FEDERAL RESEARCH PROGRAMME ON DRUGS

ABSTRACT

SUMHIT

Substance use and mental health care integration

A study of service network in mental health and substance use disorders in Belgium, their accessibility, and user's needs

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Drug addiction and mental illness are sensitive topics with different interpretations depending on the terminology used. Across the different sections of the present report, we tend to refer to substance use disorders (SUD), whatever the substance is, including alcohol, and to mental disorders or mental illness (MI). We also refer to "care" as any type of support, either medical, psychological, social, or other, and to people utilising care services or in need of care as "care users" or sometimes "users". We, therefore, distinguish people who use drugs without specific needs from people who have substance use disorders, and from care users, i.e. people utilising services or in need of care. We are using these terms in a generic sense, without any specific, normative orientation that would underlie these concepts. The conceptual framework underpinning the whole research is the personal recovery approach [1-4], key aspects of which we expound upon in the following pages. 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 of care in order to develop a meaningful life despite the possible problems related to illness [1].

The scientific literature indicates that the use of drugs among people with mental illness (MI) varies from 20 to over 50%[5, 6], while mental health disorders are also common among people with substance use disorders (SUD). People with both SUDs and MM face greater difficulties than those with one issue alone, in terms of access to services, unmet needs, compliance to treatment or relapses, social integration and personal recovery[7]. Their medical, psychological and social needs require comprehensive care from healthcare providers, particularly in terms of continuity and personalised care[1, 3, 4, 8-11]. However, in Belgium, as in other countries, care provision for these populations is divided into separate sectors, a generic mental health care sector and a sector specialised in addiction. The SUMHIT study therefore examined the needs of users of both types of service, as well as the experiences of users and professionals in accessing and delivering care. In addition, SUMHIT examined the organisational capacity of the two sectors to collaborate and integrate within the general framework of service networks implemented within the 'psy 107' reform.

Five areas were selected for the study: Antwerp (SaRA), Aalst-Termonde-St-Nicolas (GGZ ADS), and South-West Flanders (GGZ ZWVl) in Flanders; Brumenta (the Brussels network, which is made up of 4 sub-networks: Bruxelles-Est, Hermes+, Rézone, and Norwest); and the 'Réseau Santé Namur' in Wallonia. In these five areas, a number of research actions were carried out: a survey of 562 service users about their care and support met and unmet needs; 53 qualitative interviews were also conducted with service users and people who were no longer in contact with the care system. At the professional level, a survey of the organisation of services was completed by 194 generic and specialised services, and focus groups were organised with professionals and experts by experience. Finally, a literature review was carried out on interventions facilitating the personal recovery of users with substance use disorders. SUMHIT concludes with a set of recommendations that were drawn up on the basis of the study findings and discussed in focus groups with service managers, network coordinators and people involved in policy-making.

The main findings of SUMHIT confirm the high prevalence of co-morbidity between substance use disorders and other mental illnesses: service users with an unmet need for mental health care were five times more likely to also have an unmet need for substance use disorders, and vice versa. However, when the need for mental health care was met, the need for substance use care was significantly three to four times lower. Many other care needs were associated with this comorbidity, such as socio-economic needs, needs in daily activities, and needs in social relationships. This last point was an unmet

need domain for the majority of users, including those who declared the lowest number of needs. This finding shows that this population suffers from social isolation. Furthermore, needs do not affect men and women in the same way: gender is a factor that requires special attention and differentiated mechanisms for accessing care. The number of care needs, and in particular the number of unmet care needs, was associated with lower social integration and quality of life, as well as with multiple substance use.

SUMHIT also measured that 31% of users of generic mental health services had a substance use disorder. Users who use illicit drugs, particularly opiates, were more likely to be cared for in specialist addiction services than in generic mental health services, even though they were more likely to have unmet mental health needs. Barriers to care were reported by service users. They also reported experiences of stigmatisation, particularly with regard to substance use in generic services. These results can be put into perspective with the high number of services (41%) that stated that substance use was an exclusion criterion for starting care. Waiting lists were perceived by users as a sign of fragmentation and silo working, as many services have lengthy admission procedures. In addition, care users perceived a tension between treatment and personal support and felt that they were not always "really" listened to. Generic mental health services, particularly hospital and rehabilitation services, had significantly more restrictive access criteria. On the other hand, 30% of services reported having at least one peer-worker, which limits the effects of stigma and facilitates the inclusion of people with SUD. The structure of contacts between services showed that closer, formalised collaboration is possible.

Based on these results, SUMHIT formulates 12 recommendations at the macro and meso levels. They highlight the need for professionals to be better trained in the principles of personal recovery, for greater attention to be paid to the organisation and structuring of care provision on a territorial and population basis, so that the full range of care is available in a given area, for interventions to be implemented at the network level in order to facilitate access to and navigation within networks, and finally for greater attention to be paid to the deleterious effects of stigmatisation on care pathways. The authorities, for their part, are invited to put in place organisational and financial mechanisms to support this territory-based approach to personal recovery.

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