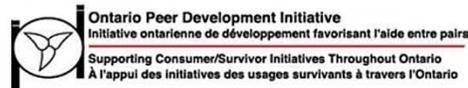




Addressing Integration of Mental Health and Addictions

Discussion Paper Submitted to the Select
Committee on Mental Health and Addictions

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How should the Government of Ontario's Mental Health and Addictions Strategy Approach the Issue of Integrating Mental Health and Addictions?

A discussion paper from Addictions Ontario, the Canadian Mental Health Association Ontario, the Centre for Addiction and Mental Health, the Ontario Association of Patient Councils, the Ontario Federation of Community Mental Health and Addiction Programs, and the Ontario Peer Development Initiative.

Our six organizations have worked independently and collaboratively to ensure a consumer focused mental health and addictions system in Ontario, and to strengthen the broad range of supports for clients, families and communities affected by these problems. Our organizations welcomed the Government of Ontario's commitment to a mental health and addictions strategy, and we offer the following perspective on how the Government's strategy can better *integrate* care for those individuals and their families that need supports.

In 2008, the Provincial Government committed itself to the development of a 10-year mental health and addictions strategy. The Minister of Health and Long-Term Care established a Minister's Advisory Group (MAG) of consumers, families, providers and researchers to provide advice on the development of the strategy. In parallel, the Ontario Legislature created an all-party Select Committee on Mental Health and Addictions to consult with consumers, families, providers and experts on the current needs and ways to improve the mental health and addictions system. Input from both committees will be used to develop a long-term strategy for mental health and addictions. It is evident from the work to date that integration is a central theme to the emerging strategy.

What is integration?

While there has been much discussion around the integration of the mental health and addictions system there is no single definition or policy direction put forward (Rush, Fogg, Nadeau & Furlong, 2008). There are many different types and levels of integration. Each type of integration can lead to quite different solutions and require different policy, governance and operational responses. Without a clear vision of what is required, the opportunity for success is compromised.

What does the integration of mental health and addictions *look like*?

Integration can be defined as "*Actively managing all elements of the continuum of health and care services required by individuals and communities in order to achieve a seamless care pathway for the individual or client group* (NHS, Dept. of Health, 2001)."

Integration of mental health and addiction services takes place at different levels:

Integration can (and should) take place at the policy level to ensure that eligibility criteria, financial incentives, workforce requirements and the like are in place to support the other forms of integration that can be implemented. Of great importance is that integration improves the ability of service providers to meet the needs of their clients/consumers in

a coordinated, cost-effective, evidence-based and accessible manner. Client-centred integration can occur at the clinical level, organizational level and service delivery level. There is no single answer to how integration should occur. As noted in the above definition, it is about building a continuum that is needs-based and is actively, not passively pursued. Collaboration, alliances, partnerships, and other mechanisms can and have been used effectively in both the public and private sectors. While organizational solutions (e.g. mergers) are often looked upon as ‘the solution’ it is only one possible approach. Moreover, consumers should have a say in the planning, coordination, implementation, and evaluation of these choices.

As the path to integration is pursued, a key decision will be whether the goal is organizations that are integrated either horizontally or vertically. Horizontal integration brings together “like” operating units as one organization, system network or other arrangement. Vertical integration brings together all or part of the production process (continuum of care) under one organization, system network, or other arrangement.

Another key question to be addressed is whether the goal is integration of mental health and addictions services or integration of mental health and addiction services within the broader health system. If the former, is it all mental health and addiction services or those that serve individuals with overlapping needs – concurrent disorders? Finally, there is a need to consider what is most important to achieve – client service integration (clinical integration) or service delivery integration (functional integration).

What can be accomplished by better integrating mental health and addiction services?

There is a wide range of clinical, sociological and cultural factors that bring the fields of mental health and addictions together. Mental health and addictions are both rooted in a complex and variable combination of biology, genetics, and life experience – particularly exposure to stress and trauma. This means that many of the clinical approaches used to treat mental health problems and addictions are the same. In both areas, there is strong emphasis on the continuum of care - an integrated and seamless system of settings, services, service providers, and service levels to meet the needs of clients or defined populations - and the need to support individualized treatment within this continuum. But the single most compelling reason to promote greater integration of mental health and addictions services is to improve the health of people who experience mental health and/or addiction problems.

There are three main areas of benefit in an integrated mental health and addictions system: continuity of care, coordination of services and efficiency. Both continuity of care and coordination of services should lead to better client experience and clinical outcomes. Clients’ experience with an integrated system should improve as a result of more streamlined and coordinated service delivery. Clients would have better continuity of care and be less likely to fall through the cracks. An integrated system should lead to better clinical outcomes due to more of a focus on prevention, better service provider coordination of client information as well as additional opportunities within the system to share information. Efficiencies would occur in two ways, better client outcomes should lead to lower hospitalization rates and use of acute services and the sharing of organizational resources such as human resources and information technology supports. It should be recognized that the report prepared for the Minister of Health

entitled “On Becoming Best Friends” found that efficiencies through back office integration and or mergers was minimal at best within the community based system.

Finally, we should acknowledge that integration of mental health and addictions will allow each system to learn from the other. The Ministry’s Addiction Housing Initiative is a good example. For both addiction and mental health problems, the provision of appropriate housing and social supports are key elements in the recovery of our clients – as well as a significant protective factor. Both mental health and addiction clients benefit from a common approach that addresses all the social determinants of health. When the Ministry announced its intention to support housing for people with substance use problems, the expertise of mental health supportive housing was relied on extensively. In fact, this initiative fostered a number of fruitful collaborations between addictions and mental health providers in communities across Ontario.

What does integration of mental health and addictions not accomplish?

Improved integration of mental health and addictions services is no panacea. Many people with mental illness and addictions – and particularly those with concurrent disorders – will require a range of health and social services, so it is unlikely that one system or care or service could ever encompass all their needs. Coordinated access and case management will still be required; of particular importance are the physical health needs of those who often have limited access to primary care.

Since integrated mental health and addictions care should improve client experience and quality of care, it is likely that there may be reduced need for re-hospitalization. Service and organizational integration may reduce some administrative expenses. But it must be emphasized that such savings would not be of the magnitude required to address significant service gaps and the overall need for greater capacity in the system. It would be misguided to rely on integration to fund significantly greater access to care for the entire system.

What can the Ministry of Health and Long-Term Care do to promote meaningful and effective integration of mental health and addictions services?

Currently in Ontario, there is no provincial strategy or framework to guide this process of mental health and addiction integration. There is uncertainty about what integration should look like and how it should be achieved. That is why our organizations recommend a provincial policy framework to guide the integration of mental health and addiction services.

Such a framework could provide guidance to LHINs and service providers on the key objectives of integration, and what general principles should govern integration efforts. We can recommend the following principles to govern integration efforts:

1. The primary objective of greater mental health and addiction service integration is improving the client experience and the quality of care.

The goal of integrating mental health and addictions services is to improve the experience of clients. People with both mental health and addiction problems often receive inadequate care; they report high levels of dissatisfaction with the care received, and difficulty in navigating a system of supports. Canadians with concurrent disorders are more likely than any other category of substance users to seek care (Ross, Lin & Cunningham , 1999), yet are four to seven times more likely to report unmet need than those who have one of a mental health or substance use problem (Urbanoski et al. 2007).

Given what we know about the experiences of those with concurrent disorders, the underlying objective should improve access to and the quality of services for those with both mental illness and addictions. Administrative integration can be successful, but even the smoothest administrative collaboration is no guarantee of improved services. There are examples of successful integration across the mental health and addictions domains that have improved integration and strengthened relationships. But improved service for those with co-occurring disorders does not necessarily follow. The tools for improving services are predominantly practical ones relating to assessment tools and service system collaboration. A reduction in the number of community support agencies will not necessarily improve clients' experiences. The success of integration should be assessed based on the experience of clients, not planners.

2. Local Health Integration Networks should facilitate local innovation, building on local relationships.

In the last few years, as the Local Health Integration Networks (LHINs) have become operational, there has been much attention paid to integration. The mental health and addictions system is under increasing pressure to coordinate and integrate services through partnerships and networks. Every LHIN is addressing addictions and mental health and 13 out of 14 LHINS have named it a priority within their Integrated Health Service Plans (IHSP). In focusing exclusively on integration, access issues and service gaps are not consistently addressed within all LHINs. Barriers to access are sometimes underestimated and, in relation to marginalized groups, often missed.

Community level coordination and planning is critical so that health care services address diverse client needs and community priorities. Since these needs and priorities are unique to each community, solutions to local community challenges cannot be effectively determined at the level of system planning. These solutions are best achieved through the engagement of health service provider agencies and client/consumer groups at the community level. Together they will determine what mechanisms are required to support each other and clients across the full continuum of care and to ensure that a vision of seamless client transitioning can be achieved. LHINs should have the flexibility to provide funding to support integration where the case can be made that integration will improve client care and the goals of provincial frameworks, strategies and policies are met.

It is important that the LHINs support agencies with collaborative efforts to integrate services. The tools for improving service depend on local people developing strong local relationships. It is critical that LHINs demonstrate an understanding of the importance of involving consumers, families and service providers in the planning, delivery, and evaluation of services.

3. There are significant health human resource considerations to all efforts at mental health and addictions integration, and these must be considered.

The workforces of the mental health and addictions systems, even within the same community, are typically quite distinct in education, accreditation, and remuneration. Good faith efforts to integrate services – particularly at the organizational level – can be challenged by the difficulty of reconciling human resource issues. LHINs must have the tools and resources to address this issue as they facilitate and support integration at the local level.

4. The involvement of people with lived experience must be enhanced and protected.

An integrated mental health and addictions system requires the involvement of people with lived experience in the planning, delivery and evaluation of a service system intended to meet their needs.

This includes the recognition that peer support is an integral component of a comprehensive basket of services. One notable example is Consumer Support Initiatives (CSIs). CSIs are self-help groups, alternative businesses or support services run by people diagnosed with mental illness, for people diagnosed with mental illness and based on the principles of inclusiveness and recovery. The growing international evidence-base on peer run initiatives demonstrates that they reduce hospitalization and 'symptom' distress as well as increase quality of life and social networks.

With respect to addictions, there are few peer support initiatives for people with addictions in Ontario and this gap needs to be addressed.

The governance of peer-operated organizations is critical to their efficacy. For example, CSI organizations should not be merged with other organizations in the name of integrated service. Peer run initiatives should have the same status and resources as other provider groups including, where required, training in substance abuse. Successful peer run initiatives should be encouraged to create equitable partnerships in order to meet the needs of their clients.

In addition to a provincial policy framework, the Ministry of Health and Long-Term Care should continue to strengthen system-wide integration of mental health and addiction services.

A goal of an integrating mental health and addiction services is that people in Ontario will have access to the best mental health and addiction services in their communities, supported by widely shared research findings and best practices. Information management systems to support the collection and use of system-wide data by LHINs and other parts of the health system is a critical component of mental health and addiction services and can facilitate the integration of a mental health and addiction system.

The province has made steps in the right direction by supporting or developing key collaborations and initiatives that strengthen the system integration of mental health and addiction. These include:

ConnexOntario Health Services Information, funded by the MOHLTC, provides access to alcohol and drug, gambling and mental health services for the people of Ontario. Besides being available 24-hours/day to those needing help, Connex provides data to service planners seeking access to quality health and human resource services information.

10-Year Provincial Mental Health and Addictions Strategy –The government's strategy paper "*Every Door is the Right Door*" cites that because mental illness and addictions are so closely linked, mental health and addictions services must be integrated.

Knowledge exchange – Ministry supported knowledge exchange provides an opportunity for communication between researchers, consumer/survivors, families, service providers, and decision-makers to exchange research, knowledge and experience. This must encompass both mental health and addictions, since learning together will help integrate the two workforces.

Ontario Common Assessment of Need – Mental health stakeholders have worked to develop a common assessment instrument. Explorations to determine the appropriateness of a similar, extended instrument encompassing addictions should be supported.

Conclusion

In the past, the treatment of mental illness and addiction has often been relegated to distinct systems of care, particularly for those with the most severe and persistent problems. Yet we have painfully learned that separating these problems from each other – and distinguishing these services from the rest of health care – works against the interest of building a strong system of care. More importantly, it works against the interests of those with mental health and addiction problems, who have demonstrated a capacity for recovery and community participation that would have been difficult to imagine a generation ago.

Collaboration amongst sectors can facilitate delivery of the 'right services' by the 'right people' at the 'right time', and thus reduce the risks and impacts of the many other health conditions associated with addictions and mental illness.

The evidence is clear that integrated support for people with co-occurring mental and substance use disorders are more effective than non-integrated treatment and support. A successful plan to improve the integration of mental health and addictions must improve the experience of clients – both those with co-occurring disorders and clients with only mental health or addiction problems. Methodical and deliberate service integration must be focused on the experience of clients, and its most successful champions must be clients and service providers at the local level.