Integrated Mental Health, Substance Use and Concurrent Disorder Service Delivery

Mental Health Commission of Canada
Commission de la santé mentale du Canada

Canadian Centre on Substance Use and Addiction

THE PROBLEM

Over the past 20 years, the case has resoundingly been made for the transformation of mental health and substance use care into a collaborative system of support. Recognizing that mental health and substance use concerns are often co-occurring, and having to access separate services can be a barrier to whole-person health, the integration of these services has been established as a best practice. Integrated care can be defined as "care that is delivered by providers from different specialties, disciplines, or sectors working together to offer complementary services and mutual support." (Kates et. al., 2011)

In Canada, system-level integration has been taking place at multiple levels, with most provinces and territories developing governance structures to facilitate collaboration. Partners in the mental health and substance use sectors have identified a number of system-level priorities, including:

- More collaboration among organizations;
- Improved access to services;
- Harm reduction, trauma-informed, culturally safe and recovery-oriented approaches to care; and
- Standardized care and outcome measures.

However, the operationalization of integration at the service delivery level has been a challenge.

WHAT WE DID

To address this gap, this literature review surveyed the landscape of operational and implementation guidelines for integrated mental health, substance use and concurrent (mental health and substance use) disorder service provision in Canada and internationally. We reviewed grey literature published in Canada and other countries with populations that are predominantly white (e.g., United Kingdom, Australia) between 2017 and 2022, written in English or French. We focused on documents that offered guidance on how to implement integrated services at the program or organization level, not at the clinical level.

WHAT WE FOUND

We reviewed 98 documents containing operational guidance, 82 of which provide guidance on integrated mental health, substance use and concurrent disorder service delivery and 16 that relate to the integration of primary care with mental health and substance use care. Among the 98 documents, 48 were produced in the United States, 37 in Canada, seven in the United Kingdom, five in Australia and one in France. The guidelines address service delivery at a number of points on the continuum of care, in both clinical and community settings. Most resources are targeted to partners working in mental health, substance use service or both provision settings, while others are directed at school, community or justice system organizations.

WHAT WE LEARNED

An Incomplete Puzzle

Just fewer than half of the guidelines refer to one or more underserved populations, with children and youth being the most common. Other underserved populations included people who are:

- Older
- Indigenous
- Racialized
- Immigrants
- Pregnant, parenting or both
- Veterans
- Involved in the justice system

and people who:

- Do not speak English
- Have experienced violence
- Live in rural settings

Numerous documents, with a broad geographic spread, address concurrent disorder care. We found no guidelines on integrated care for:

- 2SLGBTQ+ people
- People who are experiencing homelessness
- People who are underhoused
- People who are Francophone minorities
- People with low income

Most guidelines refer to more than one point on the continuum of care, most often on prevention, screening, assessment, treatment or care coordination. We found fewer guidelines that discuss the links between gender and integrated care or that focused on health promotion, harm reduction, crisis care and recovery. In terms of organizational elements, guidelines that discuss workforce issues were more common than those that addressed information sharing and evaluating and funding integrated care.

Thus, the picture painted by this literature review remains incomplete in terms of how to best integrate mental health and substance use service delivery. Although numerous guidelines consolidate learnings from various programs or studies, many approaches endorsed in the guidelines come from a specific context (e.g., practice setting, population) and thus overemphasize these approaches to care. This leaves other pieces of the puzzle underexplored.

The gaps likely reflect the still-early state of integrated care, in that implementation guidelines in some areas may not yet be available as grey literature; this may change as models evolve into best practices and as practice standards are finalized. This creates an opportunity for partners in the field of integrated care to pull existing approaches together into a comprehensive framework and identify which pieces of the puzzle can be filled in through knowledge sharing or additional testing of program models.

Tensions in Definitions of Mental Health and Substance Use

Health means different things to different populations. When we use disease-focused logics to frame research methods, we may miss integrated models that do not fit Eurocentric notions of mental health and substance use (Mead, 2002; Stinson, 2018). However, wellness-focused models can be especially valuable when planning services that resonate with populations whose knowledge systems have been marginalized. We found many different terms used in different sectors and among countries for integrated mental health and substance use care. For knowledge sharing and research, it is worth considering whether there is a need for internationally standardized language pertaining to mental health and substance use.

A Health Equity Analysis

Most of the documents recognized inequities related to mental health and substance use. Generally, guidelines took a populations approach, meaning that guidelines were created for populations that experience higher rates of

mental health and substance use concerns or face systemic barriers to care. However, this approach risks essentialism — assuming that a population has essential qualities that do not change — and obscures the common experience of intersecting or layered inequities. We found fewer guidelines that took a systems approach to equity, providing guidance on how to shift service provision to attend to oppression created by social, economic and cultural systems of power. There is an opportunity here to create guidelines that apply systemic principles of equity and intersectionality to care instead of (or in addition to) taking up one population at a time.

WHERE TO GO FROM HERE

Opportunities for Research and Knowledge Sharing

About equal numbers of the documents we reviewed were based on research or on learnings from a context-specific program or service, both of which present a challenge when there is insufficient evaluation to assess the effectiveness and unintended consequences of models. However, this combination of peer-reviewed research and context-specific reports offers a strong foundation on which to build a robust body of evidence.

Our analysis discovered numerous opportunities for research and knowledge sharing:

- More systemic and critical research on how to integrate care with marginalized populations, including more consideration of systemic and intersectional oppression and the exploration of approaches to integrated care that use different concepts of health;
- Collaborative development and evaluation of standards of care;
- Research and evaluation on:
  - The uptake of proposed models and guidelines to identify barriers and facilitators to implementation,
  - The impacts of various models on and in a range of populations and settings, and
  - The effectiveness of change management strategies used;
- A focused analysis of implementation guidelines for specific treatment models;
- Research on billing considerations and financial incentives informing integration;
- Knowledge sharing of internal organizational policy and implementation documents related to operational issues, workflow processes and change management; and
- Creation of a centralized Canadian receptacle of best practices (e.g., website, conferences) or learning opportunities to support the development of a comprehensive framework for integrated care.

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