Co-occurring mental health and addiction disorders: The elusive path to integrated care

Avra Selick, Mary Wiktorowicz
Centre for Addiction and Mental Health, Toronto, ON M4N 2A1, 'Health Policy and Management, Faculty of Health, York University, Toronto, ON M3J 1P3, Canada

ABSTRACT

Background: Co-occurrence of mental health and addictions disorders occurs at a high rate, posing significant costs to affected individuals and society if left untreated. Although decades of research and policy reports have argued the necessity of integrated mental health and addiction services to effectively treat this population, it appears as though relatively little integration has been achieved.

Methods: This exploratory study used key informant interviews to investigate the current state of integrated treatment in Ontario, Canada, potential models for integrated treatment and barriers to their implementation. Interview transcripts were analyzed inductively, and thematic analysis used to identify emerging themes.

Results: Five domains were identified: organizational barriers, system barriers, historical barriers, barriers related to stigma and discrimination, and knowledge barriers. A key challenge is the absence of provincial direction and limited evidence on the relative effectiveness of the different integrated treatment models.

Discussion and Conclusion: Insights from interviews with research, policy and provider experts clarify the relevant factors affecting the implementation of integrated treatment in Ontario. In identifying potential models of integration and the barriers to their implementation, further research is required to assess the relative effectiveness of the different integration models and to identify the critical organizational and system factors needed for successful implementation of integrated care. Avenues that merit further exploration are the fields of implementation science and complex adaptive systems.

Key Words: Concurrent disorders, health systems, integrated care, mental disorders, policy

Introduction

Substantial evidence has demonstrated the high degree of co-occurrence of mental illness and substance use. Although rates vary, it has been shown to affect up to 60% of treatment populations with an estimated international prevalence between 1% and 3%. Co-occurring disorders are associated with high levels of morbidity, unemployment, homelessness, poverty, incarceration, social isolation, and mortality. Although these are issues for those singly diagnosed as well, these risks are of particular concern for this population due to higher relapse rates, lower medication adherence, and higher hospital admissions.

From a societal perspective, the inadequate treatment of co-occurring disorders imposes enormous health, social and economic costs.

In Canada, health policy and research have placed increasing focus on this phenomenon, referred to as concurrent disorders. Consistent with international prevalence rates, 435,000 Canadians (1.7%) report being affected by concurrent disorders, and this population...
accounts for a large proportion of those using the mental health and addiction systems. Within addiction treatment services, studies have found that concurrent disorders are often "the rule rather than the exception."[3]

**Integrated treatment models**

Given the high degree of overlap between these two populations, it has been argued that treatment should be offered in an integrated manner; however, remarkably little clarity or agreement has emerged regarding models of integrated treatment. At a basic level, integrated treatment can be distinguished from sequential and parallel treatment approaches, both of which have been largely rejected in favor of integrated treatment. The sequential approach has been criticized for ignoring the interconnected nature of concurrent disorders, and the parallel approach can cause contradictory or incompatible treatment, ultimately leading to poor outcomes.[7,8]

This is where the consensus ends. There is, as yet, little agreement on what integrated treatment should entail. The most commonly presented models of integration are based on building capacity for treating both mental illness and addiction within a single provider or team though the exact mechanism of treatment varies.[9] Evidence on the efficacy of program integration remains mixed although some studies have found reduced substance use and improved psychological functioning.[9,10]

Alternatively, some argue the need for system-level integration that in order for integrated treatment to be successfully implemented, a shift is needed in how mental health and addiction treatment is conceptualized, organized, and funded. Those in favor of system integration argue it will increase system efficiency and effectiveness, reduce program and administrative duplication, and reduce the likelihood of clients being misdirected, misdiagnosed, or lost in the system, an issue repeatedly highlighted as one of the biggest barriers to treatment.[11,12] As long as, mental health and addiction services are funded, and clinicians are educated separately, service provision will likely remain disconnected, and some degree of system-level integration may, in fact, be a prerequisite to achieving any type of systematic treatment integration.

Recently, some have advocated for a broader understanding of integration to include increased collaboration or cooperation between organizations and programs. Proponents of this approach maintain that full integration is unnecessary and increased cooperation between agencies will be sufficient to improve the quality of care.[13] Given ongoing difficulties in achieving full program or system integration, this may be a more achievable goal.

**Ontario's mental health and addiction systems**

Recommendations in the literature regarding integration are reflected in decades of federal and provincial government policies advocating integrated treatment.[14-17] It is unclear, however, to what extent real integration has been achieved in Ontario. Ongoing high levels of unmet need suggest that services are either unavailable or ineffective.[5,18] An environmental scan of concurrent disorders services in Ontario[19] found variable levels of service availability across the province. They conclude that the province has no ability to systematically monitor or evaluate the type, quality, or quantity of services provided, and therefore, the real extent of implementation is unknown.[19] Although barriers and facilitators to implementing integrated treatment have been explored in other jurisdictions, very little research has addressed the issue in Canada.[5]

Given the paucity of research in this field, the aim of this exploratory study was to investigate the state of service integration in Ontario and identify the factors that support or hinder implementation efforts through key informant interviews. The findings provide direction for future research.

**Methods**

Key informants were purposively selected to gain multidisciplinary perspectives from both the addiction and mental health sectors. The final sample included five informants: The chief executive officer of an agency with residential and outpatient addiction treatment services (Service Provider 1); the executive director of an agency offering treatment programs for both addictions and concurrent disorders (Service Provider 2); two researchers who have been intimately involved with the field of concurrent disorders, at both the academic and policy level (Researchers 1 and 2); and the director of an advocacy organization for community mental health and addiction agencies (Advocacy Organization).

Interviews were conducted in July 2012 using a semi-structured interview guide focused on the current state of services for individuals with concurrent disorders, the value of service integration, what integration should look like, and factors that have helped or hindered integration [Appendix 1]. Interviews were conducted in person and by phone, audio recorded, and transcribed. The data were analyzed inductively using a thematic analysis approach.[20] Initial codes were grouped and
synthesized into higher level themes. A second researcher independently analyzed the transcripts and agreement on final themes was reached through discussion. Ethics approval for this study was received from York University.

Results

Integrated treatment: Current state and recommended models

One of the most interesting findings to emerge from these interviews is that respondents were almost uniformly more positive than the previous reports on the state of integrated treatment in Ontario. Most felt that significant progress has been made though they all emphasized the uneven rates of implementation across the province.

When specifying the type of integrated treatment that should be implemented, the informants reflected the confusion in the literature. While some advocated for integration at the team level, others felt that increased co-operation, co-ordination, and communication between agencies were sufficient, especially for less severe cases. Interestingly, two respondents argued against full treatment integration. One explained, "...you can’t have expertise in everything in one place, I actually think that we fail when we do that" (Advocacy Organization). Other respondents also made the point that concurrent disorders are really a large umbrella category and effective treatment models might vary depending on the subgroup.

The answer depends on the severity and it depends on what you mean by integrated. It is very difficult to try to create one big category for concurrent disorders because it is a very diverse population (Researcher 1).

Also raised was the idea that integration should be approached more broadly. Individuals with concurrent disorders often face other health and socioeconomic issues (e.g., medical comorbidities, housing instability, justice involvement) requiring interaction with other sectors. A common perspective among the respondents was that the need for better integration is not limited to the mental health and addiction sectors; models of integration need to incorporate the broader health and social services systems.

...the whole system of care needs to be better co-ordinated and needs to be more seamless. I think that there are substantial issues around system navigation for individuals but I don’t think that they are exclusive to, nor are they increasingly problematic in the areas of mental health and addictions (Service provider 1).

Barriers and facilitators to implementing integrated treatment

Related to barriers and facilitators to implementation, five domains emerged [Table 1].

Organizational factors include factors internal to an organization or agency that impact their willingness and capacity to implement. One internal factor highlighted as critical to successful implementation was strong local leadership.

What it takes at the local level is real leadership. Somebody to say ‘ok we have to do this in the interest of the people and we’ve got to work our way through this’ and in some areas they have been really successful (Researcher 1).

Also raised was the possibility of ground up resistance from frontline staff as agency mergers can result in job losses. This issue is further complicated by power imbalances between community and hospital organizations which can skew restructuring decisions.

Another barrier is you have hospital based mental health and addiction services, and then you have other services in the community. And the folks in the hospital tend to make more money and they tend to have more powerful unions so blending these organizations, if it is an organization

| Table 1: Domains and themes identified |
|----------------------------------------|
| **Domain**                             | **Themes**                          |
| Organizational factors                 | Strong leadership                   |
| Factors internal to an organization or agency that impact their willingness and capacity to implement | Staff resistance due to job losses |
| System related factors                 | Insufficient funding                |
| Factors external to the organization operating at a broader system or policy level | Opportunity for cost savings due to efficiencies |
| Historical factors                    | Lack of provincial direction        |
| Factors related to the historical segregation of the mental health and addictions systems | Different values and treatment philosophies |
| Stigma related factors                 | Different credential and educational expectations |
| Factors related to the presence of stigma | Contradictory best practices       |
| Stigma related factors                 | Stigma among service providers      |
| Factors related to current knowledge gaps | Stigma among policy makers          |
|                                        | Internalized stigma among individuals with concurrent disorders |
| Knowledge factors                      | Lack of common definition or terminology for concurrent disorders |
| Factors related to current knowledge gaps | Lack of evidence on effective integration models |
|                                        | Lack of evaluation of current programs |
|                                        | Lack of common information systems  |
integration, it’s complicated by unions and who has seniority (Researcher 1).

System-related factors are external to the organization operating at a broader system or policy level. Insufficient funding was raised repeatedly as a significant issue affecting mental health and addiction services in general. The challenge is not just the absence of integrated services; it is often the absence of any services. Some respondents argued rural communities were disproportionately affected, while others felt this issue was pervasive across Ontario.

I think that we lack comprehensive services, the basket of services is not complete anywhere in the province… There is a huge lack of capacity to address addiction and mental health issues in the province of Ontario on every level (Advocacy Organization).

In the larger communities, the mental health and addictions silos are coming together, but in the smaller communities the addictions system is not complete, the mental health system is not complete. Therefore it is very difficult to integrate services when both those systems are themselves incomplete (Researcher 2).

Some argued that addiction services receive even fewer resources within this neglected sector. The theme that “addiction is always the poor cousin of the poor cousins” arose repeatedly. A positive message was that the mental health and addiction field is starting to receive more attention, even if a gap exists for concurrent disorders.

There was some hope that an incentive for systems integration is cost savings through reduction of service duplication and overhead, however, there was scepticism of whether the efficiency argument leads to any real change in practice.

Sometimes I think the economic argument is so powerful that it can’t be ignored, but the problem is that it can be ignored (Service Provider 2).

Informants concluded that the system has changed significantly; however, there remain ongoing distinctions between the fields including fundamental differences in values and treatment philosophies that make integration difficult. For example, one approach to defining concurrent disorders is based on criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM); however, this approach has been critiqued for “medicalizing” the issue, particularly from the addiction sector.

Different credential and educational expectations in the two fields is another issue. While mental health workers have professional degrees, addictions workers historically, did not. This can cause professional tensions and reflects the different values embraced by the two fields.

There is a perception among people who work in mental health, people with professional degrees, that the addictions folks are not professional, they don’t make as much money, and they don’t necessarily have the same professional credentialing… and then addictions people will say ‘well we have real street credibility, we are dealing with the worst of the worst, we go by experience and we get our training and mentorship.’ So it is a bit of a professional debate still that holds it back (Researcher 1).

Expectations of addictions treatment providers are, however, changing and other informants found this to be less of an issue. To the contrary, one addictions service provider noted that most of their staff have graduate degrees.

Differing treatment philosophies also impact practitioners’ ability to care for this population. For example, abstinence-based programs may struggle with how to manage clients on psychiatric medications though informants noted that the field is increasingly moving toward harm reduction practices. In other cases, the best practice guidelines may provide conflicting direction for the two populations and specific guidelines for individuals with concurrent disorders often do not exist.

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Respondents also discussed the lack of provincial direction or unified approach toward implementing an integrated treatment model.

Historical factors include barriers that arose due to the historical segregation of the mental health and addiction systems.

I used to work at the Addiction Research Foundation, and the Clarke Institute [a mental health agency] sat on the same block and as staff people, we were not allowed to go across the street to talk with people from the other institution. That’s how distinct we were (Researcher 2).

Often times the evidence or the best practice models are in conflict with one another. So what might be good for mental illness might be bad for addiction, and what might be good for addiction might be bad for mental illness (Service Provider 1).
One informant argued the situation is even more complex. He explained that there are traditionally two worlds within addictions: Highly educated professional staff and peer workers valued for their lived experience. In mental health, three worlds exist: Psychiatry, which is focused on medication; community services, which are more psychosocially oriented; and the self-help consumer movement. All five of these differing world views need to be reconciled to achieve integration.

You have these three worlds in mental health and two worlds in addictions, and for concurrent disorders you are trying to find your way through this all. One of the challenges to integration is just trying to get these five worlds all on the same page” (Researcher 1).

Stigma was the most common issue raised by the key informants, discussed as existing among service providers, policy makers, and individuals with concurrent disorders. Stigma can cause service providers reluctance to care to these individuals, impact how policymakers allocate funding and reduce help seeking among affected individuals.

[Stigma is] systemic. It’s how funding has been allocated. Why are mental health and addictions services so poorly funded? It’s because there is this stigma and discrimination against it (Advocacy organization).

People who are substance users don’t want to be identified as mentally ill and people who are mentally ill don’t want to be identified as substance users. Nobody wants to be a double dinner winner (Service Provider 1).

Knowledge gaps related to concurrent disorders were emphasized as fundamental barriers. Regarding the definition of concurrent disorders, one respondent remarked, “Well that’s a nice question, it would be nice if the field would define it” (Service Provider 2). Issues still debated include whether definitions should require a formal diagnosis based on DSM criteria and whether behavioral addictions (e.g., gambling, gaming, sex addiction) and tobacco use should be included. Informants argued that without common definitions, it is difficult to even begin the conversation.

The need for more research and evaluation of existing programs was also discussed. Although some integration has been achieved, no evaluation has been completed. A better understanding of what effective treatment for this population looks like is necessary before it can be systematically implemented.

We haven’t really measured the integration process itself and we haven’t measured the outcome of it all so I don’t think we can really speak to the real benefits to patients yet. […] In Ontario there has been a lot going on for a decade but not too much of it has been evaluated (Researcher 1).

Finally, integration efforts are hindered by the lack of integrated or even common electronic information systems for mental health and addiction programs. There is no way of systematically tracking clients across services, complicating both service planning efforts and the delivery of coordinated or shared treatment models.

Discussion

Great strides have been made in gathering Canadian data on prevalence, cost, and unmet need related to concurrent disorders; however, Canada lags behind other countries in studying both the extent of and barriers to implementing integrated treatment.[19] Insights from interviews with research, policy and provider experts clarify the relevant factors affecting implementation of integrated treatment in Ontario.

Key informants were more positive than expected on the state of treatment integration, arguing that progress has been made, though implementation barriers still exist. Five domains reflecting current barriers emerged: Organizational factors, system factors, historical factors, stigma-related factors, and knowledge factors.

These domains align with findings from the international literature on barriers and facilitators to implementing integrated treatment.[21-23] Organizational and system level factors identified, including strong leadership, lack of program funding, and absence of provincial direction, are also raised in the literature.[21,24,25] Beyond the concurrent disorder field, these are factors commonly discussed in the general implementation literature as important for any implementation effort.[26,27] A 2013 report similarly found that in Ontario there is no provincial direction on how, when, and where to provide integrated services, and service availability is dependent on the interest, enthusiasm, and resources of local champions.[19]

Historical factors have been emphasized in the international literature. Like the key informants, the literature discusses structural issues - for example, separate staff training and education; separate funding, administration, and policy structures; different and sometimes contradictory treatment guidelines; and
Selick and Wiktorowicz: Co-occurring mental health and addictions disorders

Prevalence and co-occurrence of substance use disorders and [23,29] [25] [26] [30] address some of the broader, systemic barriers identified, in addition, implementation approaches alone may not support, this process is unlikely to be replicated in Ontario. Consensus on the integration model to adopt and financial and a substantial government grant. Diagnosis Treatment model. This was made possible, intensive nature. It has been applied to integrated care. Implementation science argues that in contrast to traditional passive dissemination, an active process is needed to ensure successful implementation. Equal effort and resources must be devoted to the implementation of a new intervention as are put into its development. [27]

Avenues meriting further exploration are the fields of implementation science and complex adaptive systems. Implementation science is the study of how to successfully implement new practices. It emerged as a response to the reality that even with clear evidence and policy, there is an enormous time lag before widespread changes to practice are achieved. [26,27] Implementation science argues that in contrast to traditional passive dissemination, an active process is needed to ensure successful implementation. Equal effort and resources must be devoted to the implementation of a new intervention as are put into its development. [27]

This approach resonates with the field of concurrent disorders where extensive evidence and policy have led to little practice change. Potential limitations to the application of implementation science are its resource intensive nature. It has been applied to integrated treatment with apparent success in the US, with the widespread implementation of the Integrated Dual Diagnosis Treatment model. This was made possible, however, by a coordinated approach to integration and a substantial government grant. [30] Without similar consensus on the integration model to adopt and financial support, this process is unlikely to be replicated in Ontario. In addition, implementation approaches alone may not address some of the broader, systemic barriers identified, such as stigma or the historical divide between mental health and addictions.

An understanding of complex adaptive systems may be needed to guide broader system, funding, and cultural shifts. [31] The complex adaptive systems' perspective posits that change is optimally fostered through organizations' capacity for self-organization and co-evolution and that processes of change must take these internal cues into account to address them. [32]

**Conclusion**

This exploratory study highlighted important areas for further exploration in the Ontario context. A first step to improve services is clear direction on what integrated treatment should look like. More research is required to assess the effectiveness of different integration models and to identify the critical factors needed for successful implementation of integrated care.

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There are no conflicts of interest.

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Appendix

Appendix 1: Semi-structured interview guide

Introduction

Thank you for taking the time to talk with me today. The goal of this interview is to get your perspective on how the Ontario health-care system currently treats individuals with concurrent mental health and addictions disorders and what barriers or facilitators exist to implementing appropriate treatment for this population. Do you have any questions before we begin?

Background

1. Can you tell me about your background? (Probes: educational background, past work experience)
2. Can you tell me about your currently work? (Probes (as applicable): Roles/responsibilities, current research focus, length of time in this position/in this field)
3. How familiar would you say that you are with issues around concurrent disorders and the availability of services for this population?

Questions

1. How would you define concurrent disorders?
2. How would you describe appropriate and effective services for people with concurrent disorders? (Probes: Should treatment services always be integrated? How do you define integration? What models of integration work best in practice?)
3. What types of services are currently available for this population? (Probes: Are available services appropriate/sufficient? Do they reflect any model of integration? Is there a difference between the official description or mandate of programs and how they function in practice?)
4. What are some factors that you think have helped or hindered the creation of appropriate services? (Probes: Where is the impetus to create these programs coming from? Why are some programs/jurisdictions more successful than others?)
5. What steps do you believe must be taken to ensure that there are sufficient appropriate and effective services available?