Integration in the context of Mental Health and Substance Use services

This paper introduces some key high-level concepts around integration and models of care. It provides the fundamental building blocks on which different models of care can be identified and analysed. It is designed as a quick access guide for those who are supporting planning for more integrated mental health and substance use services. It does not go into detail about specific interventions or definitions of 'mild to moderate' or 'severe and enduring' mental health/substance, as this is operationally defined in different ways, linked to service thresholds. Instead, this paper explore the relationship between different services providing support at varying levels of intensity.

This is an excerpt from the fuller Mental Health and Substance Use Options Appraisal document that can be found on our website. There are also other documents in this series including

- Mental Health and Substance Use – Policy and Data Sheet
- Mental Health and Substance Use – Outlining the methodology for an options appraisal
- Mental Health and Substance Use – Identifying and considering the options for change

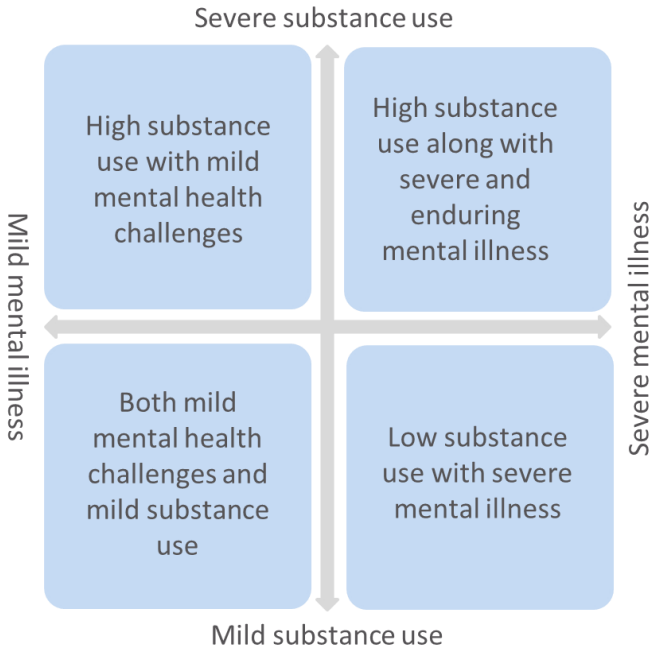
1 Summary

- Different treatment models can be emergent and signify a particular viewpoint/approach to supporting health. These impact connections across services, including relationships and culture when looking at integration and collaboration.
- Different frames of integration can help with understanding how services relate to each other, how decisions are made and how complex systems operate.
- Discussion around these concepts supports the development and description of the different options for delivering services – including enabling an assessment of options associated with readiness for change.
- These frames will also help us understand how implementation of policy and strategy relates to practical considerations around integration, collaboration and supporting complex needs across a whole system.
- The various frames of integration outlined in this paper are not mutually exclusive, and different elements of them will be of different relevance across a whole system. They will be used to describe and understand the type of approach being offered by each option; and what the dynamics of interfaces across the system are.

2 Four quadrants of co-occurring need

Underpinning the models of care and approaches to integrated mental health and substance use services is the complexity of need within co-occurring conditions. Analysis of different ways of planning services needs to be done in parallel with understanding the dynamics of co-occurring need, how these change, and how best to respond.

The 'Four Quadrants' model is a way to help understand the different cohorts of need that services can support and help identify potential gaps in supporting different dynamics of substance use and mental health concurrence.



"Mental health concerns and problem substance use can interact in many ways and varies according to the different circumstances, including the type and severity of substance use and mental health concerns. Likewise, the support required, services accessed, and care pathways required also vary. This is demonstrated in the Four Quadrant Model, which is one of several typologies developed to support understanding of the intersection between substance use and mental health"[1]

This quadrant model is noted in Ending the Exclusion[2] as a foundation for the design of services in establishing core roles and responsibilities. It is also a helpful analytical tool to stimulate discussions about how different models can support different types of need, highlight where there might be an underserved population and identify how transitions can be more complex in cases of co-occurring need.

Reflective questions to think about in relation the quadrant model are

- How does this approach support people within the different quadrants? For example:
    - Does this type of integration support better care for those who have severe mental health needs, with mild substance use?
- Does this type of integration support better care for people who require high levels of support for both mental health and substance use?
- What would happen if a person's needs changed across the quadrants?
    - Significantly (i.e. developed dependence)
    - Temporarily (i.e. heightened mental health crisis)
- How does this approach allow for flexibility around the boundaries between quadrants? For example:
    - Are the boundaries diagnosis based?
- Is it about levels of risk?
    - What is the role of presenting need in defining where a person might be within the model?

[1] https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2022/11/co-occurring-substance-use-mental-health-concerns-scotland-review-literature-evidence/documents/co-occurring-substance-use-mental-health-concerns-scotland-review-literature-evidence/co-occurring-substance-use-mental-health-concerns-scotland-review-literature-evidence/govscot%3Adocument/co-occurring-substance-use-mental-health-concerns-scotland-review-literature-evidence.pdf

[2] https://www.mwcscot.org.uk/sites/default/files/2022-09/EndingTheExclusion_September2022.pdf

3 Different treatment approaches

These different approaches are broad ways to think about how systems are set up to support people, and what the priorities are. They are not mutually exclusive, and most systems will have elements of all. However, where there is a dominant model within a system, it can impact the effectiveness of others, as well as be a signifier of cultural differences between services that can act as barriers to collaboration.

The bio-medical model – This model assumes that the primary causes of ill health are biological and therefore cured through pharmacological treatment. Therefore, the services within this model are centred on clinical interventions aimed at a 'cure'.

Features include:

- Clinically focussed where services are arranged around specific interventions.
- Primacy of clinical view and the role of the consultant and clinicians in treating and curing health conditions.
- 'New Public Management' approach to governance, looking at efficiency around throughput and output in a linear fashion.

The medical model prevalent is Community Mental Health Teams, however, this results in challenges for people with medication resistant conditions, and instances of people using substances not being supported as medication would not work in conjunction with substance use.

Social model – This model highlights the role that social and economic circumstances play in a person's health. Emphasising that things like income, housing and social networks have a significant role in driving ill health. Therefore, services within this model are centred on meeting people's basic needs and building social resilience.

Features include:

- Focus on the determinants of health (as highlighted in the Christie Commission and Marmot Review).
- Sees health as a fluctuating picture across the life course.
- Medical treatment as one part of a wider environment of interventions.
- Emphasises the importance of recovery and longer-term support.
- Requires upstream interventions and coordinated, whole system approaches.

The MAT Standards include a social model perspective by including requirements for pathways into advocacy, housing and psycho-social support

Person centred model – This moves away from thinking about causes and treatment of ill health and looking at what people want to achieve regarding their health. There is an emphasis on choice of support and services, and inclusion of non-clinical or non- physical health related outcomes within care planning.

Features include:

- Focussed on people achieving what they want to achieve.
- More cognisant of chronic conditions.
- Often enacted at service level rather than system level.

The Core Standards suggest a person-centred model by emphasising choice of services, including additional support to achieve personal outcomes.

4 Frames of integration

There are many ways to understand and look at integration. A starting point is to think about horizontal and vertical integration. This frame of integration seeks to differentiate between integration across a spectrum of intensity, where primary care and secondary care are integrated; and integration across a spectrum of needs, where different disciplines are integrated.

Vertical integration: This is a common form of integration within health services where there is a clear pathway of escalation towards secondary care where required, as well as de-escalation pathways. This can be seen in well-developed discharge planning arrangements, as well as physical health services that see primary care as a triage service into secondary care, and a locus for rehab services.

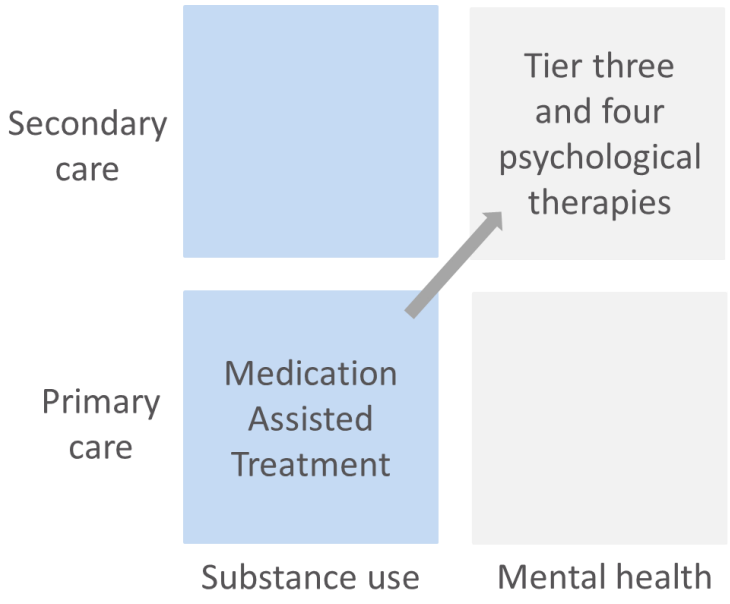
Within mental health and substance use services, vertical integration is seen through agreed pathways into secondary care and joint decision making across primary care services. Integration within this frame is usually condition specific.

Markers of a lack of vertical integration include rejected referrals, suggesting there is no shared understanding of access criteria or communication across services.

Horizontal integration*:* This refers to integration that spans services covering a range of needs, crossing condition specific or diagnostic boundaries. For example, integrated working between substance use, housing, and social interventions. This frame of integration tends to be seen in community services and supporting person centred needs. As such it sits much more in the social/person centred mode of care.

Within mental health and substance use services, horizontal integration is seen through joint delivery of support by staff in both mental health and substance use services, as well as pathways into physical health services and social work. However, it is also seen through collaboration across third sector services that can coordinate care for complex needs (including social needs). Features of this type of integration include the use of link workers, and involvement with non-health and social care related services such as citizens' advice and employability. It is also marked by well-integrated teams including nursing and social work staff.

A role for diagonal integration?
Within the context of co-occurring mental health and substance use support needs, and the changing dynamics of dual needs, there is an argument for looking at a model of 'diagonal' integration. At a basic level, MAT Standard Six requires there to be "clear pathways in place to ensure that people can access higher intensity Tier 3 & 4 psychological therapies if and when required". This suggests integration both horizontally, across specialisms, and vertically, between primary and secondary services.



Other integration schools of thought: A 2024 realist evaluation of service models and systems for co-existing serious mental health and alcohol/drug conditions[3] mapped different models of care for this cohort of people, they distilled three emergent models:

- **"Comprehensive model"**- typically included lead senior clinician (specialist expertise in COSMHAD), training/supervision programme, and additional workers supporting lead.
- **"Lead and link worker"**- a less comprehensive model typified by a lead clinician and link or liaison workers.
- **"Network"** – a shared group of interested services, some local champions/link workers, not including investment in a specific lead person.

A more developed frame for exploring integration is outlined below.

Adapted from Kodner DL, Spreeuwenberg C. Integrated care: meaning, logic, applications, and implications--a discussion paper. Int J Integr Care. 2002

This takes more of a system wide view of integration, outlining focal points for integration and therefore allowing for discussion around the desired level or type of integration at each point.

It also suggests the cultural dimension to integration that goes beyond pathways, process and service plans; and looks at how professional identity can influence depth of integration, and how this might be changed through things such as shared screening tools across specialisms.

- **Funding –** integration at this level is where the Joint Bodies Act aimed to make changes. By integrating budgets, it was hoped this would allow for flexibility to move investment to where it is required. Funding can also facilitate integration by removing barriers to collaboration created through ring-fenced funding for services.
- **Organisational –** relationships and common goals support the integration of governance mechanisms that influence service delivery, as well as improving relationships across services. Within the context of mental health and substance use, there is a need for collective responsibility for people with concurrent need, to avoid instances of people 'bouncing between services'.

[3] Harris J, Dalkin S, Jones L, Ainscough T, Maden M, Bate A, Copello A, Gilchrist G, Griffith E, Mitcheson L, Sumnall H, Hughes E. Achieving integrated treatment: a realist synthesis of service models and systems for co-existing serious mental health and substance use conditions. Lancet Psychiatry. 2023 Aug;10(8):632-643. - https://pubmed.ncbi.nlm.nih.gov/37327804/

- **Service delivery –** the noted focal points within this part of the framework highlight the importance of joint working and informed decision making. It also highlights the idea of integration of support, rather than services, whereby there is a response within a single service, to concurrent need, supported by enablers like training, cross specialty supervision, information sharing and professional networks.
- **Clinical –** integration of clinical decision making is an important element of any model. Lack of integration at this level can frustrate efforts to integrate at others. For example, there can be pathways across services, but if there is no agreement at a clinical level around the type of support a person needs, and who is responsible for that, these pathways can remain fragmented.

It is also important to think about scales of integration – i.e. how integrated services are. In the context of complex need there needs to be flexibility around how closely services work together. This idea of scale/modes of integration can be discussed at each level of the above model.

- **Co-ordinated care** – Mental health and substance use professionals **practice separately** and often in distinct locations but with integrated patient records and common funding sources. Both staff groups diagnose, case manage and oversee medication/therapies within their area of expertise; with basic screening and agreed referral routes across services where complementary services are required.
- **Co-located care** – Mental health and substance use professionals **practice in parallel**, with delineation of services according to expertise. Both staff groups diagnose, case manage and oversee medication/therapies within their area of expertise; with co-location providing informal communication that enables cross-linkage for referrals.
- **Integrated care** – Mental health and substance use professionals **collaboratively design and implement** unified care plans, with close and continuing collaboration. Both sets of staff are core members of an integrated care team that performs screening, assessment and diagnosis activities, case management and medication/therapies collaboratively.