Toward Substance Use Health and Mental Health Service Integration: Findings from a Scoping Review

Substance use health and mental health (SUHMH) are closely linked, with many people experiencing challenges relating to both at the same time. Polling by the Canadian Centre on Substance Use and Addiction (CCSA) and the Mental Health Commission of Canada (MHCC) has found that COVID-19 had significant, persistent, and complex impacts on SUHMH. At the same time, the pandemic also accelerated the evolution of innovative health policy and technology.

In response to these findings, CCSA and the MHCC undertook a systematic review of academic literature related to SUHMH service provision published between 2018 and 2021. This review reinforced the need for SUHMH integration and helped isolate some of the themes and key factors influencing the broader uptake of integrated models.

Key Findings

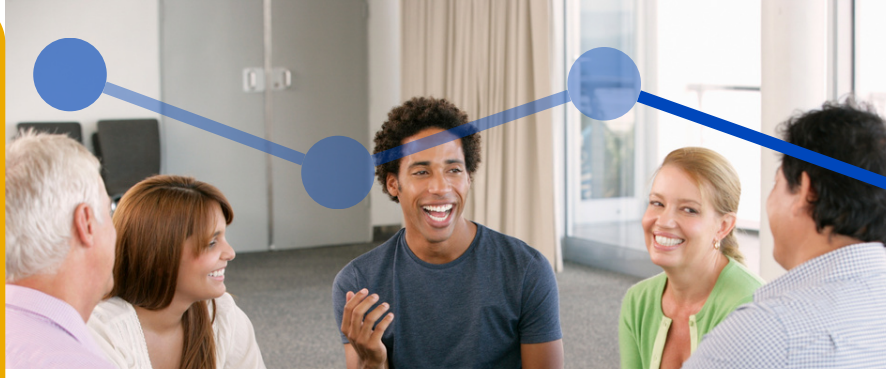
Substance use health can be better integrated into primary care as well as mental health.
Models that integrate SUHMH into primary care show promise, as such care is often the first point of contact. Yet most models focus on integrating mental health, and more needs to be done to also integrate substance use health.

Implementation science is critical to bridging theory and practice.
Research on SUHMH integration emphasizes the need to put evidence and best practices into action by identifying what must change, how change will happen, and which factors will hinder or support the change.

The SUHMH workforce plays a central role in integration.
SUHMH workforce development must address competency gaps and build interdisciplinary connections. These will help create a well-equipped diverse workforce to deliver effective care across the SUHMH spectrum.

Integrated service models must consider how to support health equity.
Integrated service models must provide equitable availability and accessibility for those who face the greatest barriers (e.g., stigma and discrimination). Culturally appropriate care and person-to-person support are critical to reducing these barriers.

Barriers and Facilitators to SUHMH integration



Emerging literature continues to identify factors that support or hinder the transformation and integration of SUH and MH systems. The following are among the most critical.

Barriers

Complex and fragmented funding

Neither public health insurance nor private health benefits consistently fund SUH and MH services, which hampers access to the full spectrum of care and limits collaboration between providers. A sustainable and comprehensive funding structure would make services more collaborative and accessible.

Workforce flexibility

With staff across the health system at capacity, there is little time for the additional duties and responsibilities required for SUH-MH integration. To support integration, workforce challenges must be addressed.

Data and performance measurement

Privacy concerns and inconsistent data collection across settings and jurisdictions complicate collaboration and data sharing. Greater SUHMH integration will need better data collection processes, common electronic health records, and standardized indicators, all protected by robust privacy safeguards.

Facilitators

Leadership

Leaders across the health system play a significant role in SUHMH integration. Health-care leaders can facilitate collaboration with interdisciplinary partners; education leaders can update curriculums to better encompass preventive care, counselling, and SUHMH; and system leaders can champion innovative models that include greater integration within primary care settings.

Implementation science

To help overcome resistance to change, implementation science supports system transformation with practical guidance on the changes to make and why and how to make them. It promotes the consistent use of specific definitions and tools for streamlining SUHMH integration. This approach can be a key enabler that helps turn evidence into action.

System organizing principles

The following system organization principles have also been identified as key facilitators to SUH-MH integration:

Person-centred
Systems should centre the lived and living experience and expertise of those who access services. These should be prioritized in the design and delivery of services, treatment, and policies.

Trauma-informed
Systems should recognize that, while anyone can have a history of trauma, it is especially prevalent among populations seeking SUH or MH services. All care should consider issues of trust and mutuality while being sensitivity to socio-historical, cultural, and gender issues.

Recovery-oriented
Systems should be designed to prioritize people's well-being, with outcomes defined in conjunction with the individual seeking services and supports. Recovery may or may not include a full remission of symptoms or abstinence from substances.

Cultural safety
Systems should prioritize cultural safety by making sure the workforce reflects the population it serves and providing training to enhance cultural competencies, including those related to language, expression and presentation of symptoms, and the inherent power dynamics of the service user-provider relationship.

To request the full scoping review report, email
mhccinfo@mentalhealthcommission.ca

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Suite 1210, 350 Albert Street
Ottawa, ON K1R 1A4

Tel: 613.683.3755
Fax: 613.798.2989

@MHCC_ /theMHCC
/1MHCC @theMHCC
/Mental Health Commission of Canada
/theMHCC

mhccinfo@mentalhealthcommission.ca
www.mentalhealthcommission.ca

Canadian Centre on Substance Use and Addiction

75 Albert Street, Suite 500
Ottawa, ON K1P 5E7

Tel: 613.235.4048
Fax: 613.235.8101

@CCSACanada @CCSA.CCDUS
@CCSACCLAT @ccsa_ccdus
Can Centre on Substance Use and Addiction/
Centre can sur les dépendances et l'usage de substances

info@ccsa.ca
www.ccsa.ca