STATE OF THE ART

SUMHIT
Substance Use and Mental Health care InTegration, a study of service networks in mental health and substance use disorders in Belgium, their accessibility, and the user's needs

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[Introduction]

Many people who have a problematic use of drugs (SUD) suffer from concomitant mental disorders, while many people with mental illness (MI) also use drugs. Patients with co-occurring substance-use disorders (SUD) and MI have more severe adverse outcomes than patients with either condition alone, in terms of accessibility to services, unmet needs, adherence to treatment and relapse, social integration, and personal recovery. However, services in the specific SUD sector and in the generic mental health care (MHC) sector have developed separately, do not always collaborate efficiently, and are used by people with different need profiles. In this context, the main objective of SUMHIT is to examine and assess the place of people who use drugs in the field of mental health care, the availability of generic mental health care for people with substance-use disorders, and the capacity of both generic mental health care and specialised substance-use care sectors to collaborate within the framework of the service networks that have been established in Belgium since 2010. Using both quantitative and qualitative data, the project addresses three levels of study. It examines (1) the met and unmet needs of people with substance-use disorders in terms of mental health care and their care pathways, (2) the experience of clinicians from the full range of generic and specialised services, and (3) the care system conditions that would make collaboration effective. SUMHIT will provide authorities and professionals with evidence-based policy and care recommendations in order to improve the continuity of care between sectors, the tailoring of care pathways to specific profiles, and to support a global approach of patients' personal recovery.

[State of the art] *4-5 pages*

Preliminary note: Drug-addiction and mental illness are sensible topics subjected to different interpretations depending on the terminology used. In this state of art, we are referring to substance-use disorders (SUD) and to mental disorders or mental illness (MI). We are also referring to "care" for any type of support, either medical, psychological, social, or other, and to "patients" for people using care services or in need for care. We are using these terms in a generic sense, without any specific, normative orientation that would underlie these concepts. The conceptual framework underlying the whole project is the *personal recovery approach* (1-4). Although the concept is also subject to different interpretations, we understand it as an approach to SUD and MI that supports the autonomy, social inclusion, empowerment, and personal resources of people in need for care in order to develop a meaningful life despite the problems due to illness.

Context: Many people who have a problematic use of drugs suffer from concomitant mental disorders, while many people with mental disorders also use drugs. Estimates of drug use among people with MI usually range from 20 to more than 50% (5, 6). In Belgium, within the evaluation of the 'Title 107' reform of mental health care delivery (2014-2015), among the 1,200 patients with severe MI recruited across all service types involved in mental health service networks, 18.5% had a concomitant diagnosis of substance-use disorder (7). Patients with co-occurring SUD and MI have more severe adverse outcomes than patients with either condition alone, in terms of accessibility to services, unmet needs, adherence to treatment and relapse, social integration, and personal recovery (8). However, in most countries, including Belgium, the specific care and assistance sector dedicated to people having SUD has developed separately from the generic mental health care (MHC) sector, despite most patients either using services in the specific SUD sector or using services in the generic MHC sector, are facing similar, complex and long-term problems, both in nature and extent. Their medical, psychological, and social needs require comprehensiveness from the part of the care providers, in particular in terms of care continuity and personalised care (1, 3, 4, 9-12).

Yet, the divide is on the side of clinician and care system practice, not on the side of patients (13). Specifically in Belgium, the lack of capacity of services to address the issues of people with multiple needs, in particular regarding patients with SUD, was pointed out as an important weakness of the mental health care reform (14). In addition, fragmentation is amplified by the complex distribution of health policy responsibilities between the Federal State and the several overlapping federated entities (Regions and Communities) (15). However, during the first two decades of the 21st century, both SUD and MHC sectors have been substantially transformed. On the one hand, at the beginning of the 2000s, the Belgian generic MHC sector was still heavily hospital-centred, with one the highest rates of hospital beds per inhabitant in OECD countries, and lengthy lengths of stay in psychiatric inpatient services (16, 17). A nation-wide reform policy of mental health care delivery, known as 'Title 107', started in 2010, establishing service networks that aimed to strengthen the community care supply, to improve continuity of care within and across sectors, to reduce the use of hospital stays, and to favour the social integration of patients (15, 18). On the other hand, a new drug policy framework, calling for a comprehensive and integrated drug policy, was established in 2001 (19). It shifted the main priority of the Belgian drug policy from enforcement to prevention and assistance. Within this policy framework, combined with the devolution of health policy responsibilities to federated entities, prevention and assistance supply sectors (including harm reduction and rehabilitation) grew importantly, with a variety of novel interventions and service types embedded in multiple approaches. Alike in the generic MHC sector, the priority in the specific SUD sector was given to community services and a strong emphasis was put on social integration over more traditional, residential drug-free treatment – though the latter remained in the continuum of existing assistance options. Therefore, an important question is raised about the interest of a higher level of collaboration or integration between the two sectors, and about how to organise it effectively.

Objectives: SUMHIT aims to examine the conditions for, and feasibility of, an appropriate articulation of the generic MHC and the specific SUD sectors, within the framework of service networks. It aims to address three levels of study: (i) patients, (ii) care professionals and services, and (iii) service networks and health systems.

The main research question is "what is the level of integration/collaboration between the MHC and SUD sectors and how can it be effectively improved?" Specific sub-questions address:

-(i) At the level of patients: the specific profile of patients using substances and receiving care from the generic MHC sector; the met and unmet care needs of people with SUD, and specifically their mental health care needs, as well as the drug-related needs of people using generic mental health care services; and the experience of people with substance-use disorders with both MHC and SUD sectors

-(ii) At the level of care professionals and services: the perceptions of care professionals in both MHC and SUD sectors about the barriers and facilitators for collaboration/integration within and across sectors, in particular regarding the service networks framework; their experience with people who use drugs in the generic MHC sector and with patients with MI in the specific SUD sector; and the evidence-based interventions or good practices implemented to facilitate collaborative care

-(iii) At the level of service networks and health systems: the organisation of collaboration between the generic MHC and specific SUD sectors in neighbouring countries; the identification of the systemic barriers and facilitators of collaboration/integration; and the availability and place of specific SUD services in the mental health service networks.

SUMHIT addresses the capacity of the Belgian mental healthcare system to encompass the needs of people with substance-use disorders within the mental health care system in a global approach of personal recovery. In particular, it examines the met and unmet needs of these patients, and the

availability of, and accessibility to generic mental health and specific substance-use services within the framework of the mental health service networks that have been developed since 2010. Therefore, it aims to provide service and network managers and policy authorities with evidence-based, stakeholder co-designed recommendations in order to improve continuity of care, personalised care supply, and personal recovery for specific profiles of patients with substance-use disorders and other mental health care needs. In addition to policy, SUMHIT is expected to have a major impact on mental-health and substance-use care sectors collaboration and integration within the established service networks, as the divide between these care sectors is common to many healthcare systems, but do not respond to most patient's needs. It will also strengthen the knowledge base on integrated care through service networks as well as on strength-based, personal recovery for people with problematic drug use. Eventually, improved continuity of care and personalised care are expected to raise the quality of care overall and the quality of life of patients.

In particular, one key weakness of the Belgian healthcare system, both in SUD and MHC care, is its low capacity for continuity of care (20). Continuity of care encompasses three main dimensions: cross-sectional continuity, i.e. the lack of consistency of care responses across multiple clinicians and services within one care episode, longitudinal continuity, i.e. the lack of continuity of contact of patients with the care system between episodes of care, and relational continuity of care, i.e. the lack of appropriate therapeutic alliance (21). Whilst relational continuity of care is mainly related to elements at the individual level, longitudinal and cross-sectional continuity are strongly affected by organisational and system dimensions. For example, research indicated that collaboration within service networks was driven by interpersonal and informal relationships rather than by formal and organisational mechanisms (22). Little is known about how to effectively organise care within service networks (23).

In other respects, for some years, literature, both on SUD and MHC, has been putting a strong emphasis on personal recovery as overarching principle (1, 4, 9, 12). Personal recovery is largely evidenced in the literature and sustained by several evidence-based interventions (3, 11, 24-52). However, the approach is still not really developed and endorsed by clinicians in Belgium. We argue that such approach is likely to favour an optimal integration of the SUD and MHC sectors (10).

In this context, at the level health and quality of life, the main impact expected is the endorsement and adoption of an evidence-based, personal recovery approach as overarching principle for continuity of care and patients' care pathway design. This includes the patient's involvement in care decisions, and the use of his/her needs and resources in defining care objectives and outcomes, in which social inclusion is a priority (44, 45, 51-53). At the level of patients, the adoption of a personal recovery approach is expected to reduce issues in continuity of care, and consequently, to reduce the risks of adverse events and crises episodes and strengthen the patient's autonomy and right to choose for the most appropriate and suitable treatment. It would reduce the whole duration of treatment and quality of care. Similarly, at the level of services and the whole care system, the personal recovery approach is likely to reduce the key issues of care continuity and fragmentation that delays the system capacity to respond to patients' needs. Therefore, it should result in a reduction of the use of crisis and emergency care, reduce the overload of most services (and reduce the time of waiting lists to access services), and eventually reduce system costs while increasing system effectiveness.

At the level of scientific knowledge and skills, a second major impact expected from the project is the strengthening of the knowledge base about the specific target group of people with co-occurring MI and SUD, their specific needs, and the barriers and facilitators they may encounter in their own journey towards recovery. A specific impact is expected for the most vulnerable subgroups. In other respects, several knowledge gaps in the literature of healthcare system and organisations are addressed with the project, e.g. in terms of network management, facilitating factors of collaboration and integrated care, care for complex needs and long-term conditions, and healthcare systems. In particular, the burden of disease related to chronic, non-communicable, and mental disorders has dramatically increased in

Western countries over the last decades (54, 55). However, Western healthcare systems have been designed for the delivery of acute care, and no system has found effective mechanisms to sustain continuity of care and personal recovery for populations with complex needs (13, 20).

Finally, the project is designed to have a major impact in terms of policy and public services, as Belgium has poorer outcomes in continuity of care compared to other Western countries (20), probably because of its intrinsic characteristics as a social insurance, regulated-market system, combined with the high and complex fragmentation of health policy responsibilities. Each healthcare system is specific, and the simple translation of policy and care interventions that proved to be effective elsewhere may not be sufficient. Therefore, by co-constructing conclusions with care and policy stakeholders, it is expected that the research will come out with recommendations that are feasible in, and tailored to, the specificities of the Belgian healthcare system.

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