

# ***Concurrent Disorders Guidelines***

A Supplement to the *Provincial Addictions Treatment Standards*



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## Setting the Context

## **Background**

Historically, substance abuse and mental health services have been developed separately; with Canada's mental health and addiction systems being independent and compartmentalized (Canadian Centre of Substance Abuse [CCSA], 2013). Hence, few services existed which explicitly worked with clients with both substance use and mental health problems. Clients were typically treated by one service alone, often for only one of their concurrent issues. As a result, other key aspects of their health were not addressed or not addressed as well as they should be. Effective intervention for clients with concurrent disorders requires integration and collaboration between mental health and addictions staff (CCSA, 2009).

In recent years considerable progress has been made across Canada improving services and systems for people experiencing concurrent disorders. This has occurred at multiple levels, including policy, local system integration and one to one work with individuals seeking help. Also, there has been additional research and evaluation studies that have further developed our knowledge base for evidence-informed policy and practice. In 2001, Health Canada released a seminal report entitled Best Practices for Concurrent Mental Health and Substance Use Disorders (Health Canada, 2002a). A summary report was subsequently prepared to support dissemination and application of the best practices across the provinces and territories and to facilitate networking and exchange (Health Canada, 2002b).

Since then, mental health and addictions services in Newfoundland and Labrador have become increasingly integrated both at the system and service delivery levels. The degree to which we have been able to achieve integration is perhaps somewhat unique amongst jurisdictions and a strength of our provincial system. At the Department of Health Community Services high level systems planning and policy development address mental health and addictions simultaneously within the provincial Division of Mental Health and Addictions. Since 2010, there has also been a Provincial Mental Health and Addictions Advisory Council which advises the Minister of Health and Community Services on key mental health and addictions matters. Many policy recommendations put forward by the Council have been targeted to both mental health and addictions such as the introduction of a provincial awareness campaign to reduce stigma and a focus on reducing wait times and increasing system efficiency.

At the Regional Health Authority (RHA) level administrative structures for mental health and addictions are also integrated in one mental health and addictions program. At the regional service delivery level many services are co-located and staff work collaboratively. There are common health information systems, referral and intake processes and procedures which enable the coordination of care. In some cases, especially in the smaller offices, the same staff provide both mental health and addictions counseling. This common organizational and operational structure increases opportunities for clients to make seamless transitions through the different mental health and addictions programs and services provided by each RHA. Collaborative planning with other RHA service areas is also enabled.

While considerable progress has been made in integrating mental health and addictions services there are still areas where integration can be improved, particularly with primary health care services and other sectors. The Addiction and Mental Health Collaborative Project Steering Committee (2014) outlines the importance of building partnerships and linkages with sectors such as primary care and with services, communities, and clients alike. The foundation to effective collaboration is engagement and building strong and positive relationships with these groups.

Due to the high level of integration in Newfoundland and Labrador it is a requirement that mental health and addictions staff understand the complex nature of a client's reality. Co-occurring substance use and mental health problems are common. Also, individuals struggle with homelessness, unemployment, lack of social supports, barriers in accessing treatment services, as well as stigma and discrimination from the community, the workplace, and the health care system. Staff must be able to provide interventions which address complex needs and help clients navigate and access additional services when required.

### **Scope, Purpose, and Target Audience**

The scope of the *Concurrent Disorders Guidelines* document is to be a *supplement* to the overarching *Provincial Addictions Treatment Standards* document which sets out the required elements of professional practice for mental health and addictions services, inclusive of the provision of service to those living with concurrent disorders. Key clinical components such as referral, intake, screening, and assessment are all covered in the Standards document. It is essential that the reader first become oriented to the Standards.

It is important to differentiate between standards and guidelines. Standards are defined as a minimum expected standard of professional and ethical behavior. A standard reflects a required course of action. Guidelines are sets of best practices developed through systematic review of available evidence on a topic. A practitioner can use guidelines to select options or guide a course of action. Guidelines differ from standards in that they are recommendations, whereas standards set out the minimal "required" course of action (National Research Council, 2011).

The purpose of this *Concurrent Disorders Guidelines* document is to provide guidelines on service provision for concurrent disorders for system level planners, clinical managers, and staff working in mental health and addictions programs in the province of Newfoundland and Labrador. Effectively integrating addictions and mental health treatment requires consideration of evidence-based practices and identifying effective strategies to modify administrative and provider barriers to integration. This document outlines evidence-informed guidelines that can enhance the ability to provide quality client care and optimal service delivery for those experiencing concurrent disorders.

## Process of Development

### Background & Process

The development of these *Concurrent Disorders Guidelines* was made possible through funding provided by Health Canada's Drug Treatment Funding Program (DTFP) – Strengthening Treatment Systems component. In 2009 a three – pronged proposal was submitted to Health Canada and funding was successfully obtained targeting the following three investment areas:

1. Evidence-Informed Practices
2. Evaluation and Performance Measurement
3. Linkage and Exchange

An Addictions Treatment Consultant located at the Department of Health and Community Services and funded through the DTFP provided overall leadership to investment areas one and three of this project. The development of the core *Provincial Addictions Treatment Standards* document, the development and implementation of this *Concurrent Disorder Guidelines* document and another supplementary document consisting of *Withdrawal Management Guidelines* comprise the “evidence-informed practices” investment area. The Addictions Treatment Consultant collaborated on the Standards as well as Guidelines development with three separate provincial working groups comprised of knowledge exchange facilitators, clinicians, and managers from the RHAs.

Dr. Brian Rush, former Head of the Health Systems and Health Equity Research (HSHER) Group at the Centre for Addiction and Mental Health (CAMH), and one of Canada's leading experts in concurrent disorders, was commissioned to prepare a paper for the Concurrent Disorders Working Group of Newfoundland and Labrador, consisting of evidence-informed practices which comprise part two of this document. This guidelines document was developed through a process of reviewing relevant literature, extensive consultation, and consensus-building with the core of the process focused on the review and adoption of Dr. Rush's paper. Editing was provided by the provincial Division of Mental Health and Addictions and the RHAs were given an opportunity to review and provide comments on the final version of the document.

## **Part One: Introduction**



## Definition

Concurrent disorders describes 'the situation where a person has both a mental health and substance use problem' (CCSA, 2010). Concurrent disorders also include problem/pathological gambling and substance use and/or other mental disorders (Rush, 2011). The Diagnostic and Statistical Manual for Mental Disorders (DSM-5) highlights the co-occurrence of mental disorders and substance use through highlighting comorbidity in the diagnostic criteria section of each category and recognizing that many symptoms experienced by one disorder are often present in others (American Psychiatric Association, 2013).

Concurrent disorders may also be referred to as:

- Dual Diagnosis (in Canada, this term is used to describe co-occurring mental illness and developmental disability)
- Dual Disorders
- Co-occurring substance use and mental health problems (Skinner, O'Grady, Bartha, & Parker, 2004).

## Prevalence

Between 40–60% of individuals with severe mental illness will develop a substance use disorder at some point during their lives (Health Canada, 2002a), almost 2% of Canadians (or 435,000 adults) have both a mental disorder and a substance use disorder (Rush et al., 2008). Rush et al. (2008) report this rate as grossly underestimated as some comorbidities such as personality disorder and posttraumatic stress disorder were not included in this study. Other reports indicate that more than 50% of those engaged in treatment for substance use are also struggling with mental illness and 15-20% of those engaged in treatment for mental illness are struggling with addictions (CCSA, 2009). A Canadian study determined the prevalence for concurrent disorders among those hospitalized for psychiatric concerns in 2010-2011 was 35.6% (Canadian Institute for Health Information [CIHI], 2013).

In Canada, the distribution of concurrent disorders among different age groups varies. The data capturing prevalence of concurrent disorders in 2009-2010 for those who were admitted to a general hospital with mental illness, demonstrates the variability across age groups. The percentages for each age group indicates that the group with the highest percentage of concurrent issues was 25-44 year olds (43.0%) followed by 45-64 year olds (26.0%), 15-24 year olds (22.6%), 65 years and older (7.0%) and finally 0-14 year olds (1.3%) (CIHI, 2012). Recent research looking at the prevalence rate for Canadian youth (ages 15-24) indicates that 3% meet the diagnostic criteria for concurrent disorders (Cheung, Bennett, Bullock, Soberman, & Kozloff, 2010).

With respect to the most common concurrent disorders, the following was found:

- *Anxiety Disorders* - 10-25% of all individuals will have an anxiety disorder at some point in their lives; among them 24% will also have a substance use disorder (Skinner et al., 2004). The prevalence rate in 2009-2010 for the population of those admitted to a general hospital with anxiety disorder and co-occurring substance use disorder was 4.6%, and increased to 5.5% for those admitted to a psychiatric facility (CIHI, 2012).
- *Major Depression* - 15-20% of all individuals will have major depression at some point in their lives; among them 27% will also have a substance use disorder (Skinner et al., 2004).
- *Bipolar Disorders* - 1-2% of all individuals will have bipolar disorder at some point in their lives; among them 56% will also have a substance use disorder (Skinner et al., 2004).
- *Schizophrenia* - 1% of all individuals will have schizophrenia at some point in their lives; among them 47% will have a substance use disorder (Skinner et al., 2004). For those admitted to hospital with a diagnosis of schizophrenia or psychotic disorders, 34.4% will also have a concurrent substance use disorder (CIHI, 2013).
- *Personality Disorders* - The prevalence of personality disorders in the general population are estimated to range from 6% to 9% (Health Canada, 2002a). The prevalence rate in 2009-2010 for those admitted to a general hospital with a personality disorder and co-occurring substance use disorder was 6.7%, and increased to 8.2% for those admitted to a psychiatric facility (CIHI, 2012).

Individuals who experience concurrent disorders characterize some of the most complex and intricate cases to treat. The experience of crisis and relapse are common for those living with concurrent disorders (CCSA, 2009). In Canada, individuals who are hospitalized with concurrent issues are more likely to experience readmission within 30 days and 1 year of discharge, and are more likely to have longer hospital stays than those who are hospitalized exclusively for reasons of mental illness or substance use (CIHI, 2013). As a result of ongoing crisis, relapse, and lack of adequate supports, the health care and societal costs for concurrent disorders is high (Adair, 2009; CCSA, 2009).

The complex needs for those living with concurrent disorders are further supported in the differences noted in readmission rates from psychiatric and general hospital settings. Those with concurrent disorders who were discharged from a general hospital were more likely to experience readmission. The research suggests that this may be an indication of efforts in discharge planning and connecting clients with adequate supports from a psychiatric setting versus a general hospital (CIHI, 2013). This underlines the importance of collaborative care for individuals living with concurrent disorders (Addiction and Mental Health Collaborative Project Steering Committee, 2014; CIHI, 2013; Health Canada, 2002b).

People with concurrent disorders encounter significant challenges, affecting their ability to cope with daily life, dealing with the stigma attached to their condition, and managing their overall health and wellbeing (CCSA, 2009). Individuals living with concurrent disorders have difficulty accessing appropriate services, resulting in unmet needs (Urbanoski, Cairney, Bassani, & Rush, 2008) and poor outcomes (Adair, 2009; CCSA, 2009). Outcomes for individuals living with concurrent disorders are identified across a range of age groups. These include premature death, increase risk for suicide, increase symptom severity, reduced quality of life, poorer functioning, and more challenges with physical health (Adair, 2009). Individuals with concurrent disorders have a higher risk of experiencing unemployment, marginalization, loss of family/friends, homelessness, and involvement with the criminal justice system (CCSA, 2009). Despite the range of negative outcomes and challenges faced by those living with concurrent disorders, it is important to remember that recovery from both the substance use and mental health problems is possible (Adair, 2009).

Concurrent disorders can begin in childhood or later in life. The earlier the onset and the more severe they are, increases the need for integrated interventions (Skinner et al., 2004). From a service delivery perspective, the earlier concurrent disorders are recognized, assessed, diagnosed, and treated, the greater quality of life the individual will have. Integrated treatment with effective collaboration and coordination of services has many potential benefits for clients including early intervention, improved access, ease in transition of care, better health outcomes, and support through recovery (Addiction and Mental Health Collaborative Project Steering Committee, 2014).

### **Etiology and Risk Factors**

There is no single cause of concurrent disorders; each person's situation is unique. Skinner (2005) suggests an interaction of risk factors, precipitating factors, and perpetuating factors to explain the development of concurrent disorders. The following are some reasons why a person may develop both a substance use and mental health problem:

- Genetic predisposition - There may be a biological factor that increases an individual's risk of developing concurrent disorders (Skinner et al., 2004).
- Family history - Alcohol or other substance use problems among family members (Adair, 2009; Health Canada, 2002a; Herie, Godden, Shenfeld, & Kelly, 2010).
- Coping strategies - In the face of an adverse or significant life event, many individuals resort to substances as a means of coping in an attempt to make themselves feel better and temporarily relieve symptoms (Herie et al., 2010; Skinner et al., 2004). The use of psychoactive substances impacts the functioning of the brain and release of neurotransmitters associated with reward and pleasure. The experience of positive feelings and altering of brain chemistry can lead to tolerance and sustained maladaptive coping (Herie et al., 2010).

- Social environment- The home, neighborhood or community where people live, go to school or work, and attitudes of their peers, family and culture toward substance use can impact a person's risk for developing mental health or substance use concerns (Adair, 2009). The presence of family conflict, chaos, or stress in the home environment may increase risk of developing concurrent disorders (Adair, 2009; Health Canada, 2002a).
- Other mental illnesses - Individuals may use substances to find relief from their mental illness symptoms and the emotions, perceptions, disturbed thoughts and feelings that can accompany those mental illnesses (Skinner et al., 2004).
- Physical illness – Individuals diagnosed with life-threatening illness may be at increased risk for developing mental health and substance use concerns (Health Canada, 2002a).
- Spiritual well-being/social isolation - Defining spiritual well-being is unique to each individual, however social connectedness may be an important component to well-being. For those who do not feel connected to others or the world around them, they may experience feelings of hopelessness and isolation. In an effort to cope with these feelings, substance use may occur (Herie et al., 2010).
- Trauma - Trauma can be defined as both an event and an experience of an event. At its core, trauma is an “experience that overwhelms an individual's capacity to cope” (Poole, 2012). Whether trauma is experienced during the developmental years, as a single event, repetitively, or is historical or intergenerational (Arthur et al., 2013), the effects can be devastating. The relationship between the experience of trauma, substance use, and mental health is complex and is supported in the literature (CCSA, 2009).
- Psychosocial factors – the individual may experience negative psychosocial impacts as a result of their substance use, such as relationship breakdown, which negatively impacts their mental health (Skinner et al., 2004).
- Experiencing marginalization or oppression – Individuals who are oppressed due to race, ethnicity, gender, age, sexual orientations, abilities, or other factors may be at an increased risk of using substances (Herie et al., 2010).
- Stigma – Those who live with mental health and addictions concerns experience stigma and discrimination which may impact on help-seeking behaviour (CCSA, 2013). Experiencing stigma may impede a person from engaging with treatment out of fear of social consequences. Only 25% of Canadians stated that they would continue to be friends with someone who struggled with substance use (British Columbia Mental Health & Addictions, 2010) and 42% were unsure whether they would socialize with someone who experienced mental illness (Canadian Medical Association, 2008).

### **The Reciprocal Relationship between Substance Use and Mental Illness**

Mental health problems and substance use problems can affect each other in several ways (Skinner et al., 2004):

- Substance use can exacerbate mental health problems.
- Substance use can imitate or hide symptoms of mental health problems leaving the mental health issue undiagnosed/untreated.
- Some substances can interact with medications prescribed for mental health concerns impacting on their ability to manage mental health symptoms.
- Substance use may interfere with an individual's ability to take medications correctly thus causing relapse.
- Relapse of either mental health or addictions concerns, can activate the symptoms of the other mental health or addictions concerns.
- Individuals may use substances to cope with their mental health problems.

### **Categories of Concurrent Disorders**

Because there are many different types of mental health and substance use problems, the combinations of concurrent disorders can be divided into seven main groups (Rush, 2011):

- Co-occurring substance use and mood disorders
- Co-occurring substance use and anxiety disorders
- Co-occurring substance use and severe and persistent mental disorders
- Co-occurring substance use and personality disorders
- Co-occurring substance use and problem/pathological gambling
- Co-occurring substance use and eating disorders
- Co-occurring substance use and attention deficit hyperactivity disorder (ADHD).

In 2013, the American Psychiatric Association published the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5). The DSM-5 serves as a standard clinical reference and guide for those working in the field (American Psychiatric Association, 2013). The terminology used by the American Psychiatric Association is widely accepted and utilized in clinical practice; however, several notable changes have been made in the latest edition. As a result, many of the references provided in this document were published using previous versions of the DSM as new publications are still emerging with the up to date criteria.

It is important to be cognizant of the changes in the categories outlined by the DSM-5 in relation to this document, as the guidelines themselves were developed prior to the publication of the DSM-5. As a result there are differences in language as reflected in the DSM-5 and these guidelines. For example, the DSM-5 has categories of depressive disorders and bi-polar and related disorders (American Psychiatric Association, 2013), whereas the guidelines utilize the term mood disorders.

## **Part Two: The Guidelines**

### **Service and System Level Integration (Rush, 2011)**

Services and supports for people with concurrent addictive and other mental disorders should not be planned in isolation of services for people with either addictive or other mental disorders but which are not concurrent. A broad system approach is required that engages multiple sectors and multiple levels of service delivery all the way from health promotion and prevention, early intervention up to high intensity tertiary care. One must also recognize that people with concurrent disorders are each on their own individual trajectory with problems, or high risk of future problems, typically emerging at a young age, and evolving over their lifespan.

Within a broad system framework those with addictive and other mental disorders must be supported in linking and transitioning across various sectors and services. These linkage mechanisms and strategies are necessary to ensure timely access to a range of medical, psychiatric, and psychosocial interventions which go beyond immediate crisis and acute care to include housing, employment, and educational supports, income assistance, and assistance with basic needs such as food access and clothing if needed. In addition to a strong focus on linkage and access to services, the planning and delivering of services must also be supported by adequate resources system supports.

There is an important distinction between service and system level integration.

### **Service-level Integration (Rush, 2011)**

This level of integration refers to the clinical interface of services and supports directly to clients including, for example, screening, assessment, intervention, case conferencing, linkage, and recovery monitoring.

There are two general approaches to service-level integration. One approach is where mental health and addiction treatment and support is brought together by the same clinicians/support workers *in the same co-located setting*.

The other approach to integration is through well-coordinated, collaborative arrangements *across two or more service providers* that ensure access to needed services and supports as well as effective continuity of care.

### **System-level Integration (Rush, 2011)**

System-level integration refers to those structures and processes that are required to ensure individuals and their families can access and engage with a continuum of services appropriate to their needs and areas of strength. Some examples include needs-based policy, planning and resource allocation, adequate funding, good governance, workforce training and development, IT infrastructure, systems for performance measurement, research, knowledge exchange, and strong leadership. The systems approach to service planning emphasizes these “system supports” as foundational to effective delivery of services to individuals and families in need.

Both service and system level integration of care are important considerations for treatment of clients with concurrent disorders. Regardless of the general approach the critical features of service-level integration include:

- A consistent explanation of the disorder(s) and spectrum of related problem areas.
- An exploration of strength areas.
- Coherent recommendations rather than a contradictory set of messages and philosophies from different mental health and addictions staff.
- Jointly developed, implemented, and monitored treatment and support plans.

### A Symptom Severity Model (Skinner et al., 2004)

The following model can help determine the severity of a client's concurrent disorder and the best suited location of treatment (Figure 1).

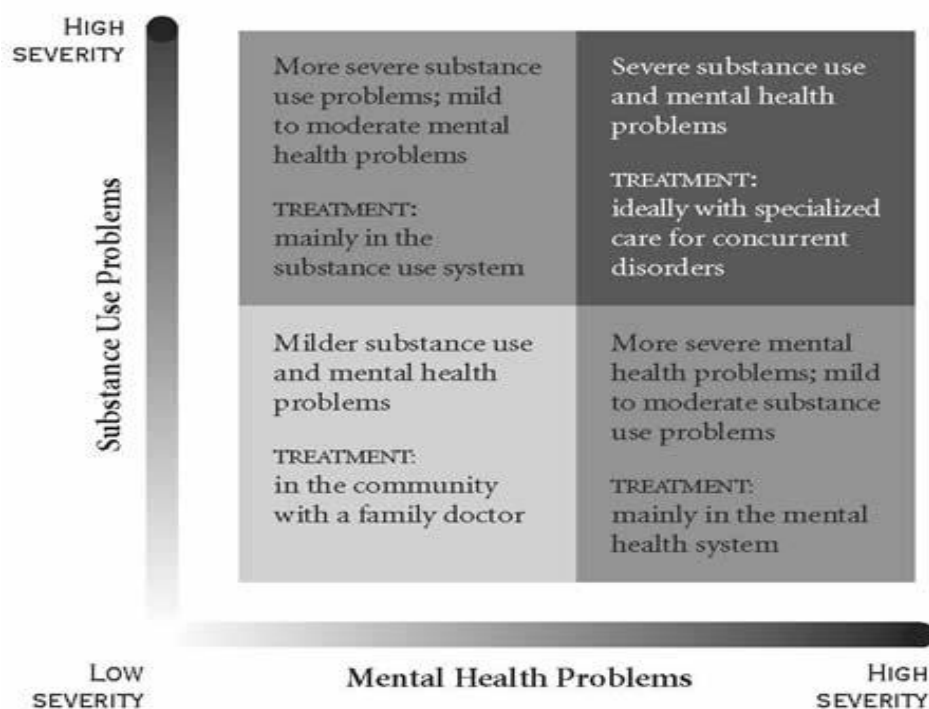


Figure 1: A continuum of concurrent disorders (Skinner et al., 2004)

### In Context

The systems of care providing mental health and addictions services in the province of Newfoundland and Labrador are highly integrated, with many services co-located, and many service providers working with both clients requiring mental health and/or addictions services. Within a highly integrated system, it may be more relevant to consider placement with the appropriate provider or program, as opposed to placement in a particular system of service. When the predominant issue is substance use, care would be provided by an addictions



program or addictions worker and where mental health is the primary concern, mental health programs or workers would lead the intervention. When concurrent issues are identified, care is provided by an integrated program, clinician who is competent in mental health and addictions treatment, or as a collaborative effort between service providers. Consideration to collaboration outside of specific programs and providers is also relevant to the context of the highly integrated system. Regardless of program or provider, partnerships with other services, supports, and care providers occurs as required (Addiction and Mental Health Collaborative Project Steering Committee, 2014; Health Canada, 2002b).

To facilitate partnerships for collaborative care and to appropriately serve clients with concurrent disorders, the following factors may be considered (Addiction and Mental Health Collaborative Project Steering Committee, 2014; Health Canada, 2002b):

- Recognizing client concerns that may extend beyond the means of the program or service provider.
- Identifying and accessing the resources required to address the clients concerns.
- Developing formal collaborations across service providers and programs that clarify expectations, roles, and responsibilities within the partnership.
- Communicating effectively across programs and between service providers on the scope of the collaboration.
- Extending collaborative efforts beyond the front-line to involve all organizational levels, including management, professional development efforts, and policy or protocol development.
- Reviewing the partnerships and making changes to support quality improvement as necessary.

### **Guidelines for Treatment and Support Services by Diagnostic Grouping (Rush, 2011)**

The following guidelines for treatment and support services are organized according to diagnostic category and consist of three areas of consideration:

- I. Integration – or the recommended type of service delivery model.
- II. Sequencing – or the recommended timing or ordering of the course of treatment.
- III. Intervention Methods – or the recommended theoretical approaches and treatment considerations.

### ***Co-occurring Substance Use and Mood Disorders (Rush, 2011):***

- I. Integration - Should occur either through a co-located service approach or collaborative care model.
- II. Sequencing - Address the mood disorder and substance use disorder simultaneously to achieve better outcomes. The high risk of suicide and suicide ideation among this sub-population with concurrent disorders also calls for a simultaneous approach.
- III. Intervention methods - Cognitive behavioural approaches and motivational interviewing are recommended. Medication can also accompany and complement cognitive behavioural treatment. This includes consideration of pharmacological approaches for

substance use disorders. Relapses are common for severe mood disorders and alcohol or drug dependence so longer term treatment and recovery monitoring is required, as is ongoing assessment. Mood related symptoms must be monitored closely in relation to substance use patterns, including periods of abstinence. A reduction in substance use, particularly alcohol use, can improve mood-related symptoms and therefore dictate changes in the treatment and support plan.

***Co-occurring Substance Use and Anxiety Disorders (Rush, 2011):***

- I. Integration - Should occur either through a co-located service approach or collaborative care model.
- II. Sequencing - Both substance use disorders and anxiety disorders shall be treated simultaneously.
- III. Intervention methods - A cognitive-behavioural approach is recommended and medication can accompany and complement cognitive-behavioural treatment. As with mood disorders, this includes consideration of pharmacological approaches for substance use disorders.

***Co-occurring Substance Use and Severe and Persistent Mental Disorders (Rush, 2011):***

- I. Integration – Although treatment and support can occur through well-functioning collaborative care models, the emphasis should be on a co-located service approach given significant challenges related to medication management, treatment participation, transportation and transitions across service providers experienced by people with severe and persistent mental illness.
- II. Sequencing – Both disorders of substance use and severe and persistent mental disorders should be treated simultaneously.
- III. Intervention – A comprehensive approach shall include cognitive behavioural-based counselling, motivational interviewing, self-help liaison, work with families and medication, including medication management and support. Providers must be aware of the “super-sensitivity” phenomenon whereby small amounts of alcohol or other substances can have negative consequences. Evidence supports a harm reduction approach to substance use. Highly structured or confrontation treatment approaches are contraindicated. Linkages must be in place for crisis response, housing, intensive case management, and transitions to and from hospital care. Longer term treatment and recovery monitoring is required, as well as ongoing assessment.

***Co-occurring Substance Use and Personality Disorders (Rush, 2011):***

- I. Integration - Should occur either through a co-located service approach or a collaborative care model.
- II. Sequencing – Consider the most relevant and common personality disorders; Research supports addressing Borderline Personality Disorders and Substance use disorders simultaneously. For Anti-Social Personality Disorder, the substance use issues should be addressed first. More research is needed to identify evidence-based treatment approaches to Anti-Social Personality Disorder.

- III. Intervention - Cognitive behavioural approaches and motivational interviewing are recommended including complementary medication. This includes consideration of pharmacological approaches for substance use disorders. For severe substance use or other mental disorders and personality disorders longer term treatment and recovery monitoring is required, as is ongoing assessment.

***Co-occurring Substance Use and Other Mental Disorders and Problem/Pathological Gambling (Rush, 2011):***

- I. Integration – Should occur either through a co-located service approach or collaborative care model.
- II. Sequencing – Research suggests addressing the combination of substance use disorder, mental disorders and problem/pathological gambling simultaneously.
- III. Intervention – Cognitive behavioural approaches and motivational interviewing are recommended to accompany complementary medication. This includes consideration of pharmacological approaches for substance use disorders. For severe substance use or other mental disorders and problem/pathological gambling longer term treatment and recovery monitoring is required, as is ongoing assessment.

***Co-occurring Substance Use and Eating Disorders (Rush, 2011):***

- I. Integration - Should occur either through a co-located service approach or collaborative care model.
- II. Sequencing - Simultaneous treatment is recommended unless there are compelling clinical reasons (e.g. life threatening) for focusing on one of the disorders first.
- III. Intervention - Combinations of medical management, behavioural strategies, and psychotherapy should be employed.

***Co-occurring Substance Use and Attention Deficit Hyperactivity Disorders (ADHD) (Rush, 2011):***

- I. Integration - Should occur either through a co-located service approach or a collaborative care model.
- II. Sequencing - Research supports addressing ADHD and substance use disorders simultaneously because the symptoms of ADHD can significantly affect participation and outcome of treatment for substance use disorders and vice versa.
- III. Intervention - Treatment for ADHD in the context of concurrent substance use disorders is challenged by the abuse potential of the stimulant medication, often prescribed for ADHD. The preferred treatment of adult ADHD is a combination of behaviour therapy and medication. The most effective medication is long acting stimulant medication. These long acting medications minimize the abuse potential because of the delayed absorption and longer response time. Non-stimulant medications are also effective in some cases and can be used as a first-line medication if stimulant abuse potential is judged to be significant. Assessment and medication trial during a period of abstinence (a few weeks or months) is ideal since symptoms of substance dependence often mimic the symptoms of ADHD. This may not be possible, however, due to the negative impact of the symptoms of ADHD on the risk of relapse. There are no counter-indications for

simultaneous evidence-informed cognitive behavioural or pharmacological interventions for the concurrent substance use disorder(s). Some clients may need to be monitored more closely than others.

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