



Canadian Executive Council on Addictions  
Conseil exécutif canadien sur les toxicomanies

**On the Integration of Mental Health  
and Substance Use Services and Systems:  
Main Messages**

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## Main Messages

1. The objective in this paper is to identify key facilitating factors, challenges and other issues which can inform discussions and concrete planning, policy and research development with respect to integration of mental health and substance use services and systems, and that are of particular relevance to the current Canadian context.
2. The rationale for integration of mental health and addiction services is strongest when presented in relation to the target population with co-occurring disorders, and especially the narrower and more clinically severe sub-group. The research literature and academic and lay arguments for integration draw attention to the high overlap in the two populations, the negative impact on treatment and support outcomes, and the challenges for people with co-occurring disorders navigating two disparate systems of services. Integration-related solutions with varying degrees of emphasis given to services versus systems-level integration strategies are viewed as solutions to the problems identified.
3. Aside from the needs of people with co-occurring disorders and their families, there are undoubtedly many other factors underlying the “integration movement”, for example, anticipated cost-efficiencies by administrators; consumer demand for services that are more easily accessed and individualized; power struggles between disciplines and models of treatment and support. These and other underlying factors need to be better understood in order to plan and evaluate the success of integration activities and strategies.
4. The rationale for the integration of mental health and substance use services and systems should rest on a stronger foundation than simply the phenomenon of co-occurring disorders. A broader perspective is needed and planners and administrators must ensure there is a net benefit of integration for those with co-occurring disorders as well as those with mental or substance use disorders, but not both.
5. A much more targeted and strategic approach to integration is also needed based on sub-populations and, in particular, based on the severity and complexity of the problems faced by the people needing assistance. Going forward, it seems more prudent for the field to mature into a more nuanced and targeted approach to integration, and with a firmer grasp of the subtleties in both the epidemiological data and the data on the effectiveness of integrated and non-integrated treatment (i.e., *what type and level of integration and for whom*).
6. To achieve consistency of terminology, the term “**services-level integration**” is recommended to connote the integration of clinical and psychosocial services made available to the person with a mental or substance use disorder (and co-occurring disorders), and their families. Integrated services can occur in a single site or across multiple providers working collaboratively. At the second level, **systems-level integration**, the focus is on structures and processes that ultimately support integration at the services level, including securing adequate resources. It is helpful to draw a distinction between governance/administrative integration (i.e. structural merger) and other kinds of activities and strategies such as joint planning, cross-training, co-location, e-health solutions to information exchange, and which may or may not involve structural merger.

7. The larger literature and practice experience concerning the integration of mental health and health services generally hold as yet untapped potential for being instructive with respect to the integration of mental health and substance use services and systems. Similarly, the broad and rapidly expanding areas of inter-organizational network theory and system theory/evaluation remain largely untapped for conceptual, practical and methodological insights. This literature shows the value of integration built upon “bottom-up”, emergent professional and organizational relationships. “Top-down” processes should support these relationships.

8. The present report can be viewed as a “follow-on” document to the 2001 Health Canada report on best practices for co-occurring disorders. Since the Health Canada report’s release, progress has been made in understanding the community and clinical epidemiology of co-occurring disorders. There has also been more research, and more research syntheses, focused on the effectiveness of integrated treatment at a clinical, programmatic level. Pan-Canadian data is now available on the prevalence of co-occurring disorders in the general population. However, it is at the systems-level where the research and development gap is most glaring.

9. At a national level, organizations such as Health Canada (under Canada’s Anti-Drug Strategy), the Mental Health Commission, the Canadian Centre on Substance Abuse, and the Canadian Executive Council on Addictions could provide collaborative leadership in this area, in partnership with various stakeholder organizations. Provincial and territorial jurisdictions should also be proactive in supporting integration activities, for example, with demonstration projects and incentives. The recent launch of the National Treatment Strategy for substance use services and systems affords a particularly compelling opportunity to ensure the integration issue includes focused strategies to support and sustain integration efforts where they are called for.

10. The over-riding goal of a concerted program of research and knowledge exchange should be to identify the most helpful and, if possible the *essential*, types of systems-level supports that translate into more accessible, effective and cost-effective treatment and support at the services level. Greater emphasis is needed on program and policy evaluation given the need for more evidence concerning integration strategies at the systems-level. More evaluation will help mitigate the risk of *pseudo-integration*, that is, the development of new structures and processes created in the spirit of better integration, but without a thoughtful assessment of risks and benefits to all concerned, and without any substantive difference being made on the ground for the person and families in need of treatment and support.

11. To address the lack of information on the nature and level of Canadian integration strategies a program of research and evaluation is needed that first catalogues and describes what has been done to date, and what lessons have been learned. Such a compilation should be done for both services-level and systems-level integration efforts. This would provide “normative” data with which to contrast results from a local/jurisdictional integration process.

12. A more *strengths-based paradigm* is also needed that can systematically assess the similarities across the respective sectors and leverage them to the benefit of different types of integration, and for different sub-populations. Examples of similarities across mental health and substance use services and systems to build upon include:

- the use of the “continuum of care” approach to system planning and the need for individualized treatment and support within that continuum;
- the importance of a coordinated network of services in the community that includes specialized services as well as other services required on a referral basis;
- the importance of self-help resources and family supports;
- the sharing of common ground in the fight against stigma and discrimination; and
- the common turf offered by chronic care models and a focus on long-term support and recovery when needed.

13. A population health perspective is needed and which acknowledges the full range of health problems experienced by people with mental health and substance use disorders. Such a perspective argues persuasively for a broader approach to service and system integration and also points to the need for closer integration with health care services (in particular the primary care physician and emergency services) in order to address people’s needs in a truly holistic fashion and avoid the multiple, disparate pathways through the health system they must now follow to seek services and support.

14. In Canada, the “integration train” has left the station for a wide variety of reasons. Improved integration offers high potential for more effective services and supports for people with co-occurring disorders, as well as those with mental health or substance use disorders but which are not co-occurring at the present time. However, we must work collectively to avoid the “integration reflex” and pursue it more thoughtfully and strategically that has often been the case in the past.

15. It is essential that any integration effort be adequately resourced and supported since many of the changes that are required are in the realm of organizational and systems culture and, therefore, require sustained efforts and ongoing corrective feedback loops to ensure the goals are being met for people needing services and supports. In the end, it will be functionally integrated services that make a difference to people’s lived experience.