Concurrent Disorders Policy Framework

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Acknowledgments

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Preamble

This policy framework addresses the needs of people living with concurrent substance use and mental health issues ("concurrent disorders"), recognizing that as a population they and their families experience significant barriers in obtaining appropriate services, with poorer outcomes in comparison to those without concurrent disorders.

The framework was developed by members of the Concurrent Disorders Ontario Network through a provincial consultation process with individuals, groups and organizations concerned with planning, developing and delivering services for people with concurrent disorders and for their families.

The policy framework recognizes that substance use and mental health issues vary in their degree of harm and severity. For example, some people have a substance use issue in which non-medical use of even small amounts of a psychoactive substance can harm their mental health; other people's substance use issues fit into an abuse or dependence diagnosis. Mental health issues include those of people living with a mild or moderate mental illness (non-severe mental illness) as well as of people living with a severe mental illness. The framework also recognizes that "family" is defined by the client and that family members can be clients in their own right.

This broad framework will require further work and adaptation to meet the needs of diverse cultural groups and marginalized communities. Strategies and models of care that are culturally appropriate and community-relevant — for example, in the Aboriginal community — will need to be identified. At the same time, older youth (16 to 24 years) are often seen in the adult system, and systems and services must consider their particular issues, including their stage of development and family context.

The policy framework also recognizes that other addictive behaviours can co-occur; in particular, problem gambling is emerging as a significant health concern. To address this issue in an integrated fashion, Ontario and other jurisdictions in Canada offer treatment services for people with gambling problems in the same location as services for people with substance use problems.

The framework expands upon former provincial frameworks that have shaped the recent development of mental health and substance use services and supports in Ontario, with a vision to improve outcomes for people living with concurrent disorders and for their families. However, many people with concurrent substance use and mental health issues, and their family members, do not make contact with specialized mental health or substance

use services. Thus the intent of the framework is to influence the delivery of services wherever people with concurrent disorders and their families seek help.

Provincial context

In *Setting the Course: A Framework for Integrating Addiction Treatment Services in Ontario,* the Ontario Ministry of Health and Long-Term Care (MOHLTC) recognized the need to involve the mental health sector in integrated planning for substance use treatment. The document explicitly identified people with concurrent disorders as one of several special populations who use services for substance use problems and who have unique needs (Ontario Substance Abuse Bureau, 1999).

Similarly, *Making It Happen—Operational Framework for the Delivery of Mental Health Services and Supports* (Government of Ontario, 2001) described people with serious mental health problems as the target population for intensive mental health services — particularly those with multiple and complex needs who are at risk for repeated or prolonged institutionalization in health care or correctional facilities. Included in this group are those with concurrent disorders or a current problem with alcohol or other drugs.

The release of these frameworks was followed by the formation of regional committees (Mental Health Implementation Task Forces and Addiction Implementation Committees) to develop regional implementation plans. The majority of these plans further articulated the services and supports and system changes required for people with concurrent disorders. In addition, the Ontario government has also recently released its *Program Policy Framework for Early Intervention in Psychosis* (MOHLTC, 2004).

A system in transition: Challenges and planning

Currently, the Ontario health care system is in transition. Decentralization of the MOHLTC to regional offices has brought together MOHLTC mental health and substance use staff under one operational umbrella. However, in many other aspects the two systems remain separate, such as in the manner of funding, organizing, administering and delivering services. Further decentralization is occurring with the formation of Local Health Integration Networks (LHINs) across the province. LHIN boards and staff are currently being recruited and trained, and it is uncertain at this time what priority

individual LHINs will give to the integration of mental health and substance use services in their areas.

Despite uncertainties about the future, many regions and communities across the province have initiated planning groups to address integrating mental health and substance use services, at the service and system level. In some areas, programs have collaborated to provide integrated concurrent disorder services. More recently, community planning tables for the new Local Health Integration Networks have identified integrated mental health and substance use services across the continuum as a high system priority.

Services for children and youth

In planning and programming for concurrent disorders treatment, the systems for children and youth are not at the same stage as the adult substance use and mental health systems. Though there is a recognized need for policy development, and there have been some activities, in the area of young people who present with concurrent mental health and substance use issues, the nature of the network of services and systems working with this population requires a separate process from that of the adult population.

Some reasons for a separate process are:

- multiple ministerial mandates, with the Ministry of Health and Long-Term Care responsible for children/youth 16 years and older and the Ministry of Children and Youth Services for children/youth under 16 years
- services for children and youth generally involving different providers, concepts, treatment approaches and terminology
- a greater emphasis on the role of family and young people’s environment (school, home, peer group) and their developmental stage (physical, mental, emotional)
- the different array of issues/disorders (e.g., attention-deficit/hyperactivity disorder, conduct disorder, learning disorders, eating disorders, suicide risk)
- the role of the risk, resiliency and protective factors framework in addressing the young person’s life
- the potential long-term developmental consequences of substance use and mental health issues.

Nevertheless, older youth (transitional youth) are still being served in the adult system—concurrent disorder services need to consider developing different approaches for this age group, approaches that take into account developmental stages, role of the family and other important people/supports in the young person's environment, and other related issues.

Services for diverse cultural groups and marginalized communities

Many diverse cultural groups and marginalized communities need to adapt this broad framework to ensure that their needs are met as they implement the principles of this framework.

Strategies and models of care must be defined. For example, the Aboriginal community needs to define its own culturally appropriate models of care. Other populations will require adaptation of the care models to ensure that they receive appropriate services.

Prevalence and impact

The prevalence of concurrent disorders is very high among people with mental health or substance use issues. For example:

- Among those with a diagnosed mental health disorder, 30 per cent will have a substance use disorder at some time in their lives.
- Similarly, among those diagnosed with an alcohol disorder, 37 per cent will have a mental health disorder at some point in their lives.
- Among those with a substance use disorder other than alcohol, the rate is even higher, with 53 per cent experiencing a mental health disorder at some point in their lives. (These rates are two to four times higher than among those who do not have a lifetime substance use disorder; Skinner et al., 2004.)

The lifetime prevalence of various mental health disorders varies in the general population, as does the likelihood of having a concurrent substance use disorder. This is illustrated in "Table 1: Lifetime Prevalence of Concurrent Substance Use and Mental Health Disorders in the General Population" (Skinner et al., 2004).

Table 1

Lifetime prevalence of concurrent substance use and mental health disorders in the general population

Mental health disorder	Lifetime prevalence of mental health disorders %	Lifetime prevalence of substance use disorders among people who have mental health disorders %
anxiety disorder	10–25	24
major depression	15–20	27
schizophrenia	1	47
bipolar disorder	1–2	56

There are high rates of anxiety disorders and mood disorders in the general population; these combined with a substance use disorder are the most common concurrent disorders. In contrast, the rates of bipolar disorder and schizophrenia are much lower in the general population, but having one of these disorders carries a higher risk of having a concurrent substance use disorder (Skinner et al., 2004).

Other international research indicates that:

- The likelihood of having a concurrent mental health disorder increases with the number of substances used (Center for Substance Abuse Treatment, 2005; Cooper & Calderwood, 2004).
- The rates of concurrent substance use and mental health disorders are increasing (NSW Health, 2000a).
- There are high rates of concurrent substance use and mental health problems among people who are homeless; these rates are increasing among both women and men (Center for Substance Abuse Treatment, 2005).

These rates of concurrent disorders in the general population are reflected in the rates among people in contact with mental health and substance use treatment systems. In general, mental health services are more likely to see people with serious mental illness such as psychosis, while substance use

services are more likely to see people with affective, anxiety and personality disorders (Commonwealth Department of Health and Aging, 2003). In Ontario, concurrent substance use problems are believed to range from 15 to 45 per cent among those receiving mental health services, and concurrent mental health problems from 75 to 100 per cent among those receiving substance use services (Rush, 2004).

A history of trauma, and the persistence of symptoms related to the trauma, presents a significant challenge for substance use and mental health systems. Gitberg & Van Wyk (2004) quote trauma history rates of 25 per cent to 66 per cent among those in substance use treatment. They further note that some, though not all, people who have experienced trauma will develop symptoms of posttraumatic stress disorder (PTSD).

People living with concurrent disorders may also have other significant life problems, such as suicidal or self-harming behaviours, homelessness, involvement with the criminal justice system, family problems, child abuse or neglect, risk of HIV/AIDS or other blood-borne diseases, and difficulty with daily living skills (Commonwealth Department of Health and Aging, 2003).

Stigma of substance use and mental health problems

The stigma associated individually with substance use and mental health disorders is magnified for those living with both disorders. A person may be judged and blamed because of his or her health problems and, as a result, experience negative feelings and avoid seeking help. Stigma may also result in social isolation, poverty, depression, loss of hope for recovery, and suicide, as well as prejudice and discrimination when seeking health care, housing, employment or other services (Centre for Addiction and Mental Health, 2005).

Effects on families

When one family member is living with concurrent disorders, it has a profound effect on the family. This effect can be compounded when other family members also have a substance use and/or mental health problem, a situation that may affect some families over several generations. In such situations, people living with concurrent disorders, and their family members, may not know where to turn for help.

Barriers and navigating the system

Significant system, program and clinical barriers impede the provision of appropriate services. Some common barriers include:

- different funding streams, planning structures and governance mechanisms
- different professional training and licensing or certification requirements
- different treatment models/approaches
- lack of a common framework/language to communicate across services and systems
- lack of mechanisms such as routine screening to identify the presence of concurrent disorders
- discriminatory admission criteria and denial of treatment
- lack of a single locus of responsibility for providing co-ordinated care.

People living with concurrent disorders also often need other health or social services; such needs can make it harder for them and their family members to navigate their way through different systems.

As a result, people living with concurrent disorders often:

- receive inadequate and unco-ordinated care
- bounce between the substance use and mental health systems
- have high rates of emergency department visits and hospitalizations
- have poorer treatment compliance and outcomes.

Inadequate treatment for people with concurrent disorders translates into an unnecessary cost to individuals, their families, communities and the health care system. However, comprehensive, co-ordinated and integrated treatment that employs evidence-based approaches can improve outcomes for clients with concurrent disorders, and thus forms the foundation of this framework (Center for Substance Abuse Treatment, 2005; Substance Abuse and Mental Health Services Administration, 2002).

A vision for Ontario

All people with concurrent substance use and mental health issues and their family members will have access to comprehensive, integrated, evidence-based and consistently monitored services that are directed toward improving the person's quality of life as defined by the individual.

Goal statement

At this time of government transition, various roles, responsibilities and processes are not yet clarified. Therefore, the responsibilities for this policy framework will need to be determined by all the players. Regardless, the network is committed to working with all the partners to realize the following goal:

To develop, implement and monitor a plan to improve services for people living with concurrent disorders and for their families, by increasing system co-ordination and integration so that the client and family experience service delivery as accessible and seamless; or "one team with one plan for one person."

Framework objectives

The objectives of a co-ordinated and integrated system of care are to:

- increase access and treatment engagement of people living with concurrent disorders and of their family members, through outreach, early intervention, appropriate screening, assessment, treatment and continuing care
- increase the quality of life of people living with concurrent disorders and of their family members
- minimize societal impact, including social and financial harm of untreated or poorly treated concurrent disorders.

Guiding principles

To support the vision, goal and objectives, system characteristics and system components of this framework at all levels of care, we have developed guiding principles, which state that services will:

focus on recovery: Client choice will be emphasized, and services will promote optimistic, respectful, empathetic and individualized care that builds on the strengths and resources of people living with concurrent disorders and of their families.

empower: The knowledge and experience of clients and their families will be respected, and they will be able to participate in the central design, administration, service delivery, staff training and evaluation of services for people living with concurrent disorders.

be least intrusive and restrictive: Services will be provided by the least intrusive means possible and in a manner that maximizes the safety, privacy, dignity and self-respect of the person, his or her family and others.

be welcoming and accessible: People will be welcomed at any door into the system (no wrong door), and will be offered seamless and timely access to services.

be effective and accountable: Services will be accountable to funders, consumers and the community by using regular process and outcome measures, consumer and family satisfaction surveys and other measures of effectiveness as defined by clients and families.

collaborate and build partnerships: Services will be planned and provided across the service delivery system with various integrative and collaborative partnerships, and will be enhanced by shared and/or cross-training and other activities.

reflect diversity: Services will acknowledge and engage differences in culture, life experiences and lifestyles of people living with concurrent disorders and of their families, in all aspects of policies, administration and service delivery.

embrace family: Family members will be engaged as clients in their own right, and services will recognize the role and value of family as defined by the client.

incorporate determinants of health: Services will address health determinants in their policies and programming, based on local population health data.

employ best practices: An evidence-based approach will be used to strengthen existing services and to develop new services.

Essential system characteristics

To provide quality care, all components of the system of care for people living with concurrent disorders and for their family members should be:

- accessible
- co-ordinated and integrated
- comprehensive

Accessible

Services are part of an agreed-upon system of care, which ensures that the service system is accessible to everyone and that services routinely screen for concurrent disorders, ensuring that people receive appropriate and timely help wherever and however they enter the service system (no wrong door).

Co-ordinated and integrated

Co-ordinated and integrated services need to be provided across service delivery systems, because substance use disorders and mental health disorders can occur together and each disorder should be considered primary. Co-ordinated and integrated treatment of concurrent disorders can best be summed up as "one team with one plan for one person" (California Department of Alcohol and Drug Programs, California Department of Mental Health, 2004). At the system level, this means developing and maintaining linkages between service providers, between areas within a system or across multiple systems, to facilitate service at the local level (BC Ministry of Health Services, 2004; Health Canada, 2001).

Depending on the severity of the person's issues and on his or her needs and strengths, co-ordinated and integrated services can be delivered to clients and their families by:

- enhancing the capability of all service providers within local substance use and mental health systems to help people and families living with concurrent disorders (no-wrong-door approach)
- having systems and services collaborate to provide the range of required services through consultation, partnerships and shared care, and fully integrated multidisciplinary treatment teams for those with the most severe substance use and mental health issues
- developing and maintaining close links with other needed services.

Comprehensive

To deliver comprehensive care, services must offer a continuum of co-ordinated and integrated care that is:

- designed to follow best practices
- accessible and available over the long term
- available at levels and intensities consistent with individual needs.

Components of a comprehensive system

Existing models or guidelines for comprehensive service systems suggest an array of services (BC Ministry of Health Services, 2004; Missouri Department of Mental Health, 2002; NSW Health, 2000 a & b). The following models emphasize the importance of ongoing, caring therapeutic relationships in achieving good clinical outcomes.

Information and prevention

Health promotion and prevention interventions use a range of community strategies to address different levels of risk and severity of problems, to facilitate early identification and intervention. Prevention activities may be directed toward:

- the general population (universal)
- subgroups of the population at higher-than-average risk of developing a concurrent substance use and mental health problem (selective)

- people who are at high risk or have already exhibited concurrent problems (indicated).

Community information and entry services inform members of the community about available services, and information/referral, intake and screening for people with concurrent disorders and/or their family members.

Assessment and treatment

Outreach and engagement tries to reach people with concurrent disorders who may not be in contact with specialized substance use, mental health or other formal services, or who have become disengaged from these services. These services also offer activities to develop trusting relationships and keep people engaged through the stages of change.

Early identification and treatment—of people showing early signs and symptoms of concurrent substance use and mental health concerns—allows services to provide prompt assessment, treatment and support, which may reduce the duration of untreated illness.

Comprehensive assessment, treatment planning and referral includes the use of standardized questions or instruments to screen for concurrent substance use or mental health issues. If problems are identified, comprehensive, integrated assessment (including specialized psychological or psychiatric assessment) and treatment planning can be done either in-house or through referral.

Short-term interventions

Crisis intervention responds to urgent problems that may involve:

- an acute medical problem
- an acute psychiatric problem, or suicidal or violent behaviour
- severe intoxication, overdose or substance withdrawal
- a combination of these problems.

Withdrawal management services offer help with voluntary withdrawal from alcohol and/or other drugs to people who are under the influence and/or in withdrawal (or in crisis directly related to these substances).

Stabilization services offer a period of community or residential support to help people who are preparing for an intensive treatment phase or who are on a wait list for a treatment program.

Long-term interventions

Case management designates a primary care worker to provide:

- ongoing assessment and treatment planning
- linking to and co-ordinating required services
- monitoring and support
- discharge planning
- client advocacy.

Assertive community treatment teams use a multidisciplinary team approach to provide:

- assertive outreach
- individualized treatment
- ongoing and continuous services
- links to other services
- monitoring and evaluation.

Community counselling and psychotherapy treatment offer, in group or individual format, a range of intensities: from one to two hours weekly or less, to intensive day/evening programming.

Residential treatment services provide a structured, scheduled program of treatment and/or rehabilitation, while the person resides in-house.

Inpatient care provides a structured, scheduled program of residential treatment for clients whose biomedical, emotional and/or behavioural problems are severe enough to require individualized medical/psychiatric care.

Other supports

Supportive housing options provide housing and related recovery/support services with different levels of supervision, programming and lengths of stay to people who are not ready/able to live independently in the community.

Supported employment provides employment supports including:

- job development/creation/employer outreach
- skills development/training for job/education
- skills training on the job
- job search skills/job placement
- employment planning/career counselling
- supported education
- supports to sustaining education/employment
- leadership.

Mutual-aid groups and peer self-help initiatives include mutual aid groups and other consumer-driven initiatives such as peer support, education and advocacy.

Family member services consider family members as clients in their own right, and offer information, education/training, counselling and support.

In addition, the system of specialized mental health and substance use services needs to be complemented by close linkages/partnership agreements with services that address other issues for people with concurrent disorders, such as:

- primary and specialized health issues
- HIV/AIDS support
- financial counselling
- parenting/child care
- leisure/recreation
- harm reduction services (e.g., methadone clinics and needle exchange programs).

Strategies to achieve the vision

To make this vision a provincial reality, we need to capitalize on the priority established in the Local Health Integration Networks' community planning process for integrated substance use and mental health services across the continuum. (It should be noted that though the strategies refer to the specialized substance use and mental health systems, other services and systems may be key partners in the process.)

The following key strategies will help us achieve the vision, goal and objectives. Strong leadership and willingness to partner within and across systems are critical for the success of these strategies. The use and order of individual strategies will depend on the needs and circumstances of individual communities. Also, although the strategies refer to the specialized substance use and mental health systems, other services and systems may be key partners in the process.

1. Develop a system plan

The new Local Health Integration Networks have given a high priority to the integration of mental health and substance use services across the continuum. This gives us the ideal opportunity to mandate and support the development and/or continuation of concurrent disorder planning groups that would take the lead in developing, implementing and monitoring a plan for integrated evidence-based concurrent disorder services. There are services and systems other than the mental health and substance use systems that may be key partners in the process.

2. Adopt a conceptual framework

"Figure 1: The Four-Quadrant Model" illustrates a continuum of problem severity and a corresponding level of service system co-ordination and integration. This model is widely used in the United States and other jurisdictions to give substance use and mental health providers a common framework and language to make decisions about how the two systems will work together.

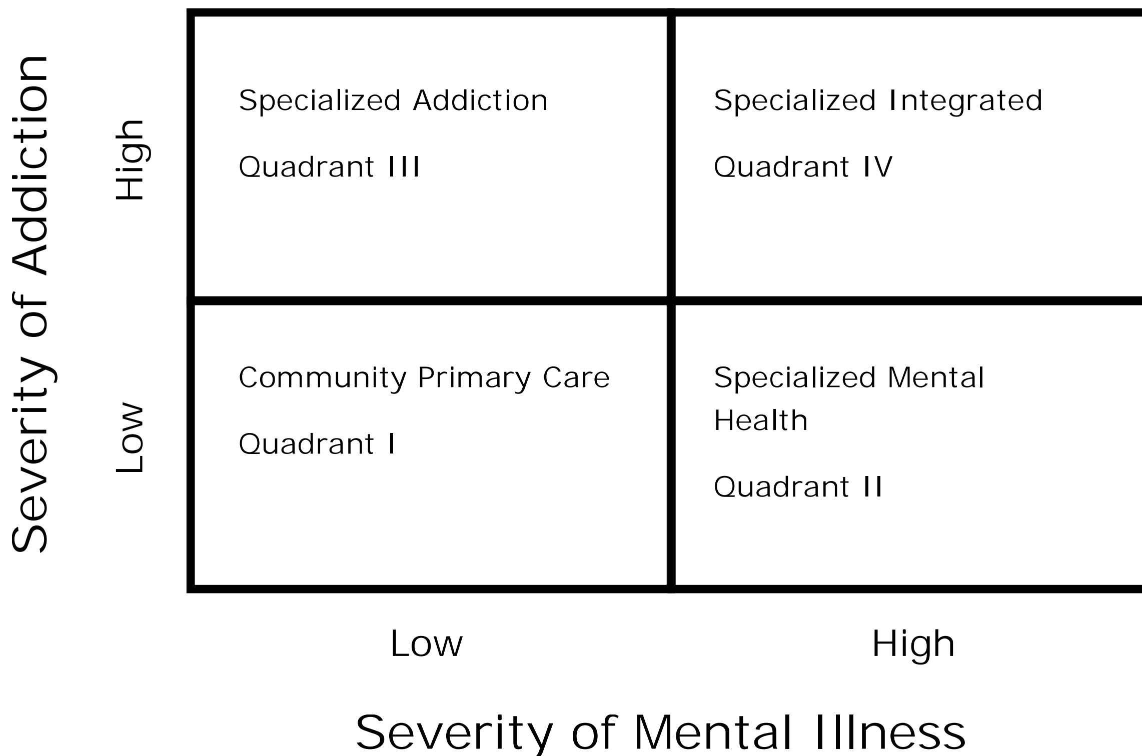
In Quadrant I, primary care settings, supported by consultation with the substance use and mental health systems, are the focus of treatment for those with low-severity substance use and mental health issues.

In Quadrants II and III, the specialized substance use and mental health systems collaborate to serve those for whom one disorder (mental health or substance use) is high-severity while the co-occurring disorder is low-severity (e.g., a severe mental illness together with a less severe substance use problem; or substance dependence plus a less severe mental illness).

Quadrant IV requires the two systems to come together to provide specialized, integrated services for those with severe and co-occurring substance use and mental health disorders.

Figure 1

The Four-Quadrant Model



3. Assess system/program capacity

Consistent with the four-quadrant model, each planning area needs to identify the current capacity of individual services within its mental health and substance use treatment systems to help people with different severities of substance use and mental health issues, and to help their family members. A recent CSAT publication describes four levels of capacity:

> Basic program*, which can provide treatment for one disorder, but screens for others and can access the necessary consultation.*
>
> Intermediate program *focuses primarily on one disorder, but also addresses some needs of the other disorder.*
>
> Advanced program *provides integrated substance use and mental health treatment by adding needed expertise and relevant interventions either internally or through collaboration with other services.*
>
> Fully integrated program *actively combines substance use and mental health interventions.* (Center for Substance Abuse Treatment, 2005, p. 6)

4. Identify and adopt best practice guidelines

Best practice principles and guidelines need to be identified and adopted at the provincial/system/program/clinical level, so that service providers within the two systems use agreed-upon approaches for client care. Several jurisdictions and institutions, both in North America and elsewhere, have developed practice guidelines that can be adapted for the Ontario context.

For example, Health Canada (2001) published best practice recommendations for concurrent disorders as part of its series of booklets on substance use treatment and rehabilitation.

Drake et al. (2001) identified the following critical components of integrated programs:

- staged interventions
- assertive outreach
- motivational interventions

- counselling
- social support interventions
- long-term perspective
- comprehensiveness
- cultural sensitivity and competence.

5. Build system/program capacity

Staff at all levels must have the appropriate attitudes, knowledge and skills, consistent with each program's mandate, to provide services for people and families living with concurrent disorders. A systems-wide concurrent disorders service plan should ideally identify current competencies, and the education and training required by staff at different levels and in every different service setting.

6. Develop partnership agreements

In most planning areas, different services will need to develop protocols, shared care or partnership arrangements to provide the components of a comprehensive system for people with concurrent disorders and for their families. Formal agreements between services should describe:

- the roles and responsibilities of partner agencies
- how client referrals are made
- admission and discharge criteria
- method of conflict resolution
- scope of practice
- responsibility of partner services for ensuring continuity of care.

Such agreements will need to include, for example, details about:

- protocols for routine screening, integrated (joint) assessment and treatment planning and referral and/or single point of access for clients entering substance use and mental health service systems
- regular case conferencing
- consultation and/or supervision across systems and services

- mobile resource teams or person to provide expertise to a variety of services/locations
- cross-system secondment or placement of clinical staff
- interagency or blended service delivery teams
- co-location of substance use and mental health services in one physical location.

7. Monitor the system

The ultimate goal is to improve identification, access, treatment and outcomes for people with living with concurrent disorders and for their families. Thus the regional or local plan should identify indicators at services and systems levels that can be used to monitor these improvements.

Moving forward

This policy framework expands on past provincial frameworks that have shaped substance use treatment and mental health services and supports in Ontario. It addresses the complex care needs of people living with concurrent substance use and mental health issues, reflecting a provincial vision, goal, guiding principles, objectives, and essential system characteristics and components. It also supports the activities of Local Health Integration Networks and concurrent disorder planning groups, in their work to improve concurrent disorder services.

However, local activities to improve concurrent disorder services must be supported by action at the provincial level:

- Ongoing research needs to be supported to enhance our knowledge about effective interventions for consumers and families and to continually update best practice guidelines. A research agenda needs to be developed through a process involving key stakeholders—including researchers, government, service providers, consumers of service and others.
- Policies and procedures need to be developed to support blended or combined funding for concurrent disorder services. The decentralization of the Ministry of Health and Long-Term Care to regional offices, the consolidation of mental health and substance use under one operational roof, and the creation of Local Health Integration Networks provide the opportunity to adopt flexible funding mechanisms for concurrent disorder services.

- Capacity needs to be built through education, and provincial standards need to be established to accredit or designate programs and/or systems, and to certify/license individual service providers/clinicians, to ensure that people and families living with concurrent disorders receive appropriate, quality services.
- A concurrent disorder policy framework needs to be developed for children and youth and their families, with leadership from a provincial network, and using a consultative process similar to the one used to develop this policy framework.
- Policy and services, focusing on and adapted to special groups with concurrent disorders and other issues, need ongoing development. These groups may include, for example:
    - members of the Aboriginal community, who need to contribute to a model of concurrent disorders care that is culturally appropriate for them, with specific strategies to meet their needs
    - members of other cultural and marginalized communities in Ontario, who need to contribute to the identification of models of concurrent disorders care and to specify strategies to achieve the vision.
    - people with other specific needs, such as acquired brain injury, developmental delays, physical or sensory disabilities, and people with problems related to aging.

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Appendix A: Glossary

Best practices: Systematically developed statements to assist practitioner and patient decisions about appropriate care for specific clinical circumstances (Health Canada, 2001, p. 24).

Evidence-based: The integration of best research evidence with clinical expertise and patient values (Institute of Medicine, 2001).

Concurrent disorders: Combined or concurrent substance use and mental health problems (Centre for Addiction and Mental Health).

Consumer: A person using or having used a health service (US Department of Health and Human Services, 2001, p. 197).

Family: As defined by the client, may include biological or social family, such as parents, siblings, partner or children, as well as friends, colleagues or any other significant person(s) in the client's life.

Indicated prevention intervention: Interventions designed for individuals who are at high risk for a condition or disorder, or those who have already exhibited the condition or disorder (US Department of Health and Human Services, 2001, p. 199).

One team with one plan for one person: A client-centred approach to offering services. "One team" can involve either an individual service provider, a team of service providers within one program/service or collaboration among service provider(s) working in different programs, to ensure that the client (one person) has a treatment plan that addresses his or her concurrent substance use and mental health issues in an integrated and co-ordinated fashion (one plan). See also "System integration" and "Treatment integration."

Screening: Various methods used to identify whether the person may have a substance use or mental health issue that warrants more comprehensive methods (Health Canada, 2001, p. 28).

Selective prevention intervention: Intervention targeted to subgroups of the population whose risk of developing a health problem is significantly higher than average (US Department of Health and Human Services, 2001, p. 202).

Stigma: A negative mark attached to people who possess any attribute, trait or disorder that marks them as different from "normal" people. This difference is viewed as undesirable and shameful and can result in people

having negative attitudes and responses toward another person (CAMH, 2005).

Substance use issue: A broad term describing a wide range of social, personal and/or physical problems as a result of any use of alcohol or other drugs, but where use has not yet resulted in substance dependence.

Substance use disorders: A diagnostic term (from the DSM-IV) that refers to a habitual pattern of alcohol or other drug use that results in significant problems related to aspects of life such as work, relationships, physical health, financial well-being, etc. Contains two mutually exclusive subcategories: substance abuse and substance dependence. In some cases, the use of substances per se (as distinct from abuse or dependence) can cause harm to people with mental health problems (Health Canada, 2001, p. 8).

System integration: The development of enduring links between service providers or treatment teams within or across multiple systems to facilitate providing services to people. Occurs when, for example, mental health treatment and substance use treatment are united by two or more clinicians/support workers working for different treatment units or service providers. Various co-ordination and collaborative arrangements are used to develop and implement an integrated treatment plan (Health Canada, 2001, p. 16).

Treatment integration: Occurs when mental health treatments and substance use treatments are brought together by the same clinicians/support workers or team of clinicians/support workers, in the same program, to ensure that the client receives a consistent explanation of his or her illness/problems and a coherent prescription for treatment, rather than a contradictory set of messages from different providers (Health Canada, 2001, p. 15).

Universal preventive intervention: Intervention targeted to a defined population, regardless of risk. This could be an entire school, for example, and not the general population per se (US Department of Health and Human Services, 2001, p. 204).

Appendix B: Overview of problem gambling

Introduction

Gambling is a very common activity among Canadians. The opportunities to gamble legally have expanded remarkably in Canada since the 1990s, with substantial increases in permanent casinos, betting on horse racing, video lottery terminals (VLTs) and slot machines during this time period. However, gambling activities can also encompass lotteries, Internet gambling, instant-win tickets and bingos. The money generated from these various activities has made gambling a significant source of provincial government revenues (Littman-Sharp, 2004). In Canada, revenues from government-run lotteries, video lottery terminals and casinos was $11.3 billion in 2002, four times higher than revenues a decade earlier (Martin, 2004). Some research indicates that increased opportunities to gamble increases both participation in gambling and prevalence of pathological gambling (Ladouceur et al., 1999).

In a recent survey of Ontario adults, 83 per cent reported gambling in the previous year (Wiebe et al., 2001). Nationally, results from the Canadian Community Health Survey (CCHS) Cycle 1.2, undertaken in 2002, showed that three-quarters of Canadians (78 per cent of men and 73 per cent of women) reported gambling in the previous year, with four in 10 gambling weekly (Marshall & Wynne, 2003).

Prevalence of problem gambling

Gambling, like other potentially addictive behaviours, may be viewed on a continuum that includes no gambling, casual or serious social gambling, risky gambling, problem gambling and pathological gambling (Littman-Sharp, 2004). In Canada, two instruments are commonly used to estimate the prevalence of gambling problems: the Canadian Problem Gambling Index (CPGI) and the South Oaks Gambling Screen (SOGS).

Scores on the CPGI can be used to classify people as at risk for gambling problems, and as moderate and severe problem gamblers. The CPGI defines problem gambling as "gambling behaviour that creates negative consequences for the gambler, others in his or her social network, or the community" (Marshall & Wynne, 2003).

Scores on the SOGS, which was derived from the DSM-III, classify people as problem or pathological gamblers. The DSM officially recognized pathological gambling as an impulse control disorder in 1980 (Ladouceur et al., 1999).

Marshall & Wynne (2003) analyzed data from CCHS Cycle 1.2. Based on scores on the Problem Gambling Severity Index (PGSI), which is part of the CPGI:

- 6.3 per cent (6.5 per cent in Ontario) of people who gamble were at risk or were already problem gamblers
- 3.7 per cent (6.8 per cent in Ontario) were at low risk
- 2.0 per cent (2.1 per cent in Ontario) were at moderate risk
- 0.6 per cent (0.6 per cent in Ontario) were problem gamblers.

Low- or moderate-risk gamblers gambled more than five times a year and showed some evidence of problem gambling behaviour, e.g. betting more than they could afford to lose; problem gamblers also gambled more than five times a year and their gambling behaviour created negative consequences for themselves, their social network or their community.

A 2001 survey of gambling and gambling behaviour in Ontario also used the Problem Gambling Severity Index from the CPGI (Wiebe et al., 2001). However, although the authors used the same cut-off scores for classifying gambling behaviours, they labelled their groups somewhat differently. Results of this Ontario survey found that:

- 16.8 per cent were non-gamblers
- 68.8 per cent reported that they gambled without any problems (similar to the 71 per cent in the CCHS).

Among at-risk or problem gamblers:

- 9.6 per cent were classified as at-risk gamblers (versus 2.8 percent in the CCHS)
- 3.1 per cent had moderate gambling problems (equivalent to the 1.5 per cent moderate at-risk gamblers in the CCHS)
- 0.7 per cent had severe gambling problems (equivalent to the 0.5 per cent problem gamblers in the CCHS).

Population characteristics

Based on the results of the Canadian Community Health Survey (Marshall & Wynne, 2003), men who gamble are significantly more likely than women to be at-risk or problem gamblers. At-risk or problem gamblers were also more likely to be slightly younger than non-problem gamblers, and to be less educated, off-reserve Aboriginal, and daily or frequent weekly (2–6 times a week) gamblers.

The authors report that, among Ontarians, higher rates of moderate or severe problem gambling were found among those who were younger (18–24 years), unattached males, students and unemployed persons, and better educated. Though those with lower incomes were less likely to gamble, they were more at risk to develop gambling problems (Wiebe et al., 2001).

The type of game played also influenced the likelihood of at-risk or problem gambling. One in four of those who played VLTs was an at-risk or problem gambler, whereas that was true for only seven per cent of those who bought lottery tickets. In Ontario, severe gambling problems were associated with gambling with a bookie and gambling at a casino (Wiebe et al., 2001).

Problem gambling takes a toll on individuals, their social networks and their communities. In Ontario, people who have a gambling problem are more likely to drink, smoke and use illicit drugs than are non-problem gamblers (Wiebe et al., 2001). Increasing severity of gambling problems is associated with income loss or debt, relationship problems, employment problems, loneliness or isolation, health problems, alcohol dependence, stress, anxiety and depression (Marshall & Wynne, 2003; Wiebe et al., 2001).

Significantly, Marshall & Wynne (2003) reported that one in five problem gamblers contemplated suicide in the year prior to the survey. In Ontario, people with severe gambling problems were most likely to report committing a crime to support their gambling (Wiebe et al., 2001). People with moderate or severe gambling problems also often have distorted beliefs about their chances of winning (Wiebe et al., 2001).

Problem gambling and concurrent disorders

As noted above, problem gamblers experience greater stress and distress than non-problem gamblers, with elevated rates of alcohol dependence and major clinical depression (one in four over their lifetime); one in five has contemplated suicide in the previous year.

Some research indicates that problem gamblers differ from non-problem gamblers in experiencing higher levels of stress before beginning to gamble and having more troubled personal and family histories (Turner et al., 2002). Research also suggests that severe gambling problems (pathological gambling) may be predated by mood disorders (Martin, 2004). As well as mood disorders, problem gambling has also been linked to the presence of attention-deficit/hyperactivity disorder (Turner et al., 2002).

Women who have gambling problems share much in common with women who have substance use problems: high rates of family substance use and mental health problems and childhood histories of physical and emotional abuse. High rates of spousal/partner problems with alcohol, anger and gambling, as well as domestic violence, were also reported (Boughton & Brewster, 2002).

Blaszczynski (2000) has developed a model of pathways to problem gambling, which integrates biological, personality, developmental, cognitive, learning theory and environmental factors. He identifies three broad sub-groups of problem gamblers:

- normal problem gamblers who do not exhibit premorbid psychopathology
- emotionally disturbed gamblers who are characterized by family histories of problem gambling, negative developmental experiences, neurotic personality traits and adverse life events, and for whom gambling is a coping mechanism
- gamblers with biological correlates of gambling reflecting impulsivity, and who also display other problem behaviours such as substance use problems, suicidality, irritability, low tolerance for boredom, sensation seeking and criminal behaviours.

Martin (2004) notes that, though the high prevalence of concurrent psychiatric and substance use disorders is well understood and actively screened for, the same is not true for gambling problems, where there is a lack of attention to assessment and treatment of pathological gambling

among people with psychiatric problems, particularly mood disorders (Martin, 2004). In a follow-up study to the original Ontario prevalence study, Wiebe et al. (2003) found that the percentage of people receiving mental health treatment increased with the level of gambling problems, from 13.9 per cent among non-problem gamblers to 41.7 per cent among those with severe gambling problems.

Conclusion

Problem gambling is emerging as a significant social problem in Ontario, and is unlikely to dissipate with the continued expansion of gambling opportunities. People with gambling problems share much in common with those with substance use problems. This is recognized in Ontario and most other provinces, where substance use and gambling treatment are co-located. As well as concurrent substance use problems, people who have gambling problems have high rates of concurrent mental health problems, which may be both causal and exacerbated by their gambling problems. However, gambling problems may be under-identified and under-treated in people who have mental health problems.

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