

Preface

Approaching concurrent disorders

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A single problem can be difficult enough to address, but when people have more than one, and perhaps many problems, even understanding how these problems relate to and affect each other can be a challenge.

Addiction and mental health workers know that many, if not most, of our clients have problems beyond those that brought them into treatment. Difficulties with interpersonal relationships, employment, finances, housing or the law often go hand-in-hand with substance use and mental health problems. We also know that when people present with either a substance use or mental health problem, their risk of having both kinds of problem is increased. Studies show that about half of the people with either a mental health or substance use disorder have had problems in the other domain at some point in their life (Health Canada, 2002; Kessler et al., 1996; Regier et al., 1990).

When people with co-occurring substance use and mental health problems seek help, the treatment they receive is too often directed at only one of these problems. Helping clients to address one key problem can sometimes start a process of change that goes on to have far-reaching positive effects; other times this approach does little to improve clients' overall situation, and may even make both problems worse. To understand how we can best help a client, we need to look at that person as a whole, and see how that person's problems overlap, disguise or exaggerate one other. Only then we can begin to offer help that is effective.

Although many people have noted the interdependency of substance use and mental health problems over the years, the notion of integrating the treatment of these co-occurring problems is recent. Clients seeking help for these "concurrent dis-

orders” have almost always had to go one place for mental health treatment and another for substance use treatment, often with little or no connection between the services. Only in the past 20 years have clinicians and researchers begun to develop and implement more comprehensive treatments for these clients.

Now that the need for integrated treatment for concurrent disorders is being more widely recognized, there is much to be done. Some clinical practices have been developed, and some of these practices have been supported by research, but much more needs to be discovered.

In this book, we draw on our understanding of existing research and “expert consensus” literature, and also on what we have learned through our work with clients here at the Centre for Addiction and Mental Health (CAMH). Our goal in sharing our understanding and experience is to allow others to take advantage of the gains that we have made, and to join us in pursuing further knowledge in this area.

If you work with clients who have substance use or mental health problems, you are undoubtedly already working with people who have concurrent disorders. If you are committed to understanding and working with clients as whole persons, then you need to understand what these problems are, how they co-occur and how you can help.

Leaving this work to specialists in concurrent disorders is not enough. People in all kinds of helping roles can provide support—people who work in the addiction and mental health systems, obviously, but also people working in other domains, such as criminal justice and corrections, health care, child welfare and family service, employee assistance programs and education.

With this book, our goal is to take information about concurrent disorders beyond academic and scientific discourse, and to make it accessible to a wider range of readers. We hope that counsellors across a diverse range of services will be better able to work with this client population, and that people with co-occurring substance use and mental health problems will get the comprehensive care they need.

DEFINING CONCURRENT DISORDERS

In Ontario, “concurrent disorders” is the term used to refer to co-occurring addiction and mental health problems (see “Defining the Terms,” below). The term covers a wide array of combinations of problems, such as anxiety disorder and alcohol abuse, schizophrenia and cannabis dependence, borderline personality disorder and heroin dependence, and bipolar disorder and problem gambling. These problems can co-occur in a variety of ways. They may be active at the same time or at different times, in the present or in the past, and their symptoms may vary in intensity and form over time.

Note that the term “concurrent disorders” as we define it here does not include co-occurring mental health problems without substance use problems, or co-occurring substance use problems without mental health problems. Such co-occurrences do of course exist, but are not the subject of this book.

Also, our primary focus in this book is on co-occurring mental health and substance use problems, although other behavioural addictions, such as problem gambling, may also be associated with mental health problems.

Defining the terms

Here in Ontario, the Ministry of Health and Long-Term Care uses the term **Concurrent Disorders** to describe co-occurring addiction and mental health problems. Other terms are used in other places and by different groups. The following list should help to clarify the confusion.

Dual Diagnosis/Dual Disorders: outside of Ontario, these terms are often used to describe what we call concurrent disorders. Much of the literature that comes from the U.S. uses these terms, and focuses on severe mental illness and co-occurring substance use problems. In Ontario, dual diagnosis is used to describe co-occurring developmental delay and mental illness.

Comorbid Disorders: Comorbid is a medical term used to describe the presence of more than one significant health problem in a person.

Mentally Ill Chemical Abusers (MICA) and Chemically Abusing Mentally Ill (CAMI): MICA is used to describe people whose primary problem is mental illness, who have co-occurring substance use problems; CAMI refers to people whose primary problem is substance use, who also have mental health problems. Both terms originate in the U.S. literature.

Substance-Abusing Mentally Ill (SAMI): SAMI is used to describe people with serious and persistent substance use and mental health problems.

Double Trouble and Double Jeopardy: These terms are sometimes used by people with co-occurring substance use and mental health problems to refer to their own struggles.

Co-occurring Disorders: This is the term used by the Substance Abuse and Mental Health Services Association (SAMHSA) in their 2002 report to the U.S. Congress.

SETTING THE CONTEXT

Much of the research in concurrent disorders has focused on people with severe mental illness—in particular, on people with psychotic disorders. The excellent work of

Drake, Mueser, Minkoff and others has provided a solid base for work with this population. Their work tends to follow the disease model of addiction, which emphasizes an abstinence-based treatment approach.

Despite the clear value of abstinence as an ideal goal, most experts in the field acknowledge that a relapse to drug use and, in some cases, not even being able to interrupt or reduce drug use, are realities with this client population, and that there is a need to continue to work with these clients even (or especially) when they are not abstinent. Looking at concurrent disorders in this way has helped people realize that these are chronic, recurring problems, and that there usually are no quick remedies. Across North America, this approach has led to the development of integrated treatment approaches and community-based care, and to a greater emphasis on open-ended case management and psychosocial rehabilitation of these clients.

When we look at people whose co-occurring substance use and mental health problems are mild to moderate, there is much less research to draw from. However, we know that, while 2.4 per cent of people in general have severe, persistent mental illness (Standing Senate Committee on Social Affairs, Science and Technology, 2002), mild to moderate mental health issues, especially depression and anxiety, are over-represented among people with substance use problems. Substance use problems also range widely in severity, with the majority of problems falling into the mild to moderate range of the spectrum. For example, it is estimated that there are four times as many people with a “drinking problem” as there are people with severe “alcohol dependence” (Institute of Medicine, 1990).

By including people whose problems fit within the mild to moderate range in our approach to concurrent disorders, our goal is not to take attention away from those with severe mental illness or addiction, but rather to extend the scope of our concern to the full set of people affected by co-occurring substance use and mental health problems. Even when problems are less severe, they still have a profound effect on the person, and on families, friends and colleagues.

A benefit of working with people whose problems are mild to moderate is that there is a greater chance of improved outcome. Less severe problems are often easier to treat. And while building social support and hopefulness about positive change is often a primary challenge when working with people with severe addiction and mental health problems, people whose problems are mild to moderate generally have higher levels of support and motivation. The presence of such factors is predictive of more positive results.

BEST PRACTICES

In *Best Practices: Concurrent Mental Health and Substance Use Disorders* (Health Canada, 2002), experts review and comment on the existing scientific literature, and provide consensus where literature does not exist. The document provides opinions

from stakeholders, including clients, and is a summation of what we know and don't know, with a large nod to what we don't know.

Constructing a best practice model is an ongoing task of bringing together evidence-based knowledge, and of creating protocols of care that we can justify on the basis of the research and what we know produces better outcomes. That task has begun, and in some areas, such as assessment and screening, there is strong evidence of the best approach. In other areas, however, we don't yet have the knowledge to be able to say, "Here's what you should do . . ." We can talk about what we do; we have materials that we can share; but we can't say they have been rigorously evaluated. This is not unlike many other domains of health care practice.

There is some crossover between our book and Health Canada's *Best Practices*. Some chapters in this book are written by people who also contributed to that document. The goal here, however, is to offer more detailed and practical information, revealing how we work to provide specialized services to clients. Some of what we present here does not yet have a best practice literature to support it, but it is included to encourage dialogue and contribute to knowledge- and skill-building in these practice areas, where clinical services are needed, in spite of the lack of a strong scientific literature.

THE BIOPSYCHOSOCIAL–SPIRITUAL MODEL

To help us understand the problems of people with concurrent disorders, we think in terms of the biological, psychological, social and spiritual factors involved in the emergence of these problems and—even more importantly—how these four vectors can become pathways to change and recovery.

For example, if a person has psychosis, or is severely depressed, medication works on the biological level to reduce symptoms. Another person, whose anxiety or anger causes out-of-control behaviours, might be able to manage better with cognitive-behavioural strategies learned in psychotherapy. For someone else, social issues may trigger distress or depression that could be improved with interpersonal therapy. And for another, spirituality can provide a pathway for recovery, as people who join 12-step fellowships such as Alcoholics Anonymous often report.

Our service has evolved in response to the needs of a set of clients in a particular urban and regional context. Over the past decade, we have committed ourselves to working with a heterogeneous client population, recognizing that outside our service there are no real options for integrated treatment for most clients with complex problems. Our treatment services have been determined by the real clients in our clinic, rather than by a theoretical model of concurrent disorders. Our inclination has been to accept all comers.

As such, our approaches have been our best practice efforts to respond to the needs of a particular clinical population. We are fortunate to be able to draw on evaluation material that has allowed us, along with emerging knowledge, to review and

reshape our activities. This is very much a continuing task, so that this book presents a picture of where we stand now, with a nod toward the past and our development, and a glance toward the future and where we see our work evolving.

ATTITUDE AND STIGMA

Most of us—and this includes professionals as well as lay people—at some point in time will experience negative feelings and thoughts that we will project onto people with substance use or mental health problems. These feelings reflect attitudes that have been formed through the influence of our families, our society, our personal experiences and our own level of understanding. Negative feelings such as fear, moralism, pity, derision and even contempt may be subtle or strong, but, either way, they can have immense power to shape and construct the perceptions we hold of the person toward whom they are directed.

It is not incorrect to describe the effects of these feelings and attitudes as hurtful. In time, these hurtful effects are shaped not just by the external attitudes of others toward people with substance use or mental health problems, but also by the internalized attitudes people with these problems have toward themselves. The mark left by these negative feelings, or stigma, can be more long-lasting than the illnesses themselves.

Attitudes change slowly. Much progress has been made toward people's accepting mental health problems as illnesses, but less so with addiction. Although both can be chronic and relapsing health problems, people tend to make a distinction between the two. Some mental health workers, for example, may see people's psychiatric problems as real illnesses, and their substance use problems as intentional behaviour. Addiction workers, on the other hand, may firmly believe that most people can recover from substance use problems, but think people with serious mental health problems are not capable of significant change. As more mental health and addiction workers learn to work with clients with co-occurring problems, and their understanding of the relationship between substance use and mental health problems increases, client care will become more responsive and effective.

The chapters in this book are intended to serve as an introduction to each of the different aspects of identifying, understanding and treating concurrent disorders. The first part provides an introduction to the field, the second looks at the programs offered here at CAMH, and the third offers some theoretical and therapeutic perspectives. The concluding section looks at what is being done here to expand the capacity of our concurrent disorder services, and what can be done in services outside CAMH to better serve these clients.

For many years, addiction and mental health service providers have worked with clients with concurrent disorders, often not having the knowledge, skill, resources or supports to work effectively with such complex problems. In that sense, the tradition has been to work with this population *in spite of* their co-occurring problems. With

the work that has been done to develop more collaborative, integrative approaches to treating concurrent disorders, and with the insights into the inclusive approach to care offered in this book, we hope our readers will be better prepared to welcome the challenges and opportunities of working with these clients, and to work with them not in spite of their co-occurring problems, but *because of them*.

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