Beyond the limitations of best practices: How logic analysis helped reinterpret dual diagnosis guidelines

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Abstract

The co-occurrence of mental health and substance use disorders is becoming increasingly recognized as a single problem, and professionals recognize that both should be addressed at the same time. Medical best practices recommend integrated treatment. However, criticisms have arisen, particularly concerning the difficulty of implementing integrated teams in specific health-care contexts and the appropriateness of the proposed model for certain populations. Using logic analysis, we identify the key clinical and organizational factors that contribute to successful implementation. Building on both the professional and organizational literatures on integrated services, we propose a conceptual model that makes it possible to analyze integration processes and places integrated treatment within an interpretative framework. Using this model, it becomes possible to identify key factors necessary to support service integration, and suggest new models of practice adapted to particular contexts.

Keywords

Dual disorders; Mental health; Substance abuse; Integration; Program theory; Logic analysis; Evaluation

1. Introduction

The prevalence of reported dual diagnosis is significant among patients in the mental health and substance abuse sectors, in addition to which many cases of dual disorders of mental health and substance use go undetected (Mercier & Beaucage, 1997). Furthermore, delivery systems do not have adequate resources to accommodate a clientele in need of multiple services, so people with dual diagnoses are often not well served. There is clearly a need to

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plan effective interventions adapted to the specificity of this clientele and its practice contexts.

Traditionally, the fields of substance abuse treatment and psychiatry have been profoundly isolated from each other, with separate histories and treatment philosophies (Brisson, 1988; Substance Abuse and Mental Health Services Administration (SAMHSA), 2003). Guidelines for the treatment of dual disorders now exist, however, bridging the gap between both communities. It is recognized that dual disorders are better addressed using an integrated approach (Ziedonis et al., 2005), which is more than a simultaneous offer of services. “Integrated dual disorders treatments involve combining and blending the delivery of mental health and substance abuse interventions for persons with co-occurring disorders.” (Torrey et al., 2002, p. 508). Dual diagnosis guidelines are largely inspired by Mueser et al. model that has proven its effectiveness.

Despite these guidelines, it remains difficult to integrate services for this clientele—not so much because of disagreements about clinical practices, but rather because of difficulties inherent in their organization. The integrated treatment model (ITM) proposed by Mueser, Noordsy, Drake, and Fox (2003) seems to work if it is applied to the letter (Torrey et al., 2002). However, the faithful implementation rate remains low (Torrey et al., 2002), and the model is not necessarily suitable for all types of clientele, nor for several forms of health systems organization, in particular because of the required restructuring of human and financial resources (SAMHSA, 2003). In response to a need brought to our attention by professionals practicing in health institutions, we decided to evaluate, using program theory analysis, the model of service organization proposed by Mueser and colleagues, and to see what alternatives might be identified beyond that model.

Logic analysis is a theoretical evaluation aimed at comparing a current or proposed intervention against scientific knowledge or expert analysis in order to better understand the intervention’s strengths and limitations. Using logic analysis, we are able to propose an interpretative framework that puts the intervention in perspective and contributes to the improvement of intervention models initially proposed. In this article, we present the logic analysis of dual diagnosis guidelines. Our analysis leads to a better understanding of service integration processes, essential in improving integration experiences for dual diagnosis clientele.

We first discuss briefly the challenges of developing an adequate solution to dual diagnoses, as well as criticisms of Mueser et al.’s ITM. Second, we present our strategy and methods, based on program theory analysis (or “logic analysis,” Contandriopoulos, Champagne, Denis, & Avargues, 2000), for evaluating the model of organization proposed in the ITM. Third, we present the ITM, or the professional model. Fourth, we review and synthesize the organizational literature of service integration in general (i.e., beyond our specific context), for an in-depth examination of integration processes. Fifth, we discuss the convergences between Mueser et al.’s professional model and the organizational models from the literature, and propose an interpretative grid for developing and analyzing new ways of providing integrated care for dual diagnoses.

We are then able to use this analysis to open new avenues of interpreting current guidelines, to identify factors that might increase successful integration, and to move toward the development of alternative models adapted to particular contexts.

2. The challenge of dual diagnosis

People who present with a dual diagnosis live with mental, emotional, and psychiatric problems, as well as with substance abuse, whether of alcohol, other psychoactive drugs or medication (Center for Addiction and Mental Health, 2002; Nadeau, 2001). Their situation is not so much a simple juxtaposition of disorders, but rather a synergistic co-occurrence, in which both disorders interact with and compound each other.

2.1. Clinical and organizational challenges

Dual diagnosis constitutes a serious clinical and organizational challenge for several reasons.

First, there are difficulties related to the characteristics of the patients themselves. Often a dual diagnosis is not merely a combination or simultaneous presence of two problems—mental illness (schizophrenia, major depression, etc.) and substance abuse (cocaine, alcohol, etc.)—but also involves multiple problems (violence, criminal prosecution, etc.) for which it is often necessary to call upon several treatment sites and resources (primary care, long-term care, criminal justice, child and family protective services, etc.) (SAMHSA, 2003; Ziedonis et al., 2005).

In addition to the broad range of services necessary, the extent to which dual diagnosis patients utilize each is considerable (Comitépermanent de lutte à la toxicomanie, 1997a, 1997b; Mercier & Beaucage, 1997; RRSSS Montréal-Centre, 1999).

Poor collaboration between these services presents further difficulties. Few professionals are interested in working with this clientele, and only a limited number of intervention environments willingly accommodate them (Nadeau, 2001). Despite the existence of practice guidelines, few practitioners receive training for dual diagnosis and most feel uncomfortable working outside their knowledge base (SAMHSA, 2003; Ziedonis et al., 2005, p. 332). Psychiatric and substance abuse services function in parallel rather than collaboratively, due largely to their cultural and structural differences (Nadeau, 2001). Services are fragmented and generally focused on specific disorders (Ziedonis et al., 2005). Furthermore, interventions implemented do not always guarantee continuity of services (Comitépermanent de lutte à la toxicomanie, 1997b, p. 6; Ziedonis et al., 2005). Successful experiences are not well known (Comité permanent de lutte à la toxicomanie, 1997b, p. 6).

Until now, the dual diagnosis issue has been studied from the clinical aspects of treatments and programs, but little attention has been paid to political or organizational questions (Drake et al., 2001). Experts recognize that, given the complexity of interactions between mental health and substance use disorders, major integration of the two sectors is required to establish adapted services.

2.2. Responding to these challenges: criticisms of the integrated treatment model

The guidelines for best practices recommend integrated treatment to better address dual diagnosis. However, there is no clear consensus on the effectiveness of such integrated treatment, due to the difficulty of retaining patients in treatment, as well as to the variety of models implemented (Donald, Dower, & Kavanagh, 2005; Mangrum, Spence, & Lopez, 2006). Mueser et al.'s model proposes an inclusive approach involving both clinical and organizational restructuring, which works if implemented with complete fidelity (Torrey et al., 2002). This model has strongly inspired the treatment recommendations of various organizations in their elaboration of clinical practice. However, the fidelity that seems to be required is difficult to attain in practice, eliciting criticisms against the ITM by clinicians in psychiatry, substance abuse and rehabilitation treating people with dual diagnosis (Center for Addiction and Mental Health, 2002).

The first criticism has to do with the organizational obstacles associated with setting up integrated teams. Drake et al. (2001) stress the difficulty of implementing this model on a large scale in the absence of a fundamental reorganization of the health system and its modes of funding not only institutions, but also professionals. The ITM requires a profound reorganization of health system functioning, a reallocation of staff, and the addition of financial resources (Bradizza & Stasiewicz, 1997; SAMHSA, 2003). Such optimal conditions are not easily achieved, which impedes implementation of the ITM.

The second criticism is that implementations are successful in only a small minority of the total number of situations in which ITM would be desirable. Even in the few cases where ITM is actually implemented despite the abovementioned difficulties, only between half and two-thirds of them have succeeded in maintaining the high level of faithfulness to the model required to ensure its effectiveness (Torrey et al., 2002). Thus, we observe a high rate of failure among those clinicians who decide to implement this model, even when they succeeded in meeting the conditions for major reorganization.

Many critics also emphasize that, while this model seems well adapted to the needs of patients with severe disorders, a more autonomous clientele would benefit from other modes of service organization (Donald et al., 2005). Drake et al. (2001) note the absence of specificity of treatments for dual diagnosis. Clément and Aubé (2002) also note the importance of being attentive to patients' clinical particularities when reorganizing services: clinical objectives for those with dual diagnosis may not be compatible with the ITM's objective of service continuity, the pursuit of which may not always lead to a desirable treatment approach. These latter comments underscore the importance of developing differentiated approaches in service organization that are appropriate to particular clienteles (Bradizza & Stasiewicz, 1997).

The ITM offers both a clinical proposition and a model for service organization as a response to the dual diagnosis issue and has the dual advantage of demonstrated effectiveness and the identification of key factors that support its implementation and program monitoring. Still, as we have seen, it does not constitute a solution in contexts where organizational, human and financial constraints are significant, and it appears less suited to more autonomous clienteles. Given the paucity of articles that would make it

possible to identify critical factors of program effectiveness (SAMHSA, 2003; Torrey et al., 2002), health professionals have no choice but to depend on the only model that seems to have proved itself.

There are, however, other possibilities to explore. The Substance Abuse and Mental Health center of Toronto, which established the guiding principles for the treatment of dual diagnosis in Canada, has conducted an interesting analysis of service integration for dual diagnosis by dividing approaches into program integration and system integration. Program integration refers to treatment approaches, which must be coherent, coordinated and adapted to the needs and abilities of each patient. System integration involves establishing sustainable links between those providing services and the treatment units (Randolph, 2000, cited in center de toxicomanie et de santé mentale, 2002, p. 19). Separating these features allows us to see the importance of organizational factors in developing new models of care and service, and suggests that it is possible to offer solutions to the identified difficulties using the organizational knowledge in the service integration literature. Given this, logic analysis (or program theory analysis) presents itself as a useful technique in rethinking service integration models for dual diagnosis.

3. Evaluation strategy and methods

At its beginning, program theory was simply called a “chain of objectives”:

The evaluation study tests some hypothesis that activity A will attain objective B because it is able to influence process C which affects the occurrence of this objective. An understanding of all three factors—program, objective and intervening process—is essential to the conduct of evaluative research (Suchman, 1967, p. 177).

After this beginning, program theory quickly became elaborated as an essential pre-evaluation step in any discrepancy evaluation (Provus, 1971). It has since appeared under such labels as action theory, program theory, and logic analysis (Chen, 2005b; Mathison, 2005). Representations of interventions also became more complex, with the causal path of the intervention often being separated from the operational elements. There is no consensus in the literature on how best to represent intervention logic. The role of logic analysis has also expanded to include an active role in the evaluation itself (Chen, 2005a) going beyond representation of the intervention. It is only recently that logic analysis became an evaluation in itself (Contandriopoulos et al., 2000). Nowadays, logic analysis proposes a theoretical evaluation of the intervention. It is a way to analyze and improve the theory of the intervention by comparing program theory against scientific knowledge. It is very useful in better understanding the intervention, with its strengths and weaknesses, and how it might be improved.

Using logic analysis we tested the plausibility of the ITM's organizational hypothesis by collating and comparing the professional and the organizational literatures. The professional literature deals with recommendations for dual diagnosis. We were able to identify the essential clinical and organizational components of the ITM. We then analyzed the scientific organizational literature on integration in general (organizational model). We compared both

literatures, to identify shared elements related to integration and those that were different, in order to re-interpret the professional model and place it in a larger conceptual model.

By integrating the professional and organizational literatures, we are able to propose a conceptual model for dual diagnosis service integration that involves a reinterpretation of the present guidelines and offers new opportunities for service organization. Our evaluation team is a multidisciplinary group composed of experts in dual diagnosis treatment, integration of services and evaluation. We have validated our analysis and the theoretical model by presenting them to experts in substance abuse treatment and in psychiatry who are involved in addressing the dual diagnosis issue.

4. The professional model: integrated treatment (ITM)

The ITM can be divided into sub-categories: essential clinical components, essential organizational components and enabling factors (see Fig. 1). Each sub-category is detailed below.

4.1. The essential clinical components

Mueser, Noordsy, Drake, and Fox (2001, 2003) note several essential attributes of integrated programs. First, integrated programs should adopt an outreach practice geared toward a patient's "natural environment" rather than the clinical one. This allows the clinician to better identify the patient's circumstances, establish a relationship of trust, and ensure medication is taken. Second, integrated treatments should be broadly contextual, that is, not centered directly on the patient's substance abuse but based on an approach whereby life habits are modified, and should take into account the effects these modifications can have on the patient. Third, the objective of integrated programs should be to promote shared decision-making with patients and their families, to maximize the chances of treatment success. Fourth, a damage reduction approach should be adopted, particularly at the beginning of treatment, aimed at decreasing the negative effects of substance abuse and establishing a good-quality therapeutic relationship between the patient and clinician. Fifth, the treatment should not impose a time constraint on the patient. Lifestyle changes can be spread out over several months or even several years. Finally, to motivate the patient, treatment should be subdivided into stages (commitment, persuasion, active treatment and prevention of relapses).

Together, these seem to be the determining factors for effective programs. Mueser et al. maintain they are dealing with principles rather than with a formal care model, and stress that adopting this model must not impede institutions' organizing themselves differently and adopting other therapeutic methods. Nevertheless, along with clinical recommendations, they propose a service organization model, with additional factors essential to the implementation of the ITM.

4.2. The essential organizational components

The ITM suggests only one healthcare team should be created. This is accomplished through one of two principal models for service organization: a new organization of practice within

psychiatry departments (“cooptation”) or the creation of multidisciplinary (mental health and rehabilitation) teams (“merger”) (Mueser et al., 2003, p. 34).

4.3. Enabling factors

Mueser et al. note various factors that support integration of services for people with dual diagnosis: strong leadership; multidisciplinary healthcare teams; development of clinical expertise in specific fields; elaboration of treatment protocols; provision of training, including training for doctors in the treatment of dual diagnosis; systematic and complete evaluation of the disorders; establishment of extensive and broad-context treatments; links with mutual aid systems; coordination of levels of care; systems for monitoring clinical cases and data; and funding to support the program.

Other factors influencing the establishment of integrated services include the financial resources on hand, leaders’ and clinicians’ propensity to innovate and the presence of strategic opportunities (Mueser et al., 2003).

5. The organizational model: integration of services

5.1. The dimensions of integration

Integration is the process that consists in creating and maintaining, over time, a common control mechanism among autonomous actors (and organizations) with the objective of coordinating their interdependencies in order to allow them to cooperate in the realization of a collective project. (Contandriopoulos, Denis, Touati, & Rodriguez, 2001, p. 41)

Based on the model of Shortell, Gillies, Anderson, Erickson, and Mitchell (1996), many experts have suggested four dimensions of integration leading to systemic integration, with certain variations in definitions and appellations: functional integration, integration of clinical teams, integration of care and normative integration (Champagne et al., 2001; Contandriopoulos & Denis, 2001; Sicotte, Lehoux, Champagne, & Gamache, 2001; Touati et al., 2001).

Functional integration involves coordination between support activities (financing, management and information modalities) and clinical activities. Integration of clinical teams involves the establishment of multidisciplinary professional teams and their continued functioning within the network structure. Integration of care consists of sustained coordination of clinical practices dealing with the health problems of each patient. Normative integration aims at ensuring coherence between the collective system of values and representations, the governance, and the clinical system.

Finally, systemic integration refers to coherence among the different levels of integration, such that the integrated system can function in a sustainable way (Contandriopoulos et al., 2001) (see Fig. 2).

Shortell et al. (1996) note that functional integration and integration of clinical teams are both necessary for integration of care, and that the integration of clinical teams is based on functional integration. However, the logical sequence may be different (Contandriopoulos &

Denis, 2001; Touati et al., 2001). Thus, even though there seems to be a relative consensus on the dimensions of integration and their definitions, the process leading to integration still remains non-consensual in these writings.

5.2. The organizational modalities

The literature on integrated services encompasses various forms of service organization: merger, cooptation, virtual integration, vertical versus horizontal integration, etc. (Fleury, 2002; Page, 2003). This literature suggests that more flexible modes of integration than merger and cooptation may exist. A common example of such flexible modes is that of service networks where professionals from multiple organizations link together and become jointly involved in the production of care. The focus of integration is more on cooperation and coordination, rather than on a specific organizational form. These considerations are important for the treatment of patients with dual diagnosis, since multiple partners are involved.

Several modalities of service organization have a significant influence on the propensity for developing cooperation and coordination: the centrality of organization, the institutions' autonomy and the nature of their links.

5.2.1. The centrality of organization—Networks can be monocentric or multicentric (Lamarche, Lamothe, Bégin, Léger, & Vallières-Joly, 2002). The term monocentric implies, in general, a limited number of partners gravitating around a reference point whose influence is central. The effectiveness of the monocentric network depends on liaison mechanisms negotiated between partners, dealing especially with transfers not only of patients, but also of information needed for continued delivery of care and services. Coordination of care is essentially sequential and generally leads to greater standardization of procedures.

A multicentric network involves a larger number of partners collectively engaged in the conception of a treatment plan. Influence is therefore more widely distributed than in a monocentric network. In this more complex context, the effectiveness of negotiated liaison mechanisms requires clinical consensus guiding the establishment of treatment plans. Coordination of care is then mostly collective, through teams of professionals jointly involved. Coordination may also be reciprocal when patients are treated simultaneously by several professionals in different organizations.

5.2.2. The nature of organizations' links—In both types of networks, the organizations maintain inter-organizational links which establish the modes of cooperation between them. Organizations may be tightly or loosely coupled, and their links can range from the rather informal (e.g. virtual integration) to the very formal (e.g. merger) (Markham & Lomas, 1995).

5.2.3. The organization's autonomy—The creation of integrated service networks brings about an interactive dynamic between organizations. At the center of this dynamic, the autonomy of each organization is a crucial issue. The negotiations that arise are influenced by characteristics of the local context, such as their respective management styles and the history of their relationships, as well as local sociodemographic and geographic

characteristics. Also, changes at structural, economic or normative levels may be used strategically by those at higher decision-making levels.

5.3. The processes of network emergence

The literature on processes of integration identifies success factors in, and certain barriers to, the progression of changes (Conrad & Shortell, 1996). The success of any clinical restructuring is emergent by nature and needs to be strongly rooted in existing modes of operation. Several other elements also seem to have a significant impact.

5.3.1. The importance of norms—Treatment plans play an important normative role in the coordination of activities. Clinical consensus (agreements negotiated among professionals on a treatment model or plan) is generally considered the most effective means of coordination, because it permits a standardization of norms (Glouberman & Mintzberg, 2001; Lamothe, 1999, 2002). Such standardization creates a single system of beliefs, a common culture where external control is replaced by internalized attitudes. When this is achieved, professionals can more easily fall back on mutual adjustment, and the unexpected can be managed cooperatively (Glouberman & Mintzberg, 2001).

5.3.2. Modifying practices—The commitment by professionals to modify their practices seems to be of crucial importance to the dynamics of emergence of any restructuring. Professionals need to deconstruct the various negotiated arrangements, both implicit and explicit that ensure the effectiveness of their practices (Strauss, Schatzman, Ehrlich, Bucher, & Sabshin, 1963; Strauss, Schatzman, Bucher, Ehrlich, & Sabshin, 1964), in order to reconstruct new ones. Studies show that interprofessional struggles are at the very heart of professionalism; it is in such competition that each profession defines its work control zone (Freidson 1970, 1984, 1985). This process corresponds to the role creation activities described by Bucher and Stelling (1969).

5.3.3. Trust—The reconstruction of negotiated arrangements depends upon the trust professionals demonstrate in practices with professionals of other disciplines. New relationships of trust must be created, as trust is fundamental to cooperation and coordination between professionals and organizations (Arrow, 1984; Coleman, 1990; Ring & Van de Ven, 1994). Trust relationships cement agreements on rules, avert the need to constantly restart negotiations, and allow a sharing of care responsibilities (Breton & Wintrobe, 1982; Lascoumes, 1996). Trust is all the more important in contexts of teamwork, and where there is little managerial control (Golembiewski & McConkie, 1975; Larson & LaFasto, 1989). Various mechanisms, such as training and internships, can facilitate the establishment of new trust relationships and channel professionals' concomitant learning (Lamarche et al., 2001, 2002; Mueser et al., 2003).

5.3.4. Clinical leadership—The presence of strong and credible clinical leadership also seems essential to the progress of change. Credibility is directly associated with the confidence of other professionals in the leader's expertise and competency (Fortin, Lamothe, & Lapointe, 2002; Lamarche et al., 2002; Mueser et al., 2003).

6. Logic analysis

The aim of logic analysis is to analyze the program theory of an intervention, resulting in the reinterpretation of its conceptualization through the pertinent scientific knowledge. A new theoretical model is then obtained that can help us evaluate the intervention's program theory. It can also be useful to implementers in analyzing and interpreting what is going on, anticipating the sources of potential problems and considering the strategies for solving them.

6.1. Convergences between the professional and organizational models

Numerous points in common can be found between organizational factors noted in articles dealing specifically with dual diagnosis patients and in the literature on service integration in general, particularly regarding factors that promote the emergence of an integrated network: relationship of trust, strong leadership, common culture, learning and training activities, communication and information sharing, innovation. These convergences can be equally observed in other articles concerned with dual diagnosis:

The strongest single predictor of implementation success was the existence of an established institutional structure related to implementation objectives. The most positive outcomes occurred at sites where mental health and substance abuse partners had a history of iterated relationships between the two disciplines. Agency partners' enthusiasm for achieving implementation goals was also found to be influenced by organizational culture [...] Results suggest that the creation of forums where implementation partners can articulate their preferences and concerns, and where mutually beneficial arrangements can be negotiated, seems to have some positive effects on networked policy implementation. Furthermore, the presence of an entrepreneurial leader who is willing to mediate between actors appears to facilitate this process of communication and exchange and encourage the development of positive interactions among networked actors (Carmichael, 2000, p. 1).

There are four critical ingredients in making system-level change: leadership, development of a common language and set of terms, organizational assessment, and internal change process (Ziedonis et al., 2005, p. 332).

The same elements are also noted in the literature since the end of the 1980s on service integration in the mental health sector. Touati et al. (2002, p. 66) note that the "consolidation of partnerships is facilitated by a learning of the actors, based notably on trust which allows one to overcome ideological differences with respect to the nature of the intervention." In Demers, Dupuis, and Poirier (2002), practitioners are perceived as unavoidable agents of integration, with the informal network, the community of practice, and mutual trust appearing as key factors in their mutual adjustment. They also note that network organization, if based on consolidation of informal links, mutual trust, shared values, and interdependencies, can mobilize people more effectively than a bureaucratic organization focused on structural changes ever could.

These important convergences make a strong case for interpreting the ITM through the organizational literature, while highlighting the importance of some variables having a significant influence on services integration. We have therefore collated the two models, proposing an interpretative grid for developing or analyzing experiences of treatment integration for dual diagnosis.

6.2. Interpretative grid for integrated care for dual diagnosis

Building upon the professional and the organizational literatures, we constructed a conceptual model for integrating services for dual diagnosis (see Fig. 3). By consolidating knowledge on integration processes, essential clinical components and enabling factors of the professional model, we can identify the essential clinical, organizational and contextual factors for implementing integration. The literature on integration also allows us to discern key integration mechanisms. Lastly, integration is considered through the concepts of modalities, forms, and dimensions. This synthesis leads to the development of a grid for conceptualizing and analyzing integration experiences. As each element in the grid has been presented previously, we will not discuss them, but will concentrate on several lessons that arise from this exercise.

6.2.1. Which model for integrated services?—Logic analysis leads to a larger vision of the significant components for interpreting integration experiences than previously proposed by the ITM. It positions the ITM as a particular model of organization. The ITM proposes two principal forms of service integration, merger or cooptation. However, other forms of service integration could be envisioned. In considering these propositions, we should take into account additional elements, such as institutions' autonomy and centrality of influence, which seem to be important factors in characterizing services integration. Also, the integration experience is best interpreted through the dimensions of integration, which could be helpful in analyzing the level of integration, a difficulty DiNitto, Webb, and Rubin (2002, p. 625) have noted. For example, members of a team working at the same place might have very different ways of conceiving dual diagnosis and treatment approaches. This would result in clinical team integration without the normative integration which is crucial in dual diagnosis. Examining the dimensions of integration may be helpful for deconstructing and understanding what is really going on.

Based on the dimensions and characteristics of broader integrated services, it is possible to offer a finer analysis of the specific dimensions and characteristics of service integration, which is an identified need in the professional literature.

“There are many different perspectives on how integrated treatment should be defined and what types of programs constitute examples of integrated treatment” (Ziedonis et al., 2005, p. 317).

Integration depends much less on the particular structure of the program (e.g. merger, virtual integration, etc.) than on the configuration of the characteristics and the coherence between the dimensions of integration.

Finally, there is a clear need to develop alternative forms of integrated services for dual diagnosis according to particular contexts of care organization. Even if the ITM currently

predominates, we should not exclude other approaches (Rosenheck, Resnick, & Morrissey, 2003). The grid we propose here may be a powerful tool for conceptualizing or interpreting integration experiences.

6.2.2. How to achieve integrated services?—To enhance service integration processes, Mueser et al. propose a monitoring chart. With our theoretical model, integration mechanisms are better identified, as well as organizational characteristics and contextual factors that may have a determining influence. Not all elements will have the same influence on integration, and their relative importance may vary according to contexts. A clearer understanding of integration processes allows clinicians and managers to better target activities to enhance integration. DiNitto et al. (2002, p. 625) noted: “most of the studies had mixed results; positive results were of modest magnitude.” Our theoretical model can help reinforce integration processes and increase the probability of successful experiences.

This model can be an important resource to practice communities in understanding integration processes and in adopting modes of operation that are appropriate to the realities of their own practice environment. A better understanding of the mechanisms and conditions of emergence also facilitates the generalization, adaptation and transfer of experiential knowledge to other sites.

7. Conclusion

Analyzing the program theory of the ITM for dual diagnosis of mental health and substance use disorders helped to identify not only important convergences between the organizational and professional literatures, but also other significant predicative factors for health services integration. Our analysis emphasized the relevance of these convergent factors to the specific context of dual diagnosis care, by validating the enabling factors identified in the ITM. It also expands on alternative integration models by taking into account the characteristics and dimensions of integration, so that these models could be better adapted to contextual characteristics. Lastly, our analysis allowed us to develop an interpretative grid for guiding and evaluating the integration of services.

According to the writings on dual diagnosis, there is clearly a problematic lack of cross-fertilization between the fields of psychiatry and rehabilitation, even though an integrated treatment approach exists and is widely available. The most commonly noted difficulty in developing an integrated treatment approach is what Glouberman and Mintzberg (2001) call “professional curtains”, which separate, in an almost impermeable manner, one medical specialty—in this case, psychiatry—from a field occupied by other professionals—in this case, substance abuse and rehabilitation. It therefore seems that the critical success factor in integrating services is the ability to promote normative integration, i.e., common values and modes of operation.

The recommendation that substance use and mental health disorders should be treated together is quite recent. Practice guidelines appear to be just the tool needed to promote interpenetration of professions (Burns, 1999; Ridgely, Goldman, & Willenbring, 1990), standardization of practices and development of a common organizational culture. This leads

us to consider best practice guidelines in a new light. Rather than constituting the final objective of service integration for dual diagnosis, should we not consider them a starting point for establishing that integration?

8. Lessons learned

Logic analysis has been shown to be a powerful tool for reinterpreting the ITM currently considered best practice in the field of dual diagnosis. The idea of identifying and separating the clinical and organizational aspects of integration has raised a great deal of interest among professionals who have attended our presentations, many of whom lack expertise in organizational theory, though they are committed to the integration of care. The conceptual model we propose helps them recognize the organizational dynamic they are involved in and supports their efforts for developing integrated care.

Logic analysis of these circumstances drew upon expertise from the fields of evaluation, organizational theory, psychiatry and dual diagnosis, and without it, this evaluation would not have been possible.

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Fig. 1.
Components of the integrated treatment model.

Fig. 2.
The dimensions of integration.

Fig. 3.
Logic model of service integration for dual diagnosis.