

Introduction

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The study of co-occurring substance use and mental health problems, or concurrent disorders, has emerged as a dynamic space, where knowledge and practice are constantly evolving. This sets the stage for lively debates among researchers, the community of professionals who work in addiction, mental health and concurrent disorders, as well as people who are affected by concurrent disorders: clients and their families. Although concurrent disorders—variously known as dual diagnosis, co-occurring disorders or dual disorders—as a discipline is just over two decades old, many clinicians have been attempting for much longer to provide comprehensive care for clients who have substance use and mental health problems.

Over the past 20 years, researchers and clinicians have worked to find common ground between the substance use and mental health systems, each of which had developed strong traditions and treatment approaches, usually funded and operated quite separately from one another. The earliest evidence-based work in the area of co-occurring substance use and mental health problems focused on people with severe mental health disorders. We now recognize that the topic of concurrent disorders encompasses a full range of co-occurring substance use and mental health problems.

MENTAL HEALTH PROBLEMS

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994) lists 16 major diagnostic classes of psychiatric disorders. Differential diagnosis requires that the therapist fit mental health problems into one or more categories based on whether the problems meet a defined set of criteria. This can be a difficult task, particularly when behaviours are the result of a complex interaction between substance use and mental health problems. In the first stages of a treatment relationship, it may be useful to take a dimensional approach that looks at problems on a continuum of severity. One advantage of this approach is that it includes symptoms that may be causing distress but that might not meet DSM criteria.

In our clinical work we find it useful to group behaviours into four dimensions:

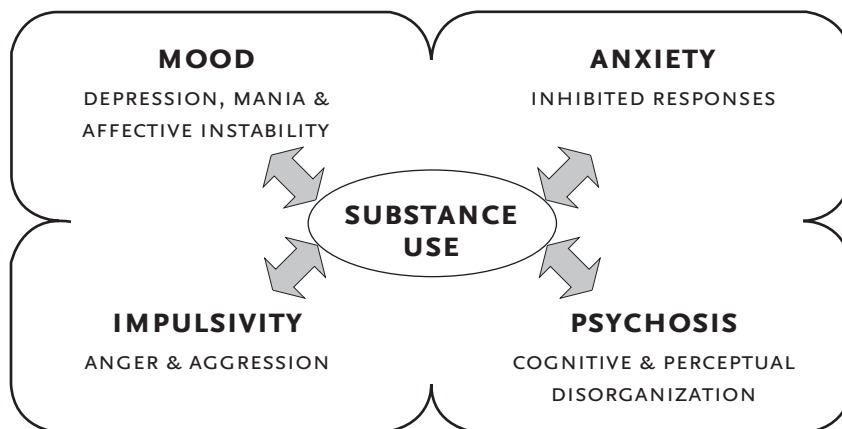
- *psychosis*: involving problems of cognitive and perceptual organization
- *impulsivity*: including problems of anger and aggression, including risk of harm to self and others
- *mood*: including depression and affective instability
- *anxiety*: involving the problematic inhibition of responses.

Personality disorders (called Axis II disorders in DSM) can also be accommodated in this model. The DSM-IV identifies three clusters of personality disorders:

- *Cluster A* (called the “odd” cluster in earlier versions of the DSM) belongs in the psychosis dimension, and includes diagnoses of schizoid, schizotypal and paranoid personality disorders.
- *Cluster B* (previously called the “dramatic” or “impulsive” cluster) belongs in the impulsive dimension, and includes antisocial, narcissistic, histrionic and borderline personality disorders.
- *Cluster C* (previously called the “anxious” cluster) can be found in the anxiety dimension, and includes compulsive, avoidant and dependent personality disorders.

FIGURE 1-1

A dimension approach to mental illness



The dimensional approach allows the counsellor to explore the dimensions in which the mental health problems are evident, regardless of whether they are Axis I or Axis II disorders.

SUBSTANCE USE PROBLEMS

We also find it helpful to take a dimensional approach to substance use, by grouping different substances into one of three broad groups, according to their effect on the body and the brain.

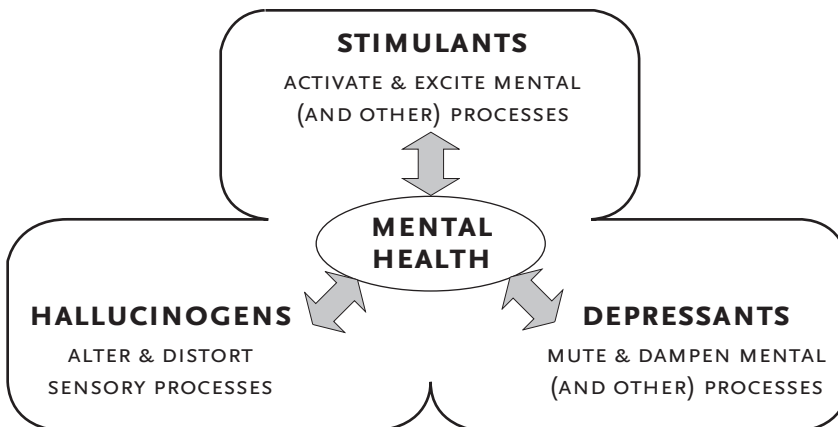
- *stimulants*: substances that excite and stimulate mental processes
- *depressants*: substances that dampen and mute mental processes
- *hallucinogens*: substances that alter and distort perceptual and sensing processes.

The number of substances that can be placed in any of these groups is formidable. Yet, from our clinical perspective, *most* clients' primary problems are with:

- alcohol
- cocaine and the amphetamines
- opioids (including heroin and pharmaceutical opioids)
- cannabis
- prescription tranquillizers.

FIGURE I-2

A dimension approach to substance use



Although, when looking at concurrent disorders, tobacco is not usually identified as the substance for which clients are seeking help, nicotine needs to be identified as problematic. Its prevalence among people who have concurrent disorders is disturbingly high, and its use will seriously affect the health and life course for many clients.

TABLE 1-1
Dimensional approach for grouping mental health and substance use problems

DIMENSION	VERBAL BEHAVIOUR	MENTAL HEALTH PROBLEM		SUBSTANCE USE PROBLEM
		AXIS I: MENTAL HEALTH DISORDERS (EXAMPLE)	AXIS II: PERSONALITY DISORDERS (EXAMPLE)	
PSYCHOSIS (COGNITIVE-PERCEPTUAL ORGANIZATION)	“weird talk”	schizophrenia, other psychotic disorders, mania	schizoid, schizotypal, paranoid	substance-induced psychotic disorder (e.g., cocaine-induced paranoia), substance-induced delirium
IMPULSIVITY (ANGER/AGGRESSION)	“threat talk”	impulse control disorders, gambling, sexual paraphilias, bulimia, alcohol or other drug abuse/dependence	antisocial, borderline, narcissistic, histrionic	substance-induced impulse control disorder (e.g., amphetamine-induced sexual disorder)
MOOD (DEPRESSION & AFFECTIVE INSTABILITY)	“sad” talk, laconia, “manic/grandiose” talk	depressive disorders, dysthymia, bipolar disorders	affective features often present in personality disorders	substance-induced mood disorder (e.g., heroin-induced depression)
ANXIETY (INHIBITION)	“fear talk”	anxiety disorders, panic disorders, phobias, obsessive-compulsive disorder	avoidant, dependent, obsessive-compulsive	substance-induced anxiety disorder (e.g., cannabis-induced anxiety disorder)

THE RELATIONSHIP BETWEEN SUBSTANCE USE AND MENTAL HEALTH PROBLEMS

Having a mental health problem increases the risk of having a substance use problem, just as having a substance use problem increases the risk of having a mental health problem (Health Canada, 2002). As well, substance use can cause behaviours that mimic symptoms of mental health problems. These substance-induced problems improve as substance use is decreased or stopped.

Factors that affect the relationship

The nature of the relationship between substance use and mental health has been a topic of concern among clients, families and professionals for years. Are the substance use behaviours causing psychiatric symptoms? Are the mental health issues leading people to use substances to get relief from their troubled mental states? Unfortunately, the relationship between co-occurring mental health and substance use problems is usually much more complicated than simple cause-and-effect:

- There can be, for example, *predisposing* factors that affect vulnerability to certain problems.
- There can be *precipitating* factors that relate to the initiation or onset of problems.
- And there are usually *perpetuating* factors that shape the way problems continue.

Even when one problem was clearly present before the other, the problems may interact, and the relationship between them may change over time.

Interaction models

Degenhardt et al. (2003) suggest four types of models to explain concurrent disorders:

- *Common factor models* explain that the same set of factors can contribute to increased risk both of substance use and mental health problems. These risk factors may be biological (genetic or disturbances in neurotransmitter function), related to temperament, social or environmental.
- *Secondary substance use models* hold that mental health problems increase the chances of developing a substance use disorder. The self-medication hypothesis, which holds that people use substances to relieve symptoms of mental health problems, is one well-known example of a secondary substance use model. This explanation appears to be more relevant when considering problems related to mood, anxiety and impulsivity than to psychosis. For example, there is evidence that people use alcohol to help them cope with anxiety problems (Thomas et al., 2003). Other theories include alleviation of dysphoria hypothesis; multiple risk factor model; supersensitivity model; and iatrogenic (problems caused by treatment) vulnerability.

- In *secondary mental health models*, substance use may precipitate mental health problems in people who would not otherwise have developed them. For example, cannabis use may precipitate psychotic symptoms in people who are already vulnerable (Hall & Degenhardt, 2000).
- *Bidirectional models* take the view that one problem increases the person's vulnerability to developing problems in the other area. For example, a person who has severe substance use problems may have problems holding a job. This in turn may increase the person's risk of developing depression.

It is also possible—if not common—to find co-occurring disorders that are largely independent of one another. That is, they are both present, but their interactive effect is weak.

Determining the functional relationship between substance use behaviour and mental health problems often shapes the counsellor's expectation (e.g., of what will happen if the client stops substance use). If the client is experiencing problems directly linked to substance use, stopping or reducing use is likely to lead to improvement in mental health symptoms. On the other hand, if the client is using substances to get relief from distressing mental states or from difficult situations, getting him or her to stop use could worsen the client's subjective experience of distress.

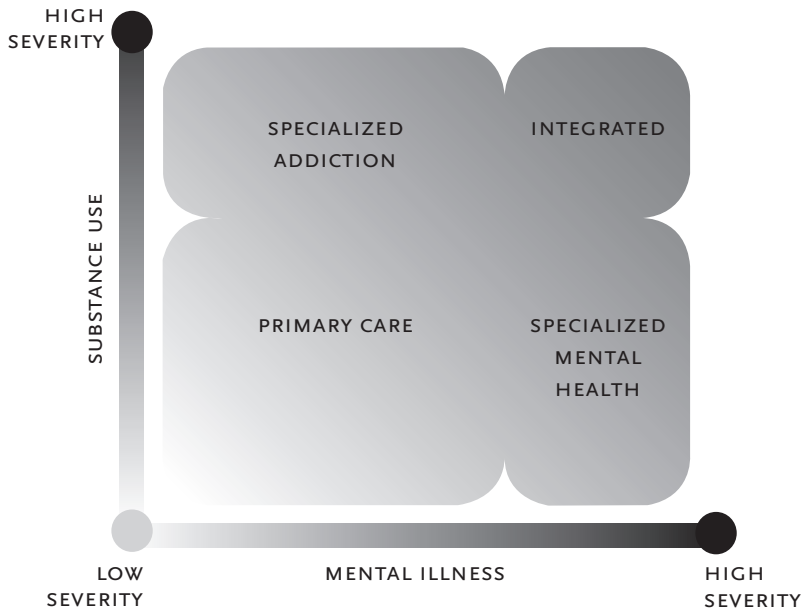
Concurrent substance use and mental health problems also vary in severity. Most mental health services are directed toward helping people who have severe mental illnesses. It is the substance use problems of this population that have had the most influence on the ways that mental health providers have approached concurrent disorders. On the other hand, the addiction treatment system works with people whose substance use problems usually range from moderate to severe. There, the prevalence of mood, anxiety and anger problems has informed the ways that addiction professionals have viewed concurrent disorders (Prim et al., 2000). Thus the treatment setting, and the identified characteristics of the population seeking help in that setting, influence the choice of screening, assessment and treatment approaches.

The four-quadrant framework, developed by the U.S. National Association of State Mental Health Program Directors (NASMHPD) and National Association of State Alcohol and Drug Abuse Directors (NASADAD) Joint Task Force, and adopted by the Substance Abuse and Mental Health Services Administration (Substance Abuse and Mental Health Administration, SAMHSA, 2003), illustrates the range and severity of concurrent disorders within both the mental health and the substance use treatment populations. The framework relates systems of care to problem severity and is intended to help substance use and mental health providers “organize the range of services that can best meet the needs of the individuals with multiple symptoms and varying degrees of severity” (SAMHSA, 2003, p. 59).

Most people with concurrent disorders have mild to moderate substance use and mental health problems. The population-base view (Figure I-3, below) suggests that all levels of the health care system are involved in treating concurrent disorders. There is overlap between these settings, and people may move back and forth based on their stage of recovery.

FIGURE I-3

A population view



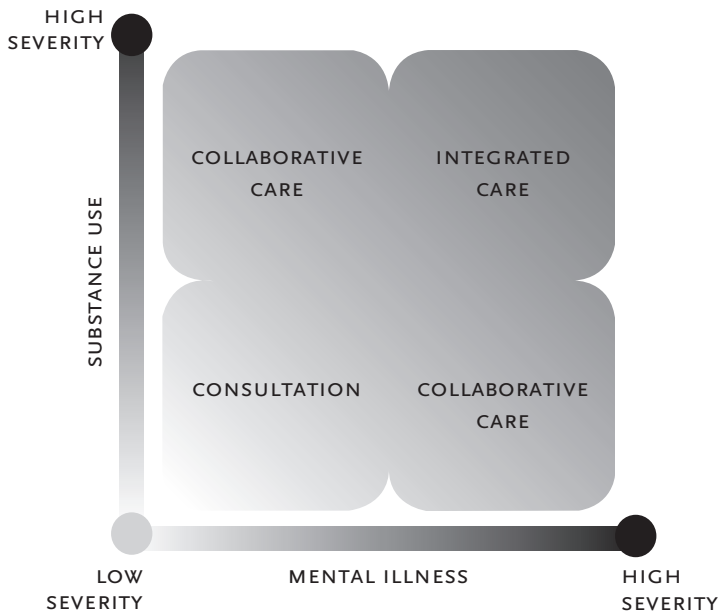
CONCURRENT DISORDERS TREATMENT

Whereas, in the past, substance use and mental health services were often part of separate treatment systems, it is now increasingly recognized that care, for many clients, needs to involve both systems and be delivered in ways that are co-ordinated and collaborative. Treatment for concurrent disorders can be provided at different levels of co-ordination (the choice of level is often determined by the level of severity of the substance use and mental health problems, and the availability of services in a community).

- *consultation*: informal linkages between substance use, mental health and other social service agencies
- *collaboration*: formal links between agencies; can be appropriate for clients who have one moderate and one severe problem (e.g., staff from a mental health and a substance use agency working together to design and implement a treatment plan)
- *integration*: integrated programs providing substance use and mental health treatment within a single treatment setting. Comprehensive integrated program models have been developed in response to the needs of clients with severe mental illness.

FIGURE I-4

Type of care



Integrated treatment

Integrated treatment is founded on the assumption that there is a close relationship between substance use and mental health problems and that one problem shouldn't be treated in isolation from the other. The concept was developed to respond to the difficulties clients had when navigating between the substance use and mental health systems. Drake and Mueser (2000) suggest that integrating treatment services shifts the responsibility for navigating and negotiating the complexities of diverse treatment approaches from clients/consumers to the people and agencies that deliver the services.

Broadly defined, integrated treatment is “any mechanism by which treatment interventions for [concurrent disorders] are combined within the context of a primary treatment relationship or service setting” (SAMHSA, 2003, p. 59). One clinician or treatment team takes overall responsibility for blending treatment and support interventions into one coherent package (Drake et al., 2004).

Much of the literature on integrated treatment has concentrated on clients who have substance use and severe mental health problems, particularly psychotic disorders. The needs of this population led to an emphasis on treating substance use and mental health problems simultaneously and within the same treatment program. The definition of integrated treatment has since been widened to also include approaches that involve co-ordination among staff from two or more agencies. This expanded

definition also allows for staging of treatment interventions within one co-ordinated treatment plan. Because the approach is co-ordinated and consistent, the treatment should appear seamless to the client (Health Canada, 2002).

PROGRAM/SERVICE-LEVEL INTEGRATION

In integrated programs or services, substance use and mental health treatments are delivered by one team of clinicians and support workers in the same treatment setting (Health Canada, 2002). Most integrated programs that have demonstrated good outcomes include:

- staged interventions
- assertive outreach
- motivational interventions
- counselling
- social support interventions (Drake et al., 2001).

SYSTEM-LEVEL INTEGRATION

If all integrated care required that clients be served in a single program, current service systems would have to be rebuilt from the ground up. As mental health and addiction providers and funders realize the need to work more effectively with clients with complex problems, they are turning to improvements that do not require the creation of a new treatment system. Existing systems can offer improved treatment for the full continuum of concurrent disorders if they establish links among treatment programs, some of which have the capacity to deliver both substance use and mental health treatment, and others that co-ordinate services among two or more agencies, allowing each agency to customize treatment to suit the population it serves (Health Canada, 2002).

COMPONENTS OF AN INTEGRATED SYSTEM

With the recognition of the high rates of co-occurrence of substance use and mental health problems comes an expectation that all substance use and mental health programs will develop at least a basic level of skill at identifying, assessing and working with clients with concurrent disorders.

Kenneth Minkoff (2001) describes four levels of agency capability, based on program categories from the American Society of Addiction Medicine. Using his model, but adapting his terminology to the language of concurrent disorders we are using here, the levels are as follows:

1. Concurrent Disorders Capable—Addictions Program: welcomes people with co-occurring disorders whose conditions are sufficiently stable, so that neither symptoms nor disability significantly interferes with standard treatment. Makes provision for concurrent disorders in program mission, screening, assessment, treatment planning, psychopharmacology policies, program content, discharge planning, and staff competency and training.

2. **Concurrent Disorders Capable—Mental Health Program:** welcomes people with active substance use disorders for mental health treatment. Makes provisions for concurrent disorders as above. Incorporates integrated continuity of case management and/or stage-specific programming, depending on type of program.
3. **Concurrent Disorders Enhanced—Addictions Program:** program enhanced to accommodate people with subacute mental health symptomatology or moderate disability. Enhanced mental health staffing and programming, increased levels of staffing, staff competency and supervision. Increased co-ordination with continuing mental health or integrated treatment settings.
4. **Concurrent Disorders Enhanced—Mental Health Program:** mental health program with increased substance-related staffing skill or programmatic design. For example: day treatment units, providing addiction programming in a psychiatrically managed setting; intensive case management teams, providing premotivational engagement and stage-specific treatment for the most impaired and disengaged individuals with active substance disorders; comprehensive housing or day programs, providing multiple types of stage-specific treatment interventions and substance-related expectations.

Approaches to treatment

Treatment for concurrent disorders needs to include:

- screening both for substance use and for mental health problems
- comprehensive assessment
- psychosocial and pharmacological interventions
- a plan for continuing care and support (SAMHSA, 2003).

However, because the population is heterogeneous, no one set of interventions will be effective for all clients with concurrent disorders (Kavanagh et al., 2003).

Evidence-based care

DEFINITIONS

Research using randomized controlled clinical trials is the gold standard for validating the effectiveness of a treatment intervention in a given population. The next best evidentiary base is research using quasi-experimental designs (comparison groups assigned by randomization), followed by open clinical trials (no independent comparison group). While the evidence base for concurrent disorders interventions is growing, very little in this domain meets that gold standard yet (SAMHSA, 2003).

The (U.S.) Institute of Medicine (2000) has suggested that, where results from randomized clinical trials are not available, it is appropriate to use the following criteria to evaluate treatment approaches:

- *best research evidence*: clinically relevant research, often from the basic health and medical sciences, but especially from patient-centred clinical research, into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative and preventative regimens
- *clinical expertise*: the ability to use clinical skills and past experience to identify and treat each client's unique state and diagnosis, to assess the individual risks and benefits of potential interventions, and to do so within the context of the patient's personal values and expectations
- *patient values*: the preferences, concerns and expectations each patient brings to a clinical encounter, which must be integrated into clinical decisions if they are to serve the patient.

EVIDENCE FOR TREATMENT INTERVENTIONS

When we consider the evidence that supports approaches to helping people with concurrent disorders, we need to look at subpopulations. Best practices guidelines published by Health Canada (2002) concluded that there was sufficient evidence to support dividing subpopulations into groups who have co-occurring substance use and:

- mood and anxiety disorders
- severe and persistent mental health disorders
- personality disorders
- eating disorders
- other mental health disorders.

For each group, the report reviewed the evidence for:

- what sequencing of substance use and mental health interventions was most effective
- what treatment approaches were most effective.

Despite the high prevalence of concurrent mood, anxiety, impulsivity and substance use problems, and depression and substance use problems (20 to 30 per cent of the general population), there is still very little evidence on appropriate treatment interventions for this group (Kavanagh, 2003). The stronger body of concurrent disorders research with clients with severe mental health problems (which occur in two to three per cent of the general population) needs to be extended to the other domains, where better evaluated treatments could help inform concurrent disorders treatment practices.

Within the concurrent substance use and severe mental illness subgroup, better evidence exists for overall approaches (integrated treatment, stage-wise treatment, motivational techniques) than for any specific treatment intervention (Drake et al., 2004). We need to know more about what components of integrated treatment are the most helpful to clients. The capacity to provide support, beyond episodes of care from which clients are discharged, appears to be an important feature in producing effective outcomes, avoiding relapses and helping clients live more successfully in the community.

Customizing the helping response to the client's stage of treatment and recovery, combined with a pragmatic harm-reduction orientation, appears to enhance engage-

ment and lead to better working relationships between client and counsellor, and to better outcomes (Roth, 1999).

In the end, even as the research knowledge base is evolving, we, as helping professionals, need to start from where we find ourselves. Some clinical questions cannot wait for an evidence-based solution (Goldman et al., 2001). The evidence-building task is more a continuing journey than a destination. Each new contribution to the literature is an occasion for reflection and re-evaluation of existing practices. Counsellors who work with people with concurrent disorders need to combine the best available evidence with clinical expertise, empathy, respect and common sense. And ultimately, because we work *with* people affected by concurrent disorders—clients and their families—we need to pass the test that they set: that they value our work because, in the face of addiction and mental health problems, it helps them live the lives they want for themselves.

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