - Mergers of smaller organizations



- Boundaries of integration efforts need to be expanded – especially to deal with physical health problems
- Co-occurring **health problems** high in both MH and SUD populations
 - Health problems are **under-detected** and **under-managed**
 - Primary care is the “**front line**” for both MH and SUD
 - Many challenges with **access**
 - **Discrimination** and **stigma** are shared challenges
 - Similar protocols and models developed for MH and primary care and substance use and primary care, including **screening and brief intervention**
 - Policy is moving towards more integration with primary care – some jurisdictions have “arrived” at this **broader playing field**

Need to improve the evidence base for integrated services?

- New systematic reviews are challenging the data on value-add of integrated clinical programs
- Standard substance use treatment can improve mental health outcomes and vice versa? When are highly integrated options needed?
- Importance of severity, level of functioning and sub-populations largely ignored in this literature
- It's likely a matter of individualized assessment and matching but much more needs to be done to assess value-add of integrated services and under what conditions

Improving the evidence-base for system supports including structural integration/mergers

- Challenges with evaluation data – difficult to pinpoint outcomes at client level
- Good evidence with respect to the impact of system integration on intermediate outcomes concerning client's continuity of care. Data suggest:
 - System integration efforts need to be targeted
 - Better success with smaller number of sectors involved
 - Better success with performance contracting
- Common sense/practice-based arguments for system supports such as core competency development, policy development for access to services, e-health and e-referral.

Gaps to address going forward:

- **Adequately resource** integration initiatives to include evaluation AND knowledge exchange component
- Advocate for **structures and processes to support** integration (in particular at the system-level) and again to share lessons learned
- Capacity for **addiction psychiatry** needs to be addressed (Ontario and national level) as it is missing link in most community/regional systems

Finally -- some lessons learned

- Integration happens by living it -- not just thinking and talking about it
- Integration, like most things, benefits from excellent personal relationships
- Integration takes time
- Integration is NOT a linear process
- Integration takes leadership
- Integration requires monitoring with performance indicators

Critical Performance Indicator

- To be seen by your new addiction or mental health colleagues as “integrated” you must be able to **say mental health AND addictions in the same sentence**, without stumbling, and more than once a month.

And this is the desired outcome for clinicians, planners, funders and researchers alike

