



Canadian Executive Council on Addictions Conseil exécutif canadien sur les toxicomanies

Statement by the Canadian Executive Council on Addictions on the integration of addiction and mental health services

December 18, 2008

The Canadian Executive Council on Addictions (CECA) is a national, non-governmental organization established in 2002 to influence public policy on substance use. Our membership consists of senior executives of substance use agencies in Canada with a legislated federal or provincial mandate. Our primary objective is to strengthen the supports and services offered to Canadians with alcohol and drug problems.

A large number of Canadians who seek the help of addiction programs live with a co-occurring mental health disorder, and many others are at risk of developing a mental health problem in their lifetime. For over two decades there has been a growing awareness of the needs of those with co-occurring disorder. This has accelerated in the past two years, in part because of the Senate's *Out of the Shadows* report, the establishment of the Mental Health Commission of Canada, and greater media attention focused on the stigma associated with mental illness.

At the same time, many jurisdictions have combined the administration and management of services that address substance use disorders with mental health programs. The goal of effectively meeting the needs of Canadians with co-occurring substance use and mental health problems is a strong force for integration – but not the only one. There is much that brings the addiction and mental health fields together, most notably the experiences of all the people we serve. Many of the clients of both systems are among the most marginalized and least powerful Canadians, subject to a stigma not shared by people with other health problems. Clients of both systems have often been victims of trauma, and require care that is highly sensitive to personal experience.

There are also important similarities in the service systems, and a strength-based paradigm is required that can leverage these similarities to facilitate integration. In both addictions and mental health, self-help resources and family support are proven to play enormous and effective roles. In both areas, there is strong emphasis on a continuum of care, and the need to support individualized treatment within the continuum. Services in both sectors span a wide spectrum of medical and community interventions that must work as a system of support, and the coordination of these services constitutes a significant challenge.

This statement addresses key questions for addiction service providers, managers and policy-makers: how can we strengthen our relationship with mental health service providers? How can we improve the service we offer to those with co-occurring disorders? What have we learned about collaboration with our mental health colleagues? How should policy-makers support integration that is proven to improve service to our clients?

Co-occurring disorders pose a significant challenge to substance use programs. The existence of a co-occurring mental health problem reduces the efficacy of addiction treatment, since this client population has relapse rates far higher than other clients. The client with co-occurring disorders is far more expensive to treat; in fact, the evidence suggests that the average health care costs of co-occurring disorder clients is greater than the sum of the two disorders in two separate clients. This provides a hint of the acuity and chronicity of the problems faced by this population, as well as the hardship faced by these clients and their families.

It should also be noted that clients who seek treatment for a co-occurring disorder tend to be distinctly less satisfied with the services we offer than those clients with an addiction-only problem.

Estimates of the prevalence of co-occurring disorders vary depending on definitions. In the addiction system, co-occurring mental disorders are clearly the rule, rather than the exception. In contrast, among people seeking treatment and support from mental health services, co-occurring disorders are the exception rather than the rule. Among certain client populations – particularly those with a serious mental illness – prevalence rates are very high. The likelihood of having a substance use disorder was four times higher for those with schizophrenia than for the general

population, and those with bipolar disorder were five times more likely to develop these problems.

Collectively, our organizations have significant experience reconfiguring administration and operations to improve service to those with co-occurring disorders. Our experience has led us to these conclusions:

1. *No single administrative system can encompass all the needs of people with either mental health or substance use problems.* Our clients are individuals with a broad range of health and social needs. Integration with mental health services may be helpful, but what about management of chronic disease, housing support, child welfare, corrections, employment assistance? Comprehensive service to clients requires organizations and systems to communicate effectively, and to ensure that transitions in care are well managed. Improving the coordination of care across different types of service is the primary theme of the recently released *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy*.
2. *Effective collaboration of addiction and mental health interventions must take place across the full spectrum of services.* The *National Treatment Strategy* recommends a tiered model of care to match the intensity of the addiction problem with the intensity of the treatment. This is consistent with a stronger population health perspective that recognizes the full range of health problems experienced by people with substance use problems. Concurrent disorders range broadly in their severity. In some cases, the solution will involve highly specialized care in a medically supervised setting; in other cases, the person's problem can be effectively addressed through self-management interventions based in community settings or primary care. There is no single program that can satisfy the need to collaboration and integration of mental health and addiction treatment.
3. *Administrative integration can be successful, but is no guarantee of improved services.* There are examples of successful administrative integration across the mental health and addictions domains that have improved integration and strengthened service relationships. But improved service for those with co-occurring disorders does not necessarily follow.
4. *With or without administrative integration, the tools for improving service are practical ones, and depend on strong relationships.* Most importantly, clients entering either the mental health or addiction system should be

screened for a co-occurring disorder, using information that can be effectively employed in treatment. This should be followed by a comprehensive assessment in order to develop a comprehensive treatment and support plan. Providing the right service for complex cases requires effective case management that can cultivate the relationships needed to overcome the barriers to administrative and professional collaboration.

5. *Funders and policy-makers should assess the effectiveness of mental health and addiction integration from the client perspective.* Integration is not an end in itself, but should translate into more effective service. Funders and policy-makers need the tools to assess the quality of integrated care for people with co-occurring disorders, and to ensure there are no detrimental effects on the majority of mental health and addiction clients *without* a co-occurring disorder.

Integration of addictions and mental health is important and extensive work, and will not be accomplished simply through reorganizations and name changes. The work of integration will be incremental.

Unfortunately, the evidence does not point the way to one perfect model. Practitioners, policy-makers, funders and administrators must commit themselves to collaboration that improves care for people with co-occurring disorders, and strengthens both systems of care.

As part of its consideration of this issue, CECA commissioned Dr. Brian Rush of the Centre for Addiction and Mental Health (CAMH) to prepare a paper on integration of mental health and substance use services. The paper is available upon request. CECA is grateful to Dr. Rush and his collaborators on the paper – Louise Nadeau, Barry Fogg, and April Furlong.