Slide 1

Concurrent Disorders

An Introductory Learning Module for Post Secondary Institutions

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

Concurrent Disorders
Training Strategy Project

1

Slide 2

Overall Learning Objectives

You will:

- Be able to define a concurrent disorder (CD)
- Understand the importance of addressing CD
- Examine your own attitudes and values
- Have a basic knowledge of treatment considerations
- Appreciate the importance of the therapeutic relationship

camh

2

Slide 3

Topics in this Module

PART I: OVERVIEW of MENTAL HEALTH & SUBSTANCE USE DISORDERS

- -Mental Health Disorders (MHD) and Substance Use Disorders (SUD)

PART II: OVERVIEW of CONCURRENT DISORDERS

- -What is CD?
- -Attitudes & Values
- -Prevalence
- -Stigma

PART III: SCREENING

- -Why screen for substance use/for mental health/for CD
- -Asking a few direct questions

PART IV: ASSESSMENT & TREATMENT CONSIDERATIONS

- -Assessment and Treatment Planning
- -Diagnostic Assessment
- -Desired Treatment Outcomes
- - What Works
- - Themes for Success
- - Your community

3

Slide 4

Concurrent Disorders

An Introductory Learning Module for Post Secondary Institutions

PART I: OVERVIEW OF MENTAL HEALTH & SUBSTANCE USE DISORDERS

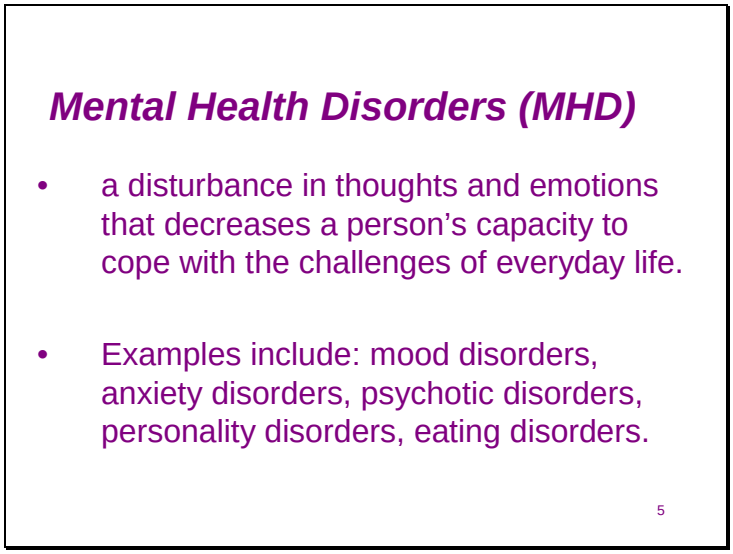
At the end of part I, you will be able to:

- -define mental health disorders
- -define substance use disorders
- -understand the continuum of severity of substance use

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

In general, this learning module uses the term “mental health disorders” although other terms may be used in direct quotes.

Slide 5



The following represents five predominant categories of mental illness as defined in the Health Canada Best Practices – Concurrent Mental Health and Substance Use Disorders.

I. MOOD DISORDERS: persistent changes in mood caused by biochemical imbalances in the brain. e.g. Major Depressive Disorder; Bipolar Disorder (manic depression); Dysthymia (a chronically depressed mood that lasts for most of the day for the majority of the time during a two-year period – Depressive Illness: An information guide, Chris Bartha et al. 1999, CAMH)

II. ANXIETY DISORDERS: feelings of anxiousness combined with physiological symptoms that interfere with everyday activities. e.g. Phobias; Panic Disorder; Obsessive-Compulsive Disorder; Post-Traumatic Stress Disorder

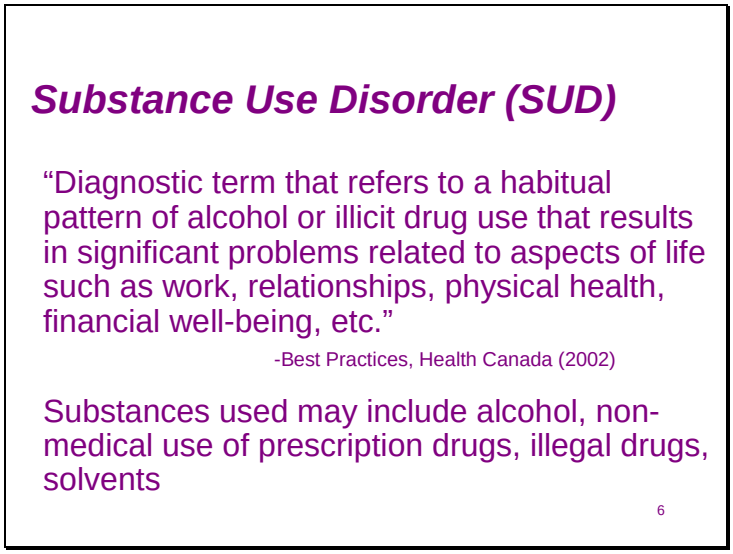
III. PSYCHOTIC DISORDERS: an active state of experiencing hallucinations or delusions and can be organic (mental illness) or drug induced. e.g. Schizophrenia

IV. PERSONALITY DISORDERS: a pattern of inner experience and behavior that is significantly different from the individual's culture; is pervasive and inflexible; is stable over time; and leads to distress and impairment. e.g. Borderline Personality Disorder; Antisocial Personality Disorder, Dissociative Identity Disorder

V. EATING DISORDERS: range of conditions involving an obsession with food, weight and appearance negatively affecting a person's health, relationships and daily life. Stressful life situations, poor coping skills, socio-cultural factors regarding weight and appearance, genetics, trauma, and family dynamics are thought to play a role in the development of eating disorders. e.g. Anorexia Nervosa; Bulimia Nervosa

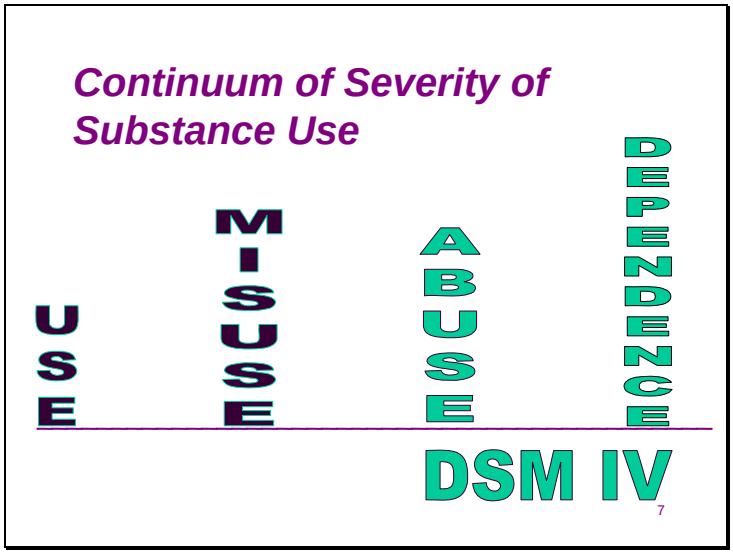
*If you want more information about mental health: please go to Centre for Addiction and Mental Health:
http://www.camh.net/about_addiction_mental_health/info_mentalhealthsa.html
*or The Canadian Mental Health Association:
http://www.ontario.cmha.ca/content/about_mental_illness/about_mental_illness.asp

Slide 6



Substance use disorders are outlined in the DSM IV.
DSM IV: Diagnostic Statistical Manual for Mental Disorders Fourth Edition is used by licensed medical staff to diagnose an individual with a mental health disorder or a substance use disorder.

Slide 7



Instructor Resource: Handout # 1 – Abuse vs. Dependence, and notes below for a more detailed description of Abuse and Dependence
There is a range of use for any substance. Abuse and Dependence are categorized under the DSM IV.

Abuse: A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by one or more of the following in a 12-month period:
Recurrent use resulting in failure to fulfill major role obligations at work, school or home (i.e. repeated absences, poor work or school performance, child neglect)
Recurrent use in situations in which it is physically hazardous
Recurrent use-related legal problems
Continued use despite having persistent or recurrent social or interpersonal problems caused/exacerbated by the effects of the substance
Note: "Abuse" is a value-laden term

Dependence: A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following in a 12-month period:
Tolerance (need for increased amounts of the substance to achieve desired effect or a diminished effect with continued use of the same amount)
Withdrawal (characteristic withdrawal syndrome for the substance or the same substance is taken to avoid/relieve withdrawal symptoms)
Substance is taken in larger amounts or over longer period than was intended
Persistent desire or unsuccessful efforts to cut down or control use
Great deal of time spent in activities to obtain substance, use it or recover from its effects
Important social/occupational/recreational activities are given up or reduced because of use
Continued use despite the knowledge that physical or psychological problems are caused/exacerbated by the substance will lead to tolerance and dependence.

Use: The use of a substance to change the mood, state of mind or state of being of the user.

Misuse: Substance Misuse refers to the use of illegal drugs and the deliberate misuse of alcohol, prescribed or over-the-counter drugs and/or substances such as solvents, glues or aerosols, which impair the individual, interfere with health, affect job performance and safety. The term "misuse" does not imply that illegal substances have a correct use.

Slide 7/Handout 1

Abuse vs. Dependence

Abuse:

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by one or more of the following in a 12-month period:

- Recurrent use resulting in failure to fulfill major role obligations at work, school or home (i.e. repeated absences, poor work or school performance, child neglect)
- Recurrent use in situations in which it is physically hazardous
- Recurrent use-related legal problems
- Continued use despite having persistent or recurrent social or interpersonal problems caused/exacerbated by the effects of the substance

Note: "Abuse" is a value-laden term

Dependence:

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following in a 12-month period:

- Tolerance (need for increased amounts of the substance to achieve desired effect or a diminished effect with continued use of the same amount)
- Withdrawal (characteristic withdrawal syndrome for the substance or the same substance is taken to avoid/relieve withdrawal symptoms)
- Substance is taken in larger amounts or over longer period than was intended
- Persistent desire or unsuccessful efforts to cut down or control use
- Great deal of time spent in activities to obtain substance, use it or recover from its effects
- Important social/occupational/recreational activities are given up or reduced because of use
- Continued use despite the knowledge that physical or psychological problems are caused/exacerbated by the substance will lead to tolerance and dependence.

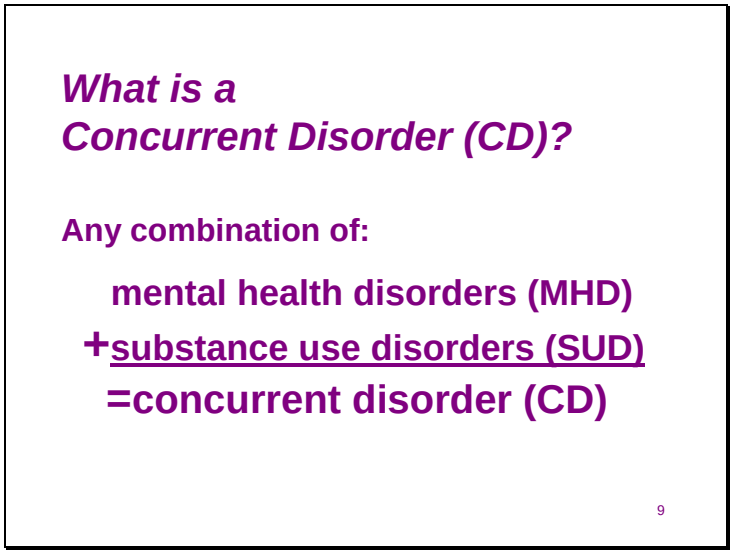
Slide 8

Concurrent Disorders
An Introductory Learning Module for Post Secondary Institutions

PART II: OVERVIEW of CONCURRENT DISORDERS

At the end of part II, you will be able to:
-describe concurrent disorders
-understand the prevalence, effects of and stigma relating to concurrent disorders

Slide 9



Different names have been used over the past two decades to describe the co-occurrence of mental health and substance use disorders. They include:

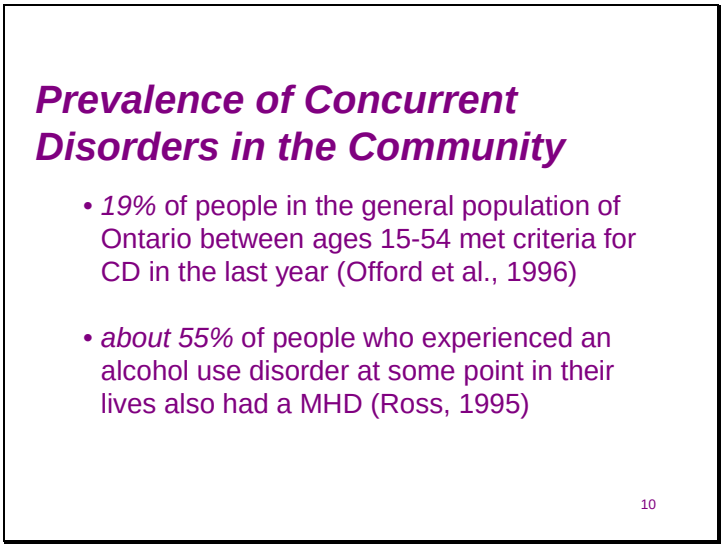
- Dual diagnosis (now used in Canada for people who have a mental illness and a developmental disorder)
- CAMI (chemically abusing-mentally ill)
- MICA (mentally ill-chemically abusing)
- SAMI (Substance abusing-mentally ill).
- Also referred to “Co-Occurring disorders” in the United States.

(Best practices, Concurrent Mental Health and Substance Use Disorders, Ottawa: Health Canada, 2002)

Examples:
Marijuana use and Bipolar Disorder
Alcohol use and Depression
Narcotic use (sleeping pills) and Panic Disorder
Marijuana use and Schizophrenia

Note: **Nicotine** is often overlooked but should be taken into consideration as a problematic substance for health reasons

Slide 10



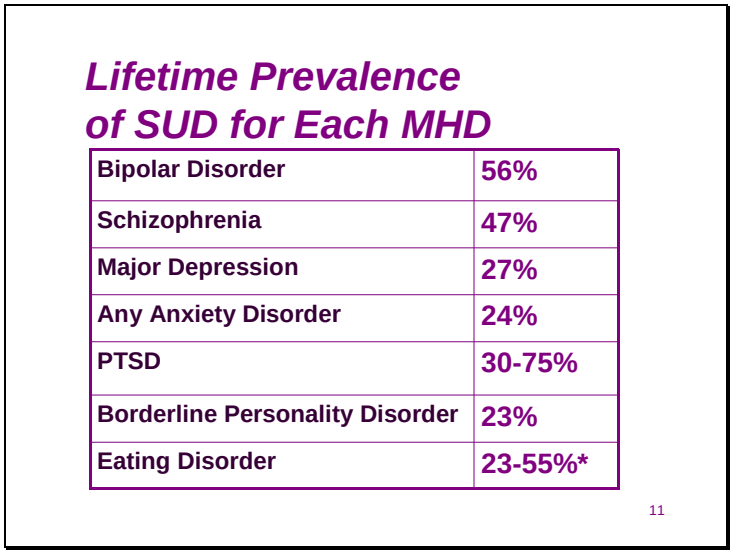
(Ontario Ministry of Health, 1994; Ontario health survey 1990: Mental health supplement, Ontario Ministry of Health, Toronto.)

Note: Statistics vary depending on the study and the criteria that is used:

You will find a wide range of statistics based on the following:

- lifetime occurrence (stats will be higher) vs. snapshot of current situation
- DSM diagnosis vs. symptom reporting
- treatment setting vs. community
- mental health treatment setting vs. addiction treatment setting
- the study being quoted
- substance being investigated (more disclosure of alcohol since legal, than cocaine)
- gender.

Slide 11



Lifetime prevalence indicates that there is a Substance Use Disorder (SUD) during a specific period(s) of time in the person's life. It does not mean that the SUD is necessarily an ongoing problem. Clinicians need to be cautious about stereotyping specific groups based on prevalence trends. For example, among individuals identified as having Bipolar Disorder, 56% have met criteria for a substance use disorder at some point in their lifetime.

Estimates of prevalence may vary between studies depending on:

- whether lifetime, 6-month, or 1-month prevalence is captured
- what criteria are used to establish presence of each disorder

The key message for learners is that concurrent disorders are very prevalent.

Sources:

Rates that appear in the table for **bipolar disorder, schizophrenia, major depression, any anxiety disorder** are taken from CAMH's "Concurrent Substance Use and Mental Health: An Information Guide". The primary source for the Information guide was a large US study called the ECA study- see: Regier, D.A., Farmer, M.E., & Rae, D.S. (1990). *Co-morbidity of mental disorders with alcohol and other drug abuse*. Results from the Epidemiological Catchment Area (ECA) study. Journal of American Medical Association, 264, 2511-2518.

PTSD (Post Traumatic Stress Disorder): Brady et al, 2001, Jacobsen et al, 2001, Najavits et al. 1997

Borderline Personality Disorder: p.60 of "Best Practices – Concurrent Mental Health and Substance Use Disorders". Note: Someone with an Antisocial Personality Disorder is 21X more likely to have a substance use disorder.

Eating Disorders: p.65 of "Best Practices – Concurrent Mental Health and Substance Use Disorders". Note: The prevalence rate is higher with Bulimia than Anorexia Nervosa. The numbers reflect the high end of the each disorder.

Slide 12

Why are Concurrent Disorders Important?

- Poorer treatment outcomes than if person has either a mental health disorder or a substance use disorder
- Concurrent disorders affect many areas of a person's life
- People living with concurrent disorders are common in every treatment setting – they are the expectation not the exception.

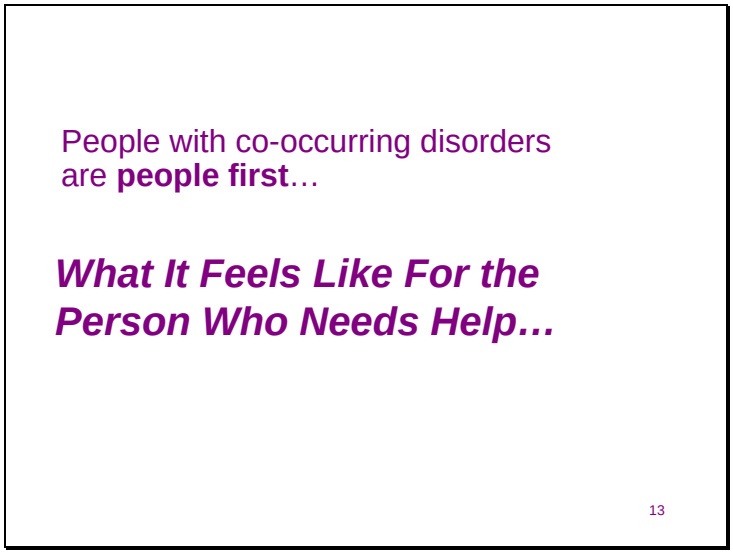
12

TEACHING ACTIVITY: Ask students to brainstorm the areas of a person's life that might be affected by concurrent disorders

Some possible answers include:

- **High treatment program drop out**
- **Loss of family/friends**
- **Violence (more likely to be a victim of violence)**
- **Suicide**
- **Criminal justice system involvement**
- **Increased risk of homelessness**
- **Poor response to medication (substances may interfere with intended effects of prescription medication)**
- **Relapse and/or re-hospitalization**
- **Harmful interaction between psychiatric medication & substances (weakened effect, heightened effect)**
- **Financial problems**
- **Medical problems (e.g. HIV, Hepatitis, sexually transmitted infections, others…)**

Slide 13



Instructor Resource: Handout # 2 – Consumers' quotes

TEACHING ACTIVITY: Divide class into small groups of four or six. Using the handout, give each group one quote to review. Allow for 10 minutes of discussion about the effects or impact that a concurrent disorder has on a person. Groups report back to the class about their discussion.

Consumers' quotes:

"I've gotten help for each individual thing, but to get help for, like at the same time, you fall between the cracks, and if one of your disorders is worse than another, and then one doctor thinks you're seeing somebody else, basically nobody's helping you, nobody follows up, you kind of disappear in there".

"…The threat of being punished for being an addict and having any sort of mental illness…that we are in some way responsible for this, we brought this upon ourselves, and if we don't do A, B, or C, then our children will be taken, and our welfare will be cut, our housing will be gone … there's just such an extraordinary threat and that just absolutely adds on to already extraordinary pressure…it's very demoralizing"

"What (mental health) providers do is they'll look at me and say…'forget about the mental health issue, you've got a real substance abuse problem, and you've got to go get help for that', and either they ignore the using or the fact that I have an addiction, or else they won't even deal with the mental health aspect of it because I've been using."

"This admission, that admission, this specialist, that specialist, but nobody's really doing anything, nothing's really getting done, just a whole bunch of appointments going nowhere."

-Quotes from consumers interviewed for Best Practices in 2002

Slide 13/Handout 2

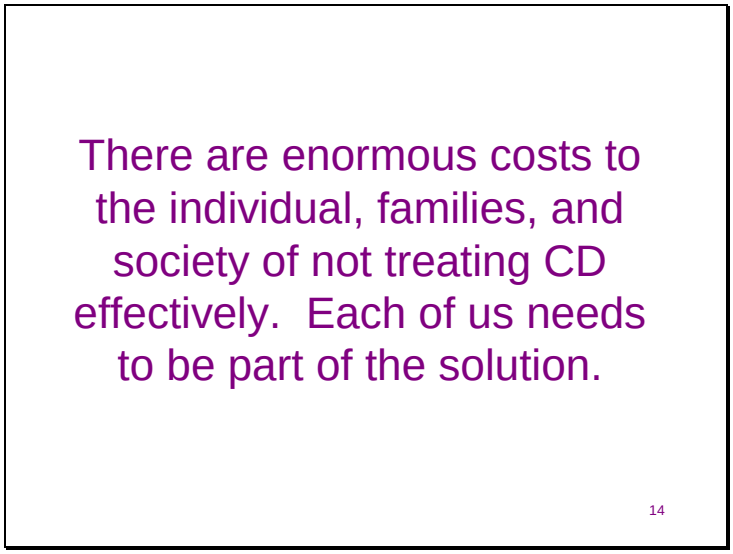
"…The threat of being punished for being an addict and having any sort of mental illness…that we are in some way responsible for this, we brought this upon ourselves, and if we don't do A, B, or C, then our children will be taken, and our welfare will be cut, our housing will be gone … there's just such an extraordinary threat and that just absolutely adds on to already extraordinary pressure…it's very demoralizing"

"What (mental health) providers do is they'll look at me and say…'forget about the mental health issue, you've got a real substance abuse problem, and you've got to go get help for that', and either they ignore the using or the fact that I have an addiction, or else they won't even deal with the mental health aspect of it because I've been using."

"This admission, that admission, this specialist, that specialist, but nobody's really doing anything, nothing's really getting done, just a whole bunch of appointments going nowhere."

"I've gotten help for each individual thing, but to get help for, like at the same time, you fall between the cracks, and if one of your disorders is worse than another, and then one doctor thinks you're seeing somebody else, basically nobody's helping you, nobody follows up, you kind of disappear in there".

Slide 14

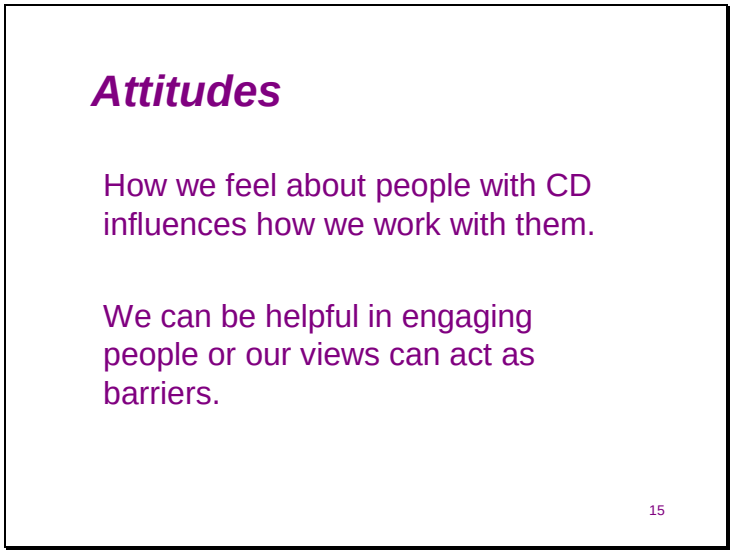


TEACHING TIP: instructor should tailor the slide to apply this to the audience you are working with. Provide examples, such as "In your role as a *service provider** what are ways that you would use this information? What ways can you make a difference?"
*Nurse working in a hospital crisis intervention program, social service worker working in a housing program

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 to working with clients as whole people, 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.

Slide 15



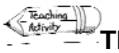
KEY POINT: Some mental health workers, for example, may see people's psychiatric problems as real illnesses, and their substance use problems as intentional behaviour. Addiction workers, on the other hand, may firmly believe that most people can recover from substance use problems, but think people with 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.

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 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.
(Skinner, W. 2005, Treating Concurrent Disorders: A Guide for Counsellors". Toronto: CAMH)

Slide 15 – con't



TEACHING ACTIVITY: Rethinking Normal

1. Ask participants to form groups of two, three or four. Provide each small group with paper and pen.

2. Divide the groups into two sections: One section will take on the label "addiction" and the other section will take on the label "mental illness."

3. Ask the small groups that were assigned the label "addiction" to write down all the negative stereotypes (words or phrases) that society attributes to this label (e.g., through media, etc.). Ask the other groups to do the same for the label "mental illness."
It will be important to acknowledge that it may feel uncomfortable and difficult to see and hear these words. Remind participants that, by the end of the presentation, they will walk away with some strategies designed to stamp out this stigmatizing language.

4. Ask participants how they felt about doing this exercise.

5. Ask a representative from each small group that was assigned the term "addiction" to give three words or phrases that his or her group came up with. (Write them out on the flipchart). After all the "addiction" groups have had a turn, ask if there were any more terms to add to the list. Repeat this step with the small groups that were given the term "mental illness."
Mix up the "addiction" and "mental illness" terms on the flipchart page.

6. As the participants are viewing the list you can use the following script to guide discussion:

Can you imagine leaving your home every day knowing that this is what people are thinking about you? (Pause.)
What are some of the challenges and barriers that people with concurrent mental health and substance use problems face because of these negative stereotypes? (Discuss.)
Society also attributes negative stereotypes to people based on race, gender, sexual orientation, disability, immigration status, being overweight, etc. Imagine the additional challenges and barriers that people with concurrent mental health and substance use problems face if they also experience stigma and discrimination related to these other areas. These labels and stereotypes indicate that a person is somehow "abnormal." Yet when we think of all the layers of stigma that society has created through negative stereotypes, it makes you wonder who actually falls into the category of "normal."
(Beyond the Label, CAMH, 2005)

Slide 16

Instructor Resource: Handout # 3 – Who Wears the Label

TEACHING ACTIVITY: Who Wears the Label? *(Beyond the Label, CAMH, 2005)*

LEARNING GOALS:
• to understand that substance use and mental health problems know no bounds and can enter someone's life anywhere and at any time
• to realize that people with substance use and mental health problems can and do recover, and continue to enrich society with their contributions.

Rethinking Normal:

WHO WEARS THE LABEL?

People living with a substance use and/or mental health problem often feel ashamed, embarrassed and fearful of being judged. These feelings come from being stigmatized by society's negative stereotypes and by labels like "alcoholic," "addict," "psycho" and "mentally ill." For example, the terms "crackhead" and "psycho" often conjure up images of violence.
This stigmatization can lead to prejudice and discrimination, creating barriers for people to seek the help they need. People who live with a substance use and/or a mental health problem want society to know that they are so much more than the label that has been attributed to them. "I'm a human being. These are just some of my warts—but we all have them" (Kittel Canale, 2001, Stigma of Addictions: Final Report. Toronto: CAMH).
With this activity, participants can witness the immeasurable contribution that these famous people, who have lived with or are living with a substance use and/or mental health problem, have given to society.

1. Have participants look over the list of famous people. Ask participants to identify the name of someone they recognize and tell the group what talents or accomplishments that person has given to society. The answers can be written on the flipchart and then taped up around the room.

2. Ask the group to identify some of the barriers these people may have had to overcome because of stigma. (Discuss.)

Slide 16 – con't

3. At the end of the exercise, distribute Handout 2, which lists the famous people and their accomplishments, so the participants will be able to pass on this information to others.

 **TEACHING TIP:** Point out to participants that although you have given examples of famous people who have lived with mental health and/or substance use problems, most people living with these challenges are not in the public eye—they are someone's mother, father, daughter or son.

KEY MESSAGES:

• People living with substance use and/or mental health problems make many important contributions to society.
• People can recover from co-occurring substance use and mental health problems.
• Society must learn to look beyond the label and see a person with strengths, talents and wisdom.

Note: Given the prevalence of concurrent disorders, it is likely that 40 to 60% of these famous people have lived, or are living, with co-occurring mental health and substance use problems. For example, actor and director Drew Barrymore talks about her substance use problem and depression in the book *Beyond Crazy,* by Scott Simmie and Julia Nunes (2002). And biographical accounts of Winston Churchill and Judy Garland indicate that they were also living with concurrent mental health and substance use problems.

For additional TEACHING ACTIVITIES see the Beyond the Label toolkit, CAMH, 2005

Slide 16/Handout 3

“Who wears the label?”

People who have lived with substance use and/or mental health problems

MENTAL HEALTH PROBLEMS

Depression

Buzz Aldrin (astronaut)
Ron Ellis (NHL hockey player)
Abraham Lincoln (American president)
Elizabeth Manley (Olympic figure skater)
Tennessee Williams (writer)
Virginia Woolf (writer)

Bipolar disorder

Patty Duke Astin (actor)
Winston Churchill (former British prime minister)
Ted Turner (founder of CNN)
Ludwig van Beethoven (composer)
Vincent van Gogh (Dutch post-impressionist painter)

Anxiety disorder

Roseanne Barr (actor/comedian)
Nicolas Cage (actor)
Shayne Corson (NHL hockey player)
Aretha Franklin (singer)
Howard Hughes (tycoon)
Ricky Williams (NFL football player)
Oprah Winfrey (actor/talk show host)

Schizophrenia

Emily Carr (artist)
John Nash (scientist—portrayed in movie *A Beautiful Mind*)

Eating disorder

Karen Carpenter (singer)
Mary-Kate Olsen (actor)

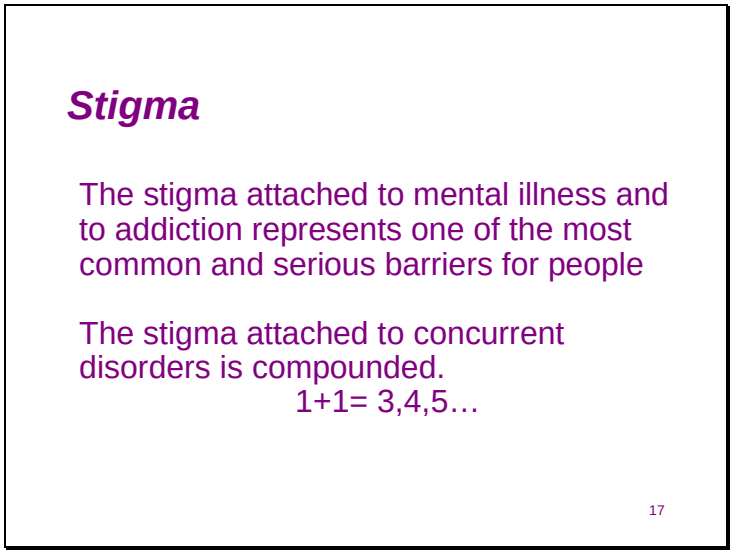
SUBSTANCE USE PROBLEMS

Drew Barrymore (actor and director)
Robert Downey, Jr. (actor)
Judy Garland (actor and singer)
Jack Kerouac (beat generation writer)
Sir Elton John (musician)
Edgar Allan Poe (writer)
Cole Porter (composer of Broadway scores)
Leo Tolstoy (writer of *War and Peace*)
Mathew Perry (actor from *Friends*)
Jann Arden (singer)
Ernest Hemingway (writer)

Note: Given the prevalence of concurrent disorders, it is likely that 40 to 60 per cent of these famous people have lived, or are living, with co-occurring mental health and substance use problems.

For example, actor and director Drew Barrymore talks about her substance use problem and depression in the book *Beyond Crazy*, by Scott Simmie and Julia Nunes (2002). And biographical accounts of Winston Churchill and Judy Garland indicate that they were also living with concurrent mental health and substance use

Slide 17



The stigma attached to mental illness and addiction represents one of the most common and serious barriers to help seeking & diagnosis, to effective treatment & quality of life, and to acceptance in families, communities, & the general public.

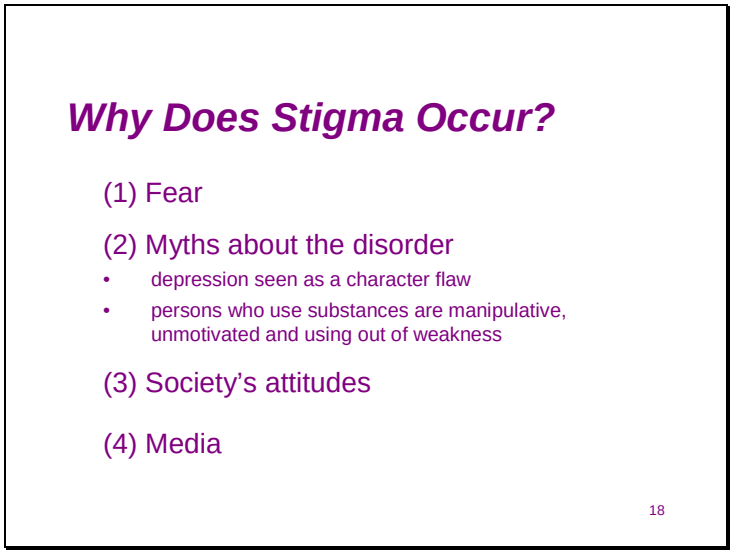
"The serious stigma & discrimination attached to mental illnesses are among the most tragic realities facing people with mental illness in Canada" (Report on Mental Illnesses in Canada, 2002)

<u>NOTE</u>: People who are living with a concurrent disorder will experience compounded effects

- There may be more than one mental health problem and more than one substance involved
- The effects of one may make the effects of the other worse, thus exacerbating symptoms and making the person's life more challenging.
- This could in turn put the individual at risk of losing his or her housing, job and perhaps social support networks.
- They may also be at risk for medical problems.

(Beyond the Label: CAMH, 2005).

Slide 18



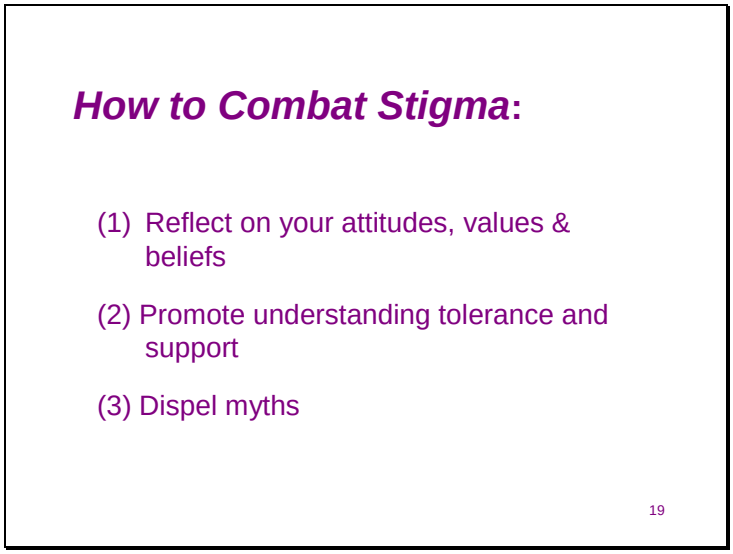
(1) Fear: of what we do not understand or of what is unknown. Media coverage often perpetuates the myth that people with CD are violent & dangerous.

(2) Myths about the disorder: depression is seen as a character flaw; persons who use substances are manipulative, unmotivated and using out of weakness

(3) Society's attitudes: thoughts or behaviours associated with the illness; people believing there is no hope for the person's recovery

(4) Media: misleading portrayals in movies, sensationalized stories on news and in newspapers, stereotyping

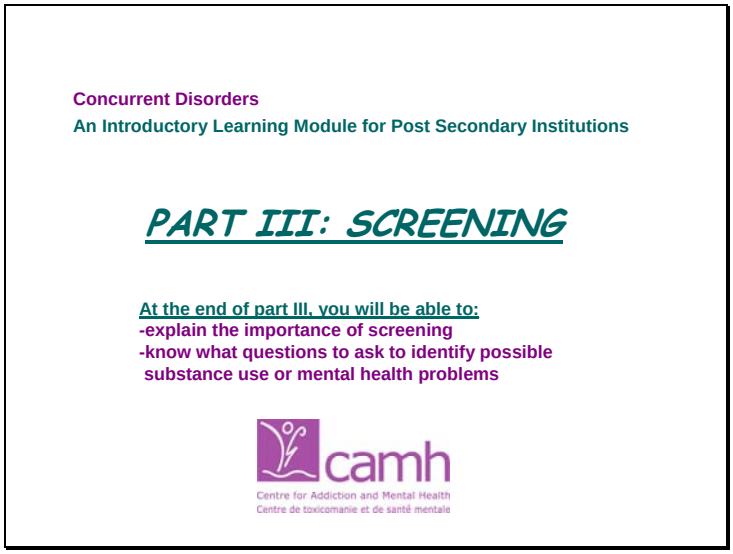
Slide 19



Other ways to combat stigma:

- Recognize the effects of language and the media
- Humanization – in every day contact
- Advocacy and legislation to improve acceptance and fight discrimination

Slide 20



Screening vs. Assessment:

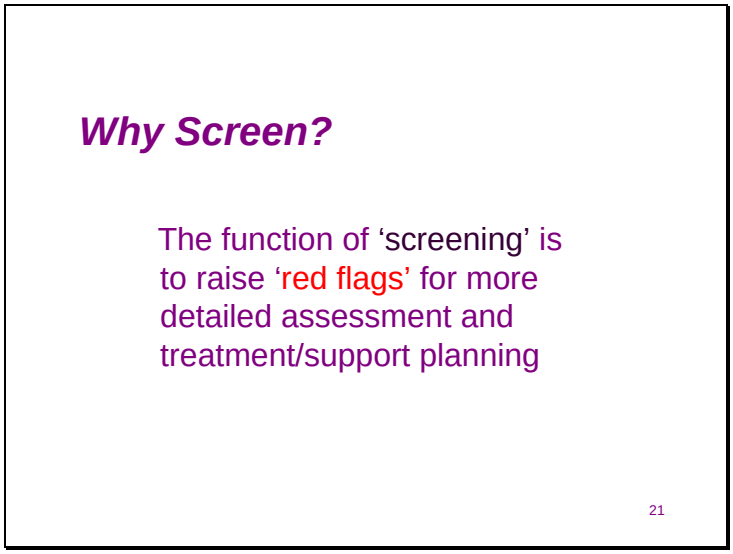
Screening: "Recognition" to identify whether an individual **may** have a mental health or substance use problem that warrants more comprehensive assessment. Screening does not make a diagnosis or give a complete profile of psychosocial functioning or needs. The function of screening is to raise "red flags"

Assessment: An in-depth investigation of the mental health or substance use problem and the inter-relationship between the two. The assessment is closely linked to treatment planning and the delivery of quality services that match the client's needs.

The four major functions of a comprehensive assessment for concurrent disorders are to:

- Diagnose both the addiction and the mental health disorder, while including crucial information for planning treatment and delivering services
- Serve as baseline information to compare with results of the same measures at the end of treatment, to identify client change and overall impact of treatments
- Foster a therapeutic relationship between the client and the service provider, and give the client a chance to better understand his or her problems
- Investigate the interrelationship and causes of mental health and substance use disorders.

Slide 21



Why is screening important?
The goal of screening for CD is to determine whether the client needs to be more formally assessed for substance use disorders, mental health disorders or both.
Screening is the first step in an integrated treatment approach, because it helps to identify whether there is more than one problem that needs to be addressed.

In a mental health setting, screening for **substance use** will flag when substance use might be a problem for a client. It will help decide whether or not to arrange a formal substance use assessment. Also, knowing what substances a person with mental health problems is using has direct implications for client care and management. For example, it helps to anticipate possible adverse interactions between the substance use and psychiatric medications *(all medications including psychiatric medications)*, and how the substance use might exacerbate any mental health symptoms.

For similar reasons, it is important to screen for possible **mental health problems** in an addiction setting. While screening can be done in many different ways to suit the clinical setting, begin by asking a few basic questions and follow up with a simple, cost-free screening tool. Generally, the information gathered by screening is self-reported, which may affect the accuracy. A client may try to give the "right answers" if he or she fears negative consequences for admitting to a substance use or mental health problem. Other considerations include using questions that are appropriate for the client's age, culture, and literacy level.

Some examples of "red flags" are:

-Cigarette smoking (3-4X more likely to have an SUD)

-Male

-Younger

-Lower education

-Single or never married

-Good pre-morbid social functioning

Slide 21 – con't

-Family history of addiction

-Any childhood mental health disorder, such as Conduct Disorder

-Antisocial Personality Disorder

-Relationship problems

-Higher affective symptoms (e.g. depression/suicidality) increases vulnerability to SUD

-Job difficulties (performance, attendance)

-Disrupted housing/instability

-Disruptive behaviour/violence

-Treatment non-compliance (medication, missed appointments)

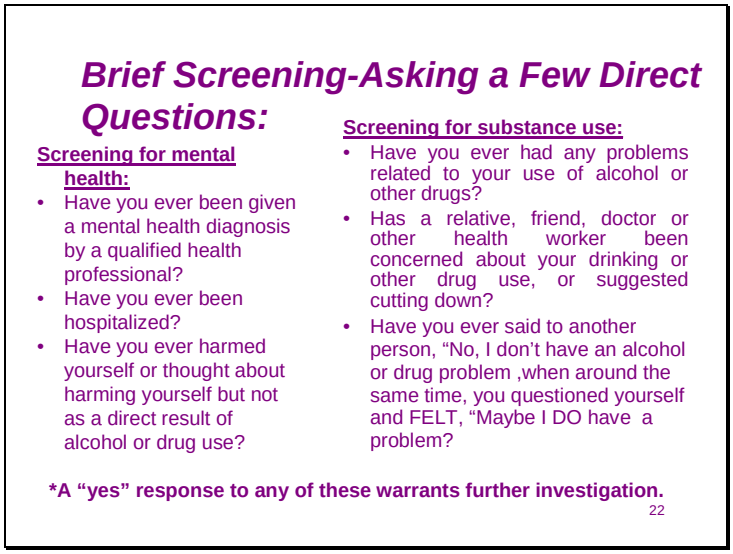
-Legal problems

-Physical symptoms (pupils, sweats, shakes, smell)

-Physical diagnoses (e.g. liver problems)

Depending on geographic location and availability of specialized mental health services, etc., the mental health assessment may be more challenging to access than the substance use assessment. People may have to be referred to multiple services to receive a comprehensive mental health assessment.

Slide 22



Instructor Resource: Handout # 4 and 5 - Case Studies, Handout #6 Asking questions

TEACHING ACTIVITY: Have students form groups of two or three. In groups of two, both are in a role-play; in groups of three, the third person observes and provides feedback about the interaction. One student role-plays Steve (case study below), and the other is a service provider in a setting of your choice. The service provider will use the questions provided to screen for both mental health and addictions. Have the students then role-play again but switch roles and use the case study of Jane.

Questions for feedback:
Overall how did you feel during the interview?
Were you able to gather information about possible concurrent disorders from the client?
In the future, how would you change the way you screen for CD?

It is useful to ask some questions about substance use, to see if this might be an area of concern. When questioning is non-judgmental and supportive, clients are more likely to respond truthfully. If clients do not trust the care provider or fear negative consequences of admitting to substance use, they are less likely to admit to any substance use.

Adding some basic questions about mental health to your intake interview is much better than not asking any mental health questions at all, though there is the potential to miss identifying problems in some clients.

No wrong door approach: People can have both their addiction and mental health concerns addressed no matter which agency they present to. This does not mean people are never referred to another agency – it emphasizes linkage between services.

Studies have not yet been conducted on the reliability, validity, sensitivity and specificity of this level of screening instruments currently being used for mental health disorders. Instead, recommended questions are based on current best practice. Screening does not result in the diagnosis of a mental health problem, but instead indicates a suspicion that a problem may exist. (Best practices, Concurrent Mental Health and Substance Use Disorders, Ottawa: Health Canada, 2002)

Slide 22/handout 4

Steve is 32:

Steve has a diagnosis of schizophrenia and is connected to the outpatient mental health program. He has a psychiatrist and a case manager, and medication is part of his treatment plan. Steve has disclosed the use of crack cocaine, which he uses in binges, particularly when his monthly disability cheque arrives. His substance use has had negative consequences on his mental health (has produced psychotic symptoms), and also, may jeopardize his housing situation since substance use is not tolerated in the supportive housing arrangement where he lives. Steve recognizes the consequences of ongoing use, but still values the enjoyment and escape he gets from it. He is open to receiving help to explore his concurrent disorders issues, but feels ambivalent about giving up use entirely.

Slide 22/handout 5

Jane is 38:

Jane's previous psychiatric diagnoses have included dysthymia, panic disorder, post-traumatic stress disorder and, more often, borderline personality disorder. Even with many assessments and admissions (most notably in psychiatric emergency departments), she is not linked to follow-up treatment. Her efforts to get help have met with rejection from treatment programs due to her substance use, or recent self-harm behaviour related to her ongoing suicidal ideation. She has also had repeated admissions to substance use programs, including: withdrawal management, outpatient and residential programs. Addiction counselling has failed to address her concurrent psychiatric issues, and as a result, she feels that she is not adequately understood. She has been told she has "high needs", and requires "intensive treatment" which agencies are "not able to offer at this time." This has left her feeling like a 'system misfit' and has reinforced her feelings of hopelessness and despair.

Slide 22/Handout 6

Brief Screening – Asking a Few Questions

Screening for mental health:

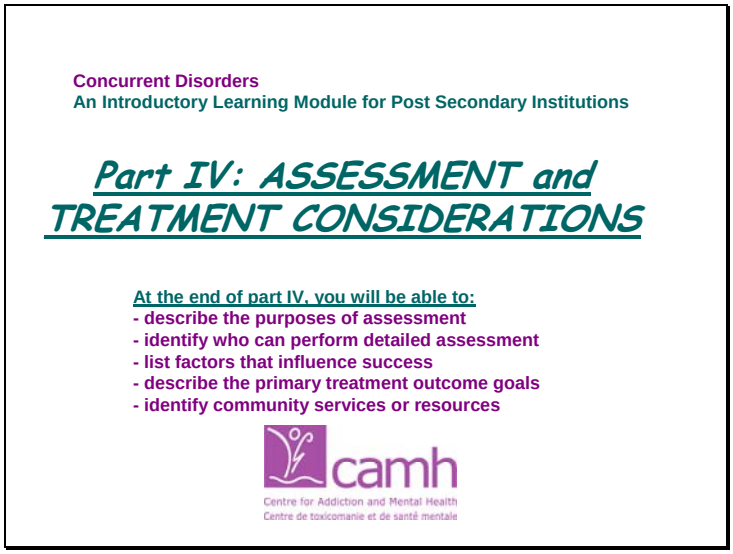
- Have you ever been given a mental health diagnosis by a qualified health professional?
- Have you ever been hospitalized?
- Have you ever harmed yourself or thought about harming yourself but not as a direct result of alcohol or drug use?

Screening for substance use:

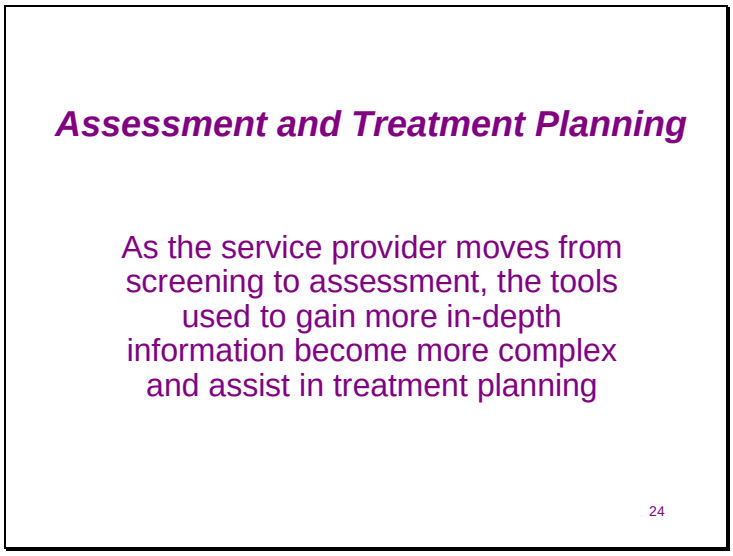
- Have you ever had any problems related to your use of alcohol or other drugs?
- Has a relative, friend, doctor or other health worker been concerned about your drinking or other drug use, or suggested cutting down?
- Have you ever said to another person, "No, I don't have an alcohol or drug problem, when around the same time, you questioned yourself and FELT, "Maybe I DO have a problem?"

*A "yes" response to any of these warrants further investigation.

Slide 23

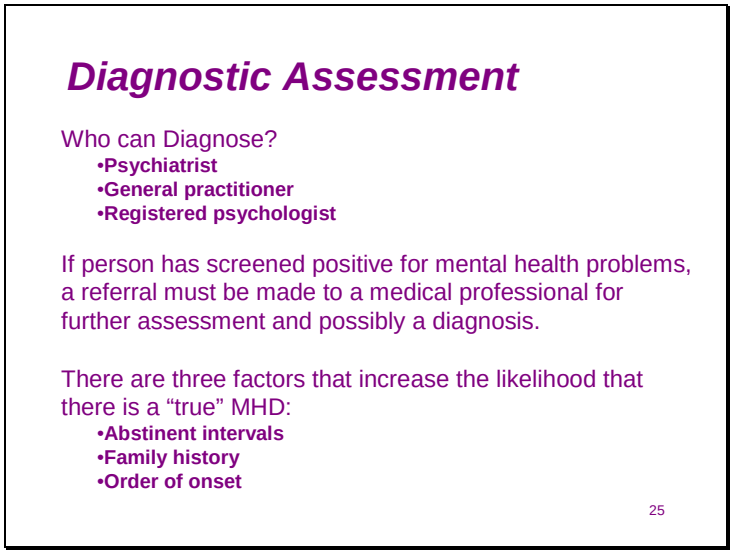


Slide 24



CAMH is developing a “roadmap” for CD screening and assessment. As the above statement suggests, the tools outlined on the roadmap become more and more complex. When a clinician uses the first tools suggested on the roadmap, the information gathered will be quite generic and basic. It will be able to provide a broad overview of the person’s concerns and problems. As the list of tools on the roadmap progress, they begin gathering more comprehensive information about the person, eventually leading to a complete detailed assessment for the person that will greatly assist in treatment planning.

Slide 25



Note: medical professional can include: a general practitioner, a psychiatrist, or a registered psychologist.

There are 3 factors that increase the likelihood that there is a "true" mental health disorder:

- Abstinent intervals: Mood/psychotic symptoms were sustained during periods of abstinence from use of substances
- Family history: Mood or psychotic disorder
- Order of onset: Mental health disorder predated the development of the substance use disorder

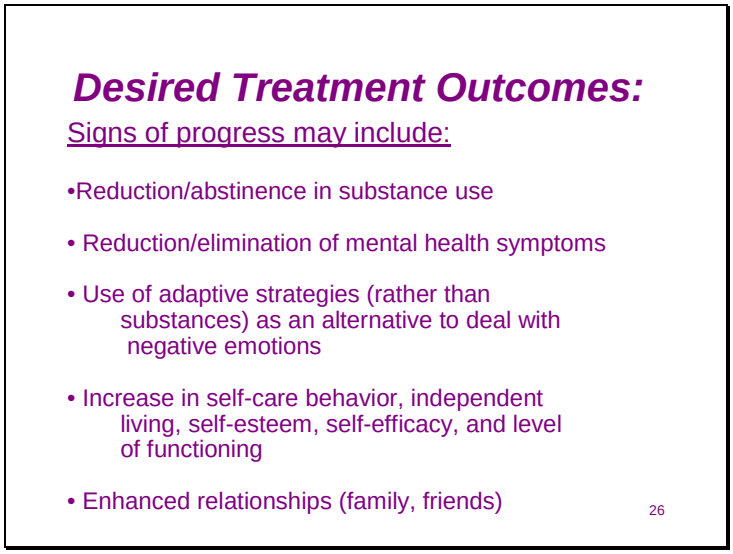
A comprehensive assessment is needed for clients of mental health services who are thought, on the basis of screening, to have a substance use disorder; clients of addiction services who are thought, on the basis of screening, to have a mental disorder, and; clients of another health sector who are thought to have both an addiction and mental health issue.

A comprehensive assessment for concurrent disorders must address the nature, impact and interaction of the mental health and the substance use disorders.

An assessment is not only used to make a diagnosis, but it also:

- Builds a therapeutic alliance with the client
- Identifies the severity of symptoms
- Allows the collection of a thorough history of the client
- Allows the care provider and the client to discuss consequences of substance use and mental health problems, and concerns in other areas such as work, housing and relationships
- Allows for crisis management and stabilization.

Slide 26



Lack of progress may be reflected by:

- Increase in substance use
- No change in substance use despite repeated efforts
- Substitution of one substance with another
- Unable to follow through on treatment plans
- “Binge pattern” substance use

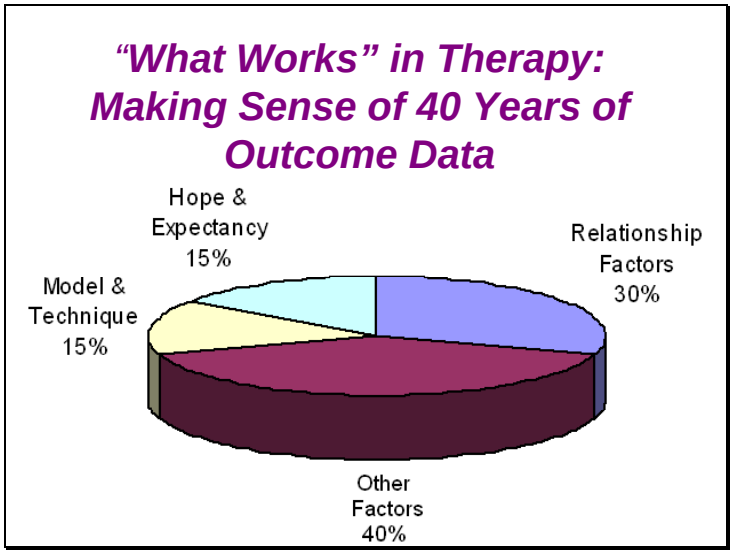
Slide 27

Themes for Success

"The most significant predictor of
treatment success
is an EMPATHIC, HOPEFUL,
CONTINUOUS TREATMENT
RELATIONSHIP,
in which integrated treatment
and co-ordination of care
can take place through
multiple treatment episodes."

-Ken Minkoff

Slide 28



Dr. Michael Lambert states that the research base for this interpretation of the factors was extensive and spanned decades. He refers to these "big four" as "common factors" that lead to change in someone's life, regardless of the therapeutic model used by the therapist or counsellor.

The image shows that the counsellor or therapist is not the only one that can make a difference in people's lives as they struggle to make a change related to co-occurring substance use and mental health problems. As the person is going through this process of change, she or he may come in contact with many people in different systems: housing workers, employment workers, welfare workers, shelter workers, CAS workers, probation and parole officers, psychiatrists, physicians, nurses, intake workers, receptionists and others.

Relationship factors—30 per cent: Research has shown that regardless of which counselling model is used, it is the warmth, empathy, caring and non-judgmental attitude that the counsellor brings to the relationship that can make the difference.

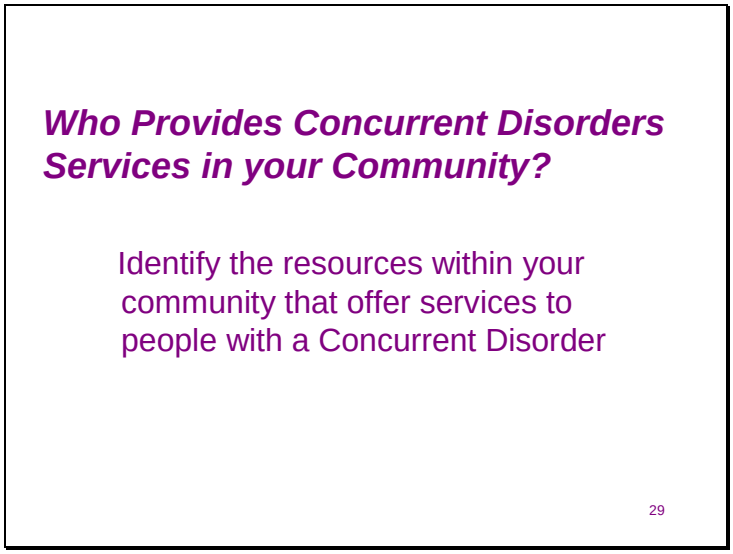
Other factors—40 per cent: Circumstances outside of therapy and what the person brings to the counselling session that can contribute to recovery. These factors, also called extratherapeutic factors, include client strengths, supportive elements in the environment and even chance events. Examples of factors that can contribute to successful outcomes are persistence, faith, a supportive grandmother, a mutual support group sponsor, membership in a religious community, a new job, a decent affordable home or a crisis successfully managed.

Hope and expectancy—15 per cent: The belief that things can and will get better.

Model and technique—15 per cent: Although model and technique are important to effecting behaviour change, we often focus too much on this aspect of the change process.

(adapted from Beyond the Label, CAMH, 2005)

Slide 29



Instructor Resource: Handout # 7 – Who Provides Services in Your Community?

TEACHING ACTIVITY: Distribute handout of the same name. Ask students to think about local agencies and identify those that offer services for CD. The activity could be completed as a group or individually. If it is to be completed by students individually, allow a few minutes afterwards for discussion as a group. It is a good idea for the instructor to be knowledgeable about community resources to ensure that the information is accurate.
Who provides CD services in your community?
List all addictions and mental health services, general health and social services that work with people who have a concurrent disorder in the community
Be certain to identify if the organization offers specific concurrent disorder services or if it is a generic service that will work with people who have a concurrent disorder. Currently the reality is that most service providers do not offer specific services for CD.
How would the lack of specific resources impact the work you do?

OR (alternate activity) handout #8 - Bookmark

TEACHING ACTIVITY: Using the **Connex***Ontario* website find a list of service providers in your region that offer specialized concurrent disorders treatment. Have students use those resources to make up a bookmark following the sample found in handout eight. If no specialized services exist in your community, have students list generic mental health and addiction related resources. ConnexOntario may not capture specialized services provided to diverse communities. Students should therefore be encouraged to look beyond that website.

To assist with the exercise please use the following:
Go to: www.connexontario.ca
Click on: “Drug and Alcohol Registry of Treatment”
Click on: “finding treatment then Online Treatment Directory”
Click on: “Treatment Type” and “Specialized Treatment”
Choose “concurrent disorders clients” under the “specialized population” drop down list.

Slide 29/Handout 7

Who Provides CD Services in your Community?

Identify local community resources that offer services for people with a concurrent disorder. Keep in mind that presently the reality is that most service providers do not offer specific services for CD.

Service Name and Contact info	Service Type -General health -Social service -Addiction -Mental Health	Service offered

How would the lack of specific resources impact the work you do?

Slide 29/Handout 8

Resources Related To Mental Health & Addictions

CRISIS LINE – 544-4229

AIDS & Sexual Health Counselling
1 800 668-2437

Alcoholics Anonymous
(613) 342-8452

Canadian Mental Health Association
1 800 875-6213 www.ontario.cmha.ca

Centre for Addiction and Mental Health
1 800 463-6273 (Info-Line);
(613) 546-4266 www.camh.net

Eating Disorder Clinic
(613) 548-6121

Health Counselling & Disability Services
(613) 533-2506
http://www.queensu-hcds.org/

Health Services Information
www.connexontario.ca

KAIROS – Youth Addictions Counselling
(613) 542-6559 kairos@post.queensu.ca
post.queensu.ca/~kairos/index.htm

Kingston Lesbian Gay Bisexual Association
(613) 531-8981

Lennox Addington Addiction Services
(800) 420-9734; admin@l-aas.com
Lennox Addington Mental Health Services
(800) 267-7877; lacmhs@lacmhs.ca

Options for Change
(613) 546-1758

Pathways for Children & Youth
(613) 546-8535
www.pathwayschildrenyouth.org

Queen's Chaplain
(613) 533-6944
http://www.queensu.ca/dsao/chaplain/groups/queensUniversityChaplain.html

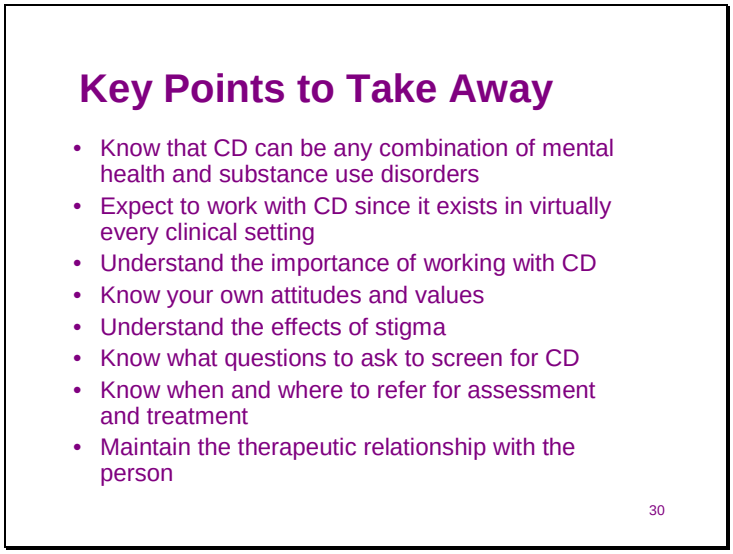
Schizophrenia – Open the Doors
www.openthedoors.com

Telephone Aid Line Kingston (TALK)
(613) 544-1771 Any night from 7pm-3am

Using the bookmark on the left as a template, create a bookmark referencing services in your own geographic location.

Use the **Connex***Ontario* website, to find a list of service providers in your region that offer specialized concurrent disorders treatment. If no specialized services exist in your community, list generic mental health and addiction related resources. ConnexOntario may not capture specialized services provided to diverse communities. You should consider looking beyond that website.

Slide 30



Having completed this workshop, participants should be able to:

- Define a concurrent disorder (slide 9)
- Describe the importance of addressing CD in their work (slide 12)
- Examine his or her own attitudes and values (slides 15 - 19)
- Demonstrate a basic knowledge of screening (slides 20 - 22)
- Demonstrate a basic knowledge of assessment and treatment considerations (slide 23 - 26)
- Appreciate the importance of maintaining the therapeutic relationship (slide 27-28)
- Identify resources that offer services to people who have a concurrent disorder (slide 29)

Slide 31

These are additional practical resources to which students can be directed.