Canadian Executive Council on Addictions
Conseil exécutif canadien sur les toxicomanies

On the Integration of Mental Health and Substance Use Services and Systems: Summary Report

Brian Rush[1]

Barry Fogg[2]

Louise Nadeau[3]

and

April Furlong[4]

December 18, 2008

[1] Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health
[2] Manitoba Addictions Foundation
[3] Département de psychologie, Université de Montréal
[4] Consultant, Centre for Addiction and Mental Health

Introduction

Historically, the design and deployment of publicly funded human services (e.g., health, social, education, corrections) has been compartmentalized. Over time, however, the complexity and overlap of people's health and social needs has become more evident and called into question the initial separation of many health and social services. A major factor driving inter-organizational collaboration and integration among human services generally is the escalating cost of delivering services, and the need to "rationalize" these services in order to reduce expenditures through enhanced efficiency. Also, the increasing complexity and intractability of a given problem domain contributes to a "reverse pressure" to form various types of inter-organizational relationships and cross-sectoral strategies to better address people's needs.

The co-occurrence of mental health and substance use problems is a case in point where there is a heightened awareness of the challenges in trying to address people's needs through two largely independent systems of services. The additional need for a wide range of health and psychosocial services such as primary care, supportive housing, employment, education and family supports further challenges the delivery of comprehensive and collaborative care to those with co-occurring disorders. The call for integration has been strengthened by the evidence on the high overlap and complex needs of people with co-occurring mental health and substance use disorders. Other factors, less clearly articulated, are also likely to have been at play, such as the trend toward more individualized services; advances in information technology facilitating sharing of information; competition across prevailing models of treatment and support (e.g., bio-medical, psychosocial rehabilitation, recovery), and as noted above, factors aimed at containing costs and increasing efficiency.

Given the 'call for integration', and the scope of some integration strategies, it has become increasingly equally important to assess the risks of various types of integration for the large segment of the population that do NOT have co-occurring disorders. It is also important to consider potential benefits and risks associated with certain types of integration of mental health and substance use services within the context of the broader health and social service system(s). In short, it is important to ask if we are focused on integrating services at the "right" level and for the "right" people. Finally, it is important to note that no clear consensus has emerged regarding what "integration" actually means, either theoretically or practically, nor is there agreement on the "business case" for better integration across these two sectors.

Our objective in this paper is to identify key facilitating factors, challenges and other issues that we believe can inform discussions about closer integration, or actual integration processes. We briefly summarize the national context in Canada for working towards improved integration. We conclude with suggestions for a more cautious, targeted approach to integration activities and strategies and with a call for more evaluation and sharing of lessons learned across Canada. We also offer some suggestions for additional environmental scanning and research that we feel can build upon our deliberations here.

Rationale for Integration Based on Co-occurring Disorders

The rationale for integration of mental health and addiction services is strongest when presented in relation to the target population with co-occurring disorders; especially the narrower and more clinically severe sub-group. Indeed, the research literature and academic and lay arguments for integration typically draw attention to the high overlap in the two populations, and then proceed to emphasize the impact on treatment and support outcomes, and the challenges for people with co-occurring disorders navigating two disparate systems of services. Integration-related solutions are then proposed or summarized with varying degrees of emphasis given to program versus system-level integration strategies.

Health Canada (2001) defines the population with co-occurring disorders as "*those people who are experiencing a combination of mental/emotional/psychiatric problems with the abuse of alcohol and/or another psychoactive drug.*" However, the term "co-occurring disorder" belies the many combinations and permutations of mental and substance use disorders, as well the co-occurrence of these disorders with a wide range of physical health challenges. Overuse of the term "co-occurring disorder" may actually detract from a much-needed focus on sub-populations and problem severity, especially as these relate to the need for differential treatment and integration strategies.

With co-occurring disorders, the dimension of time is also critical. Both a cross-sectional perspective (i.e., the implications of co-occurrence in the immediate past) and a life-course perspective (i.e., the implications of co-occurrence over the lifetime) are important when considering the role of co-occurring disorders in the discussion of better integrated mental health and substance use services. From many perspectives, the *current* overlap of problems is the most relevant, for example, in working with a client to develop treatment and support plans and strategies for program retention. Systems-level integration needs to be sure to consider the trajectories of co-occurring disorders over the life course, for example, integration of prevention and early identification services.

The overlapping populations: The overlap between mental and substance use disorders is much higher in clinical samples compared to the general population. The most recent cross-sectional population surveys in both the US and Canada show that co-occurring disorders are the exception rather than the rule among those with mental or substance use disorders (e.g., about 15% to 20% among those with substance use disorders). This contrasts with an overlap between 70% and 80% for people in substance use treatment. Recent research in Ontario suggests the degree of overlap among people being served by the overall mental health system is around 20%, but also that this differs markedly for different types of services and demographic sub-groups. It is important to keep in mind that the degree of overlap tells only part of the story regarding co-occurring disorders – even a small percentage of people with co-occurring disorders can present many challenges and costs to the system in meeting their needs. However, it is also important that people using the epidemiological and clinical data be explicit in their choice of sub-populations and data reporting methods and how these data support various integration activities and strategies.

Experiences accessing services: People with co-occurring disorders are more likely to seek care, accounting in large part for the higher prevalence of co-occurring disorders in mental health, substance use, and more generic health care services. This higher utilization translates into higher health care as well as costs in many other sectors (e.g., welfare). That said, a very significant percentage of people with co-occurring disorders do not seek any help at all and those that are engaged with community services are more likely to report inadequate and unsatisfactory treatment and support.

Several studies have reported on the significant systemic, administrative, knowledge-based and attitudinal barriers to optimal care for people with co-occurring disorders. Treatment outcome studies in both sectors consistently report the negative impact of co-occurring disorders on treatment retention and effectiveness.

Services-level integration: Integration at the clinical, services-level has come to mean *both* integrated single-site, treatment teams and collaborative partnerships across more than one provider. The best evidence exists for the single-site model but this is probably because it has been more thoroughly studied. The evidence generally points to the value of integrated clinical services for people with co-occurring disorders, although two new research syntheses suggest a cautious approach is warranted. There is a need for more research on integrated treatment that is strategically targeted at different sub-populations and severity levels.

Integrated treatment at the services-level is probably not necessary for all people with co-occurring disorders. To the extent that some people with mental health problems benefit from traditional single-focus substance abuse treatment, and vice versa, also suggests that integrated treatment needs to be targeted at specific sub-populations who will benefit.

Systems-level integration*:* In addition to services-level integration, where the focus is the individual and his/her family, systems-level integration focuses on structures and processes that are aimed at groups of people with co-occurring disorders and that ultimately support integration at the services-level. Some of these supports are concerned with ensuring an adequate resource base is available for high quality service delivery, as well as ensuring cost-efficient administrative operations such as human resources, information technology, procurement and the like. Other systems-level supports and strategies are more directly linked to improving services for clients and their families, examples being cross-training and credentialing; policies and procedures for accessing services; joint planning; e-health initiatives that support and safeguard the transfer of client information; and performance indicators and other types of quality improvement processes.

It has proven challenging to link systems-level integration activities and strategies to improvements in client health outcomes and there is a real shortage of studies at this level specific to the integration of mental health and substance use service systems. The most comprehensive review of systems-level integration in the mental health field generally found that integration strategies were positively and consistently related to improved *intermediate* outcomes related to continuity-of-care. Systems-level integration seemed to be more effective when characterized by stronger management arrangements, fewer service sectors involved and system-wide implementation of intensive case management and centralized access to services. Thus,

there is some evidence supporting systems-level integration if it is targeted, relatively circumscribed and focused on client access and navigation. Much more work needs to be done at the systems-level, and recognizing the many types of systems-integration activities sub-populations that may or may not benefit.

Strategic supports for integration**:** In the United States supports for both services-level and systems-level integration activities have been strategically implemented (e.g., by the Substance Abuse and Mental Health Services Administration (SAMHSA)), thereby acknowledging the reality that integration doesn't happen simply because someone says it is important. Indeed, since the literature on co-occurring disorders is consistent in pointing out that the two service systems are separated by deep historical and cultural barriers, it should come as no surprise that considerable support would be required to bridge these two worlds. Data are not available at a national level in Canada to say with confidence what technical and other supports for improved integration have been put in place in the various provinces and territories.

Paralleling best practice reviews in other jurisdictions, the 2001 Canadian best practice report on co-occurring disorders brought the needs of this population to the fore and served as a catalyst for many initiatives aimed at improving integration at the services and system levels for this population. Some examples of current supporting initiatives include the Mental Health Commission; the new National Treatment Strategy for substance use services and supports; the Drug Treatment Funding Program within Health Canada; and initiatives underway to review treatment services within the National Native Alcohol and Drug Abuse Program.

Summary: Although there are probably many reasons underlying the current movement towards improved integration of mental health and substance use services and systems in Canada the rationale has been most overt and evidenced-based with respect to improving access to, and effectiveness of, services for people with co-occurring disorders. The argument remains sound although the population-level and clinical-level epidemiological data call for a more targeted approach and a better recognition of the nuances of the data for different sub-populations. Similarly, the data concerning the added-value of integrated services and systems could most certainly benefit from more evaluation, and again from more focus on sub-populations based on severity and demographic characteristics.

Integration Models

There are many ways of conceptualizing and describing "integration" and the following is a list of some but not all approaches in the literature.

- *Integration as a hierarchy of levels*: These have variously been described as integrated treatment, integrated programs and integrated systems. Some confusion has existed around the use of the term "systems evaluation".
- *Integration as vertical or horizontal processes and structures:* These are commonly used in the planning of integrated health systems but not commonly used to describe various integration options for mental health and substance use services and systems.

- *Integration as a "tiered model":* The tiered model of a system of substance use services and supports that is embodied in the National Treatment Strategy contains many features of vertical and horizontal integration. While the model provides a solid conceptual foundation for the integration of mental health and substance use services and systems, it also advances a broader vision for more collaborative and integrated care with many other service systems as well.
- *Integration as a continuum:* Integration relationships can be conceptualized along a continuum such as networking, coordinating, cooperating, collaborating and integrating, with a focus on the degree of different domains, such as level of trust.
- *Integration as partnership:* Integration in the partnership literature may refer to "alliances", "networks", "collaborations"; "cooperation", "joint working" and "integration". It is widely accepted that partnerships move through various stages and exist on a continuum of *breadth* and *depth*.
- *Integration as continuity-of care:* The literature on continuity-of-care calls for better coordination across multiple systems of treatment and support systems and over time. Literature in this area also asserts the importance of provider and consumer perspectives in the assessment of continuity-of care and provides useful measures for evaluation integration activities and strategies.

Given the range of concepts and terms, clear definitions and models are required to facilitate planning and evaluation of relationships between the two service systems. The distinction between services-level integration and systems-level integration is compatible with each of these various models and critical for future planning and evaluation.

There are three areas of research and knowledge exchange that have been under-utilized in past work on the integration of mental health and substance use services and systems. These are (a) the literature on the integration of mental health services and systems within the broader health system; (b) inter-organizational network theory; and (c) systems theory, in particular complexity science and complex adaptive systems.

The Integration of Mental Health and the Broader Health System

Strong arguments can be made that, rather than focus on the integration of mental health and substance use services and systems, a more appropriate use of expertise and resources would be devoted to better integrating mental health and substance use services and systems AND health services generally, in particular primary care. Some of the more cogent points for consideration follow.

- It is widely recognized within the respective research literatures on substance use and mental health that physical co-morbidities are extremely common.
- Contact with health services is common to both areas and epidemiological and health services research data also consistently show that for both mental and substance use disorders the primary care physician is the "front line".

- Physical health problems get insufficient attention in both substance use and mental health services. Conversely, substance use and mental health problems are under-detected in health services and this negatively impact outcomes.
- Integration of many specialized services with primary care is a topic of high interest and research.
- Discrimination and stigma are shared challenges in accessing services in the health system.
- The need is recognized in both areas of mental health and substance use for better integration with the larger health system.

Systems and Inter-organizational Network Theory

Systems theory teaches us that the process of change inherent in moving toward better integrated services at the individual and systems level is context-dependent and likely to be non-linear and non-controllable. Systems-related ideas also inform us that real and sustainable change is built from the bottom up and that the most important role for high-level "big world" systems integration is to support the individually focused and "small-world" integration processes that begin with individual clinicians, caseworkers and program managers. Systems evaluation typically draws on mixed evaluation methods that go beyond linear logic modeling, causal-based statistical methods and emphasize contextual factors in the interpretation of data, for example, on the processes and outcomes of integration.

These lessons learned from systems theory are consistent with many of the ideas and methods contained within inter-organizational network analysis. Network theory elucidates the factors that underlie the development of naturally formed networks, therefore, providing guidance to understanding costs and benefits of integration from different perspectives. The methods of network analysis also aid in mapping out, understanding, and quantitatively measuring the kinds of relationships involved in delivering better outcomes for individuals with mental health, substance use and co-occurring disorders.

In discussing the epidemiological data on co-occurring disorders, we emphasized that the degree of overlap between mental and substance use disorders varies substantially across various sub-groups. It is likely that both formal and informal inter-organizational networks evolve around the provision of services to particular sub-populations (e.g., young males with high criminal justice involvement; women with histories of trauma; people who are homeless, living in extreme poverty and severely marginalized). Network analyses conducted in the area of chronic disease prevention suggests that it is within these smaller, more circumscribed service delivery "cliques" that the concept of "integration" may be the most meaningful and translated directly into improved client outcomes.

Lastly, network theory helps us to articulate the potential value of different types of networks. In underscoring the importance of the 'broker' role in the dynamic network model we are reminded that the potential added-value and sustainability of a network approach does not just "happen" – it requires facilitation and strategy to maximize the potential.

Summary and Conclusions

What we set out to accomplish: Our objective in preparing this report was to raise awareness of several important issues and key data relevant to the integration of mental health and substance use services and systems, and of particular relevance to the current Canadian context. In the process we anticipate this will contribute to more informed discussions and concrete planning and policy development with respect to integration. In "taking stock" of the issues we have been: challenged to describe the types of integration strategies that have been tried and/or planned due to the lack of synthesized information on Canadian experiences; we have marshaled new data on the epidemiology of co-occurring disorders in Canada; given an update of the literature on integrated treatment at the services- and systems-levels; and brought forward some new ideas from other areas that we think should contribute to the deliberations about the integration of mental health and substance use services in Canada.

"Siloed" systems and "siloed" research and development*:* The topic of mental health and substance use integration parallels a wider discussion, and a much wider research and practice literature, on the integration of mental health and health services generally. We feel that this larger literature and practice experience concerning health and mental health holds 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.

The rationale behind the movement for integration: This report has traced the rationale and enthusiasm underlying the call for improved integration of mental health and substance use services and systems. While it is apparent that much of the push for integration comes from the literature and expert opinion with respect to co-occurring disorders, we reiterate here that there are likely many other factors also at play, but which remain largely unexplored and undocumented (e.g., 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). We suggest that there are many types and levels of integration, some of which are of very high relevance to people with co-occurring disorders (e.g., integrated clinical teams; cross-training). Other levels and types of integration are much broader in scope and will clearly be of high relevance to all people with mental and substance use disorders (with or without co-occurring disorders). The best example of the latter would be the high-level organizational and structural merger of mental health and substance services and/or systems.

We suggest that 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. On the one hand, we argue for a broader perspective and call for planners and administrators to ensure there is a net benefit of integration activities and strategies for those with co-occurring disorders as well as those with mental or substance use disorders but not both. On the other hand, we also advocate for a much more targeted and strategic approach 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*).

The current Canadian situation in relation to the larger field: In many respects the present report can be viewed as a "follow-on" document to the 2001 Health Canada report on best practices for concurrent disorders (Health Canada, 2001). Since the release of the Health Canada report, progress has been made in understanding the community and clinical epidemiology of concurrent disorders. There has also been more research, and more research syntheses, focused on the effectiveness of integrated treatment at a clinical, programmatic level.

We now have our own pan-Canadian data on the prevalence of co-occurring disorders in the general population. Although better data on treatment populations have also been forthcoming, more information on clinical sub-populations is needed in jurisdictions across Canada. Canadian researchers can continue to contribute to the larger published literature on the effectiveness and cost-effectiveness of integrated versus non-integrated treatment services (single-site or multiple-provider) as well as explore unique Canadian issues (e.g., the needs of First Nation, Inuit and Métis populations for culturally appropriate treatment and support; partnership models unique to our system of universal health care such as family health teams, and services appropriate to our mix of urban/rural/remote and immigrant/non-immigrant populations).

However, it is at the systems-level where the research and development gap is most glaring. 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.

A major difference of critical importance between the two sectors: In substance use services, co-occurring mental health problems appear to be the rule rather than the exception, and the opposite seems to be true for mental health services where high rates of overlap are restricted to certain sub-populations. The implications of this for integration-related issues need to be more fully assessed in relation to services-level screening and assessment. At the systems-level, it is likely that the motivations for better integration will be different, for example, mental health services may be more likely to seek support with selected, high need cases, while the substance use sector may be looking for broader kinds of support and more internal capacity building. We offer these few ideas simply to spark further dialogue and analysis about varying motivation for integration within the two systems and how that may or may not be related to the prevalence and profile of people with concurrent disorders encountered in the respective systems.

The role of problem gambling: We have not devoted attention here to the important issues and challenges that arise for the integration of mental health and substance use services and systems due to the overlap and treatment challenges associated with problem gambling. There is no

shortage of population-based and clinical epidemiological data showing the close relationship between problem gambling, substance use disorders and a wide range of mental disorders. Treatment for problem gambling is now essentially integrated into substance use service systems across Canada and the involvement of mental health services is not well-understood. Given the epidemiological data and other clinical research data on treatment outcomes, it is probably time to consider the full spectrum of co-morbidities, including problem gambling, in the discussions about integrated services and supports.

***Back to the future with respect to terminology*:** To achieve consistency of terminology we suggest the term "*services-level integration*" be used 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. This term should apply whether these services are provided by one clinician; a team; a program; a multi-program organization; or multiple, independently operated programs or organizations in the community. In the end, what services-level integration strategies must share are common messages, consistent policies regarding access and program participation, common treatment, support and continuing care plans at the individual level, and shared information (with the consent of the person being treated/supported).

Integration at the services-level is distinct from a second level, namely "*systems-level integration*". 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. Governance/administrative integration may be helpful in securing an adequate resource base for high quality service delivery, and this may be a critical but understated goal of integration. Governance/administrative integration also typically aims for improved cost-efficiency in administrative operations such as human resources, information technology, procurement and the like. Other systems-level integration activities and strategies are more directly targeted at improved services for clients and their families, examples being cross-training and credentialing; policies and procedures for accessing services; joint planning; e-health initiatives that support and safeguard the transfer of client information; and various quality improvement processes. This latter group of system supports have in common, or at least *should* have in common, a clear and unequivocal link to improved access to services, continuity-of-care, and more cost-effective treatment and support offered to people seeking help.

A logic model articulating the link between these systems-level activities and strategies is essential for good planning and evaluation of outcomes. It is important to recognize that integration strategies with a strong governance/administrative component must attend to the concrete supports required for integrated services that benefit clients and their families. It is equally important that integration efforts that are being driven more from the bottom-up ensure they have adequate leadership and resources to make and sustain improvements in integration at the services-level. Top-down or bottom-up is probably not an either/or choice, but rather how best to achieve the right balance for the right organizational and community context.

Systems theory, in particular emergence theory and complex adaptive systems, and the study of inter-organizational networks, provide valuable lessons for those wishing to develop better integration between mental health and substance use services and systems. The essential lesson learned is that the formation of effective *networks* (one important form of integration at both the services and systems-levels) is not a linear, predictable process. Further, network formation is a developmental process that is unlikely to be created *only* by top-down administrative decree. Services-level integration strategies between individual clinicians/support workers and community organizations are often focused on particular sub-populations and are likely critical to a successful treatment and support experience for them. Work in other areas provides some evidence that such "small-world" integration is likely to make a larger contribution to client outcome than integration activities more distal from the client (e.g. joint membership on planning councils). The high-level "big world" integration of funding and other administrative processes and structures will be challenged even further to impact client outcomes without strategically supporting smaller scale integration that is, in turn, targeted directly at the individual level.

The importance of evaluation*:* Going forward, we would argue that more emphasis should be placed on program and policy evaluation, since much more evidence is needed concerning integration strategies at the systems-level. While important findings emerge from work on integration in the mental health field generally, surprisingly little has been conducted with respect to mental health and substance use services and systems specifically. Without a strong emphasis on evaluation there is considerable risk of *pseudo-integration,* that is, the development of new structures and processes created in the spirit of improved 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. This suggestion for more evaluation is not meant to downplay the challenges in conducting evaluation on integration-related activities and strategies that transcend individual clinical and program contexts. Although systems-level evaluation is challenging, experience to date in mental health services research and many other fields, show that it is possible if designed and resourced properly. Furthermore, new innovative evaluation strategies drawn from partnership evaluation and other evaluation models such as Realistic Evaluation and Emergence Theory have been largely untested in this area and may prove valuable.

Building upon our two-level distinction as defined above, 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 system-level supports that translate into more accessible, effective and cost-effective treatment and support at the services level. A variety of evaluation models will be required suggesting that a multi-disciplinary, multi-method approach will be advantageous. Whatever evaluation methods are chosen they must be sensitive to context issues (i.e., specifying under what conditions a particular integration strategy "worked"), including a clear description of the population of focus as well as organizational and community culture.

It will also be important to use the idea of "models" of integration quite judiciously. "Models" help to organize one's thinking and specify potential pathways to various outcomes. They are also helpful for categorizing, describing and contrasting alternative approaches. However, model-based planning does not always translate, however, to model-based evaluation strategies.

In other words, the goal of evaluation is not necessarily to search for the *optimal model* (since it will rarely be transferable or feasible to implement with complete fidelity); but rather to search for the most important features of different models that seem to be most helpful in what context.

Since so little information is currently available on the nature and level of integration strategies that have been planned and implemented in Canada, a reasonable starting place for a program of research and evaluation should be to simply catalogue and describe 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.

Attending to workforce development*:* While there are many specific systems-level integration activities and strategies that are worthy of considerable research, the issue of training and education of clinicians and support workers should be high on the list of priorities. This should include identification and assessment of core competencies required to navigate increasingly complex clinical and psychosocial issues that arise in relation to improvements in integration. Core competencies should also be identified for mental health and substance use professionals working in the context of non-specialized services such as primary care, emergency, and corrections services. There are also many other critical issues related to disparity in working conditions and wages across the mental health and substance use service systems; issues of supply in relation to demand; credentialing; job satisfaction and other issues related to workforce retention. In the end, a competent and satisfied workforce will be required to implement and sustain virtually any meaningful services-level integration activity. This is too often forgotten in the discussion of integration "strategy".

Populate a Risk/Benefit Matrix for all integration strategies*:* Our cautionary notes on the literature on the prevalence of co-occurring disorders *at the population level* clearly shows that the majority of people with substance use or mental disorders do NOT have co-occurring disorders. This also seems to be the case for the current mental health system as a whole, where the high rates of overlap are confined to important sub-populations. In addition, it is important to keep in mind that it is not just the size of the overlap that matters but also the degree of severity and complexity of problems since even a small percentage of people can require high intensity and high cost services. Our review of various models and approaches to integration also shows us that there are many different strategies both at the services and systems-level, and again need to be better considered for different sub-populations.

Taken together these observations caution us to be very clear in specifying the benefits AND the potential risks to all those who may be impacted by a given integration strategy, especially in populations where the overlap is not substantive. The table below serves as a potential template for such an assessment of risks and benefits. The three main sub-groups are identified across the top, although this could be further broken down according to the needs of the specific situation (e.g., by gender, by age). It is likely helpful as well to break this down by severity/complexity and undertake the exercise for risks/benefits of integration strategies aimed at primary, secondary or tertiary levels of treatment and support. To support future use of the template we brainstormed a list of potential benefits and risks for the three sub-populations – people with co-occurring disorders, people with mental disorders and people with substance use disorders. The example of

integration as administrative integration/mergers and the list of potential benefits and risks is included in the main report.

Proposed risk/benefit matrix for different types/levels of integration

	Substance Use Disorder Only	Mental Disorder Only	SUD and Mental Disorders
Services-level Integration			
Single-site team approach			
- Risks			
- Benefits			
Multiple-provider approach			
- Risks			
-Benefits			
Systems-level Integration			
Non-administrative			
-Risks			
- Benefits			
Administrative integration/mergers			
-Risks			
-Benefits			

Although such a template would be of value in local/jurisdictional integration processes it would also be informative to incorporate this tool more formally into a national environmental scan with respect to the integration of mental health and substance use services. This would best be done in a series of national focus groups including a broad range of stakeholder perspectives from across Canada to obtain a better understanding of the range of perceptions concerning risks and benefits for various integration options. This could then provide “normative” data with which to contrast results from a local/jurisdictional integration process. Having results available on a national scale could also contribute to the development of toolkits and other tools to counter perceived risks and maximize perceived benefits.

Further explore similarities that can be leveraged: It is important to note that the literature on co-occurring disorders has tended to highlight the differences between the mental health and substance use services and systems – differences that often serve as barriers to effective and more integrated treatment and support. It is important to further explore these differences in the Canadian context since this will help set some concrete targets for improvement at the systems-level. It will also be helpful in considering which if any of these differences are unique to the population with co-occurring disorders as opposed to mental health and substance use separately. Some differences are also deeply rooted in the historical development of the two service systems; individual self-selection into the field; training requirements and organizational/system cultures; diagnostic versus non-diagnostic methods of assessment and the role of medical and psychosocial interventions. These differences will not be easily overcome in situations where more integration is deemed desirable.

We suggest, however, that this focus on differences be supplemented with a more *strengths-based paradigm* that systematically assesses the similarities across the respective services and systems; similarities that can potentially be leveraged 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.

This list hints at an important point raised at a recent video-seminar on the integration issue sponsored by the Alberta Alcohol and Drug Abuse Commission, namely that the actual services and supports delivered within the two service systems are rather similar once you get past significant differences in the approaches used for assessment and determination of the problems to be addressed in a treatment and support plan. Indeed, one might argue that there are more similarities than differences; the similarities perhaps ignored in the face of some of the major attitudinal barriers to working better together.

Maintain a population health perspective: Health Canada has identified population health as a key concept and approach for policy and program development aimed at improving the health of Canadians. A population health approach has two objectives: 1) to maintain and improve the health status of an entire population; and 2) to reduce inequalities in health status between population groups. In so doing, it must take into account a broad range of individual, environmental, cultural and societal factors that effect entire populations. Given the increasing prevalence and burden of disease related to mental health and substance use problems, the population health perspective has particular relevance to any discussions of improving each sector, either individually, or via integration.

Concretely, what are the implications of a population health perspective for integration of mental health and substance use services and systems? Interestingly, we think this question has never really been asked before.

Firstly, we think a population health perspective requires that we acknowledge the full range of health problems experienced by people with mental health and substance use disorders. The focus of past analyses of population data here in Canada has been on mental health and substance use and much more needs to be done to explore and assess the implications of co-morbidity with other health problems. If the data mimic the complexity seen in clinical samples—and there is every indication the information will—it will argue persuasively for a broader approach to service and system integration than mental health and substance use specifically. In particular, it will point to the need for closer integration with primary care services in order to truly address the full range of needs. However, there is likely to be an ongoing and important role for

specialized mental health, specialized substance use, and even specialized co-occurring disorder services to provide treatment and support to people experiencing the most severe and complex problems. This is a key message embedded in the quadrant model as well as the tiered model advocated in the new National Treatment Strategy. Both are consistent in pointing the way to a strong role for primary care and other health services, including emergency departments.

As helpful as the quadrant model has been in past planning efforts for integration of mental health and substance use services and systems, our collective thinking on integration might be advanced if it was clearly acknowledged that the ***size*** of each quadrant depends on the population in question. The same holds true for the relative size of the population appropriate for consideration in each tier of the tiered model. Considering the quadrant model for illustrative purposes, and without drawing upon schematics to make the point, the general population data on co-occurring disorders would suggest that the number of people in the "low-low" quadrant is much higher than in the "high-high" quadrant. This argues for systems-level strategies with a more "upstream" focus such as case-identification, brief intervention and referral. Also recognizing the trajectory that many people take *across* the various quadrants through the life-course places more emphasis on primary prevention.

Once the lens shifts to the population currently engaged in treatment and support services, the relative size of the "high-high" quadrant grows significantly and the focus must be on tertiary interventions, including comprehensive assessment of case complexity and appropriate consultation or referral for specialized services. Again a trajectory, life-course perspective calls for adequate supports to help with the transition to lower intensity services and maintaining a good quality of life.

These ideas embody the population health perspective and articulate the essence of both the traditional quadrant model for co-occurring disorders and the tiered model of the National Treatment Strategy that is much broader in its vision. These ideas also point to a glaring lack of longitudinal population-level data that would help us understand the trajectory of people with mental and substance use disorders and, therefore, the degree of overlap from a life course perspective, as well as a better understanding of the severity of the disorders and the links between the onsets at different points in time. Such data would probably show a much higher degree of overlap than is evident in cross-sectional studies as people transition in and out of mental and substance use disorders, and also speak to the need for upstream interventions that could benefit from closer integration of mental health and substance use services and systems.

Closing thoughts*:* In closing, we trust this report has offered "food for thought" to assist in deliberations on the integration of mental health and substance use services and systems. We hope it proves useful in de-briefing on past integration experience and offers concrete support for integration efforts currently underway, or being considered. Lessons learned from the past have been difficult to identify, hence the strong recommendation for much more evaluation and knowledge exchange. We also recognize that our report offers more in terms of the "why's" and "what's" of integration and rather little in terms of the "how's". Our essential conclusion is that the "integration train" has left the station for a wide variety of reasons, and that 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 also suggest that, collectively, we work to avoid the "integration reflex" and pursue it more thoughtfully and strategically that has been the case in some situations in the past. It is also 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, are going to 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.