Continuity of Care for People with a Concomitant Mental Illness and Addiction Problem: Responsibility of Users and Organizational Perspective

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Key Implications for Decision Makers

These messages are subject to the following qualification: the data used were obtained primarily from users served by mental health resources, often in primary care, and their workers. Users of the study have a dual problem of mental illness and addiction, and the mental health problems targeted essentially include schizophrenic problems and emotional psychoses. The messages below and the report as a whole must be viewed through this specific prism.

♦ Continuity appears to be an inadequate concept for studying the issue of links between services addressing separate problems. In fact, several aspects of continuity of care can be assessed independently of the presence of integration of services, and the performance of each aspect does not necessarily translate into overall performance in terms of clinical consistency. Continuity of care is not a panacea and its definition must be tightened and developed in greater depth.

♦ Consideration of the perspective of users in assessing the organization of services has its limits: it is narrowly defined, highly centred on their experience, and not based on variables that structure the healthcare system. Thus, although the user’s perspective is necessary to verify the presence of certain aspects of continuity of care, it is not sufficient in itself.

♦ In the context of our study, the commitment of workers to services users does the most to promote continuity of care. Workers are the ones who create the links and thus the continuity of care. The introduction of organizational models or rules should give consideration to this variable.

♦ To place the user at the centre of the system is also to recognize the importance placed on the user’s link with the worker and promote the organizational arrangements that maintain and strengthen that link. Users place more importance on people than procedures.

♦ Responsibility for this client group must be clearly assigned to an authority in the system. Compartmentalization of the healthcare system is verified in this study and the consequences are more dramatic for client groups with multiple problems. Users often are monitored only for one problem; rules often exclude services. Currently, no resource considers itself responsible for integrated follow-up, and accountability is defined by problems, not individuals as a whole.

♦ Without integrated services, the chronic nature inherent in the dual pathology of mental illness and addiction absolutely requires significant investment by healthcare services in intake for this client group.

♦ Training needs are numerous and pressing. These involve addiction tracking and intervention in the mental healthcare system, an integrated approach to dual problems, a sound understanding of the operational logic that characterizes mental health and addiction interventions, team work, and building overall consistency in intervention. Training could also be used as a means to create the necessary links between workers involved with this client group, regardless of their origin and qualifications. The key is to consolidate skills and eliminate feelings of impotence.
Executive Summary

The organization of mental healthcare services has been transformed in recent decades, focusing in part on reducing the use of institutions and relying more on delivery of ambulatory services that are as close as possible to individuals’ life settings. Despite laudable efforts to this end, major shortcomings still affect the organization of ambulatory mental health services. Fragmentation and discontinuity of care are the problems most often reported as users lament the lack of liaison between the various intervention authorities. These difficulties are aggravated when there is more than one health problem.

Against this backdrop, interest has developed in continuity of care and services, especially when assessing or measuring the operation of services. In turn, while continuity is considered desirable and even constitutes a priority for planners and managers in the healthcare system, there is no commonly accepted and/or operational definition of what continuity is or could be. Moreover, the definitions and aspects proposed to reflect this are essentially the result of work conducted by researchers and managers. The perception of service users has had little or no influence on conceptual developments surrounding the concept of continuity of care. There is a consensus, however, among Canadian researchers and managers to begin with the users’ point of view, their experience with services, to determine the existence of continuity of care and to assess its attainment.

The findings of the research presented here involve people with a dual diagnosis of mental illness and addiction and takes on the presumption that the integrated approach to treating the dual problems is the best-known option for this client group. Unlike the American system, however, Quebec’s healthcare system lacks integrated programs specifically designed for this client group. To obtain the required assistance, it therefore must rely on existing ambulatory services, whether delivered in mental health or addiction. In this context, the focus is no longer integration of the two networks, but rather the existence and nature of links established by their services, which has been addressed as part of our study from the perspective of continuity of care. Specifically, we sought to verify the presence of this continuity and determine “where,” “when,” and “how” breaks occurred between mental health and addiction services. The concept of continuity therefore is central to this study and has been explored from the perspective of service users as well as workers.
Very early in our work, we were able to note that there were few links, if any, between the two service networks and thus no continuity of care as initially defined. In this new context, the analysis was structured in light of four main concerns: 1) user movement between mental health and addiction services; 2) study of the aspects linked to continuity of care and their respective contribution to its actualization; 3) the characteristics of existing organizations in mental health and addiction, given the client group studied; and 4) identification of the specific aspects of statements by users and workers on continuity of care. These are the main findings of this research.

1. In the way we defined it, there is no continuity of care between mental health and addiction services, yet this is a condition deemed necessary to offset the absence of an integrated approach to clients with concomitant mental health and addiction problems; the formal links between mental health and addiction services are virtually non-existent.

2. The user’s link with mental health services, especially for specialized resources, is good, but there is little or no intervention in the problem of addiction; this can be explained by the chronocity of the mental problems involved, based on the selection criteria for this study.

3. Services are used in isolation, although the transfer of information between physicians is well established. This situation is an obstacle, in part, to achieving overall consistency of interventions. However, informal links may result in isolated initiatives by persistent, dedicated workers.

4. No resource feels genuine accountability for this client group, with the presence of the second condition usually justifying this position.

5. The workers, most of whom (in this study) work in mental health, acknowledge that they have limited expertise to intervene in the twofold problem and agree that they would have to improve their addiction training, especially for tracking and intervention, beyond support and the usual treatment.

6. This client group is negatively portrayed, and workers say they have little hope that intervention will change anything.
7. Given the conditions linked to comorbidity, some of the fairly explicit rules in effect effectively deny this client group access to certain resources; one example is the requirements associated with group interventions in community addiction resources.

8. Mental health and addiction services operate on different approaches to care, which probably hinders development of their links: addiction interventions focus more on a single overdose episode, while mental health intervention more closely resembles medium and long-term monitoring of a chronic disease.

9. Users are extremely sensitive to workers’ “bedside” manner but much less to their procedures; this is a crucial aspect that appears to favour maintenance of the link between the worker and the user, which argues for a measure of stability in workers.

10. A user’s link with his worker is valued and appreciated, but very fragile because of the high mobility of primary care workers, especially in community organizations.

11. The concept of continuity of care, as defined in this study, poses problems, primarily in three areas:

   a. most aspects can be analysed independently of the existence of links between mental health and addiction services, which suggests that the very essence of continuity of care differs from the presence of these links;
   b. overall performance in the aspects selected does not allow us to predetermine overall consistency directed toward the achievement of shared clinical objectives; this is a major benefit sought through actualization of continuity of care; and
   c. the user’s perspective is based directly on his experience and comes down to very narrowly defined concerns: meeting certain expectations, the presence of interaction and especially the quality of relationships, rated primarily on the worker’s human characteristics. The user’s viewpoint on organizational aspects is not well developed.