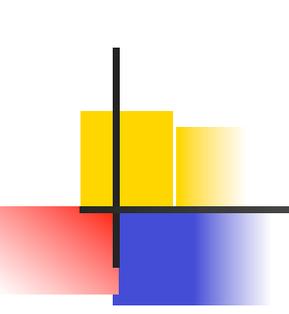
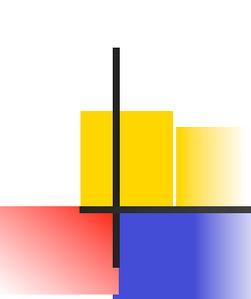




Concurrent Disorders: ***From Understanding to Practice***



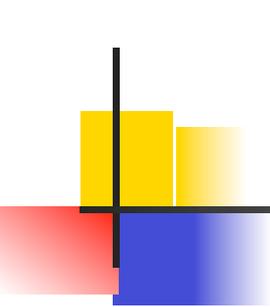
***What are challenges for you in
working with people with
mental health and
addictions?***



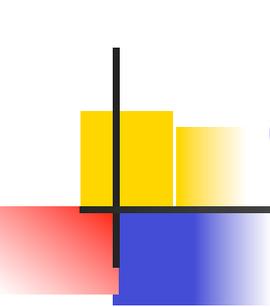
What are people talking about when they use the term “complex” clients?

- Clients that frustrate workers.
- Clients that are multiple service users.
- Clients that often have substance abuse, medical and mental health challenges.
- Clients that do not appear motivated are willing to change.

What we are talking about are people.....

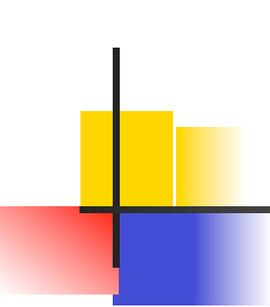


*Clients usually living with a
Concurrent Disorder...*



Concurrent Disorders

- Someone who has both mental health and substance use disorder.
- Have also been referred to as “Dual Diagnosis or Co-occurring Disorders”.
- Both are serious conditions and need to be treated at the same time.

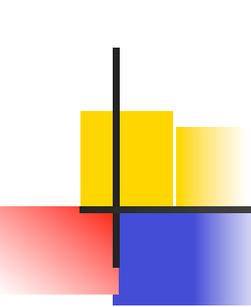


Prevalence Concurrent Disorders

<u>Mental Health</u>	<u>%People</u>	<u>%Substance</u>
Anxiety disorders	10-25%	24%
Major depression	15-20%	27%
Bipolar disorder	1-2%	56%
Schizophrenia	1%	47%
Antisocial PD	3%	60-80%
Borderline PD	2%	40-60%
Gen. Population		15%

(Skinner, O'Grady, Bartha & Parker, 2004)

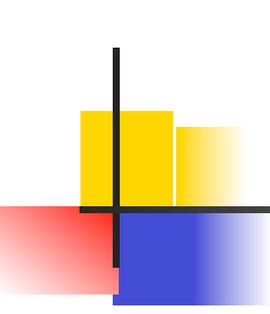
PTSD	8%	40-60%
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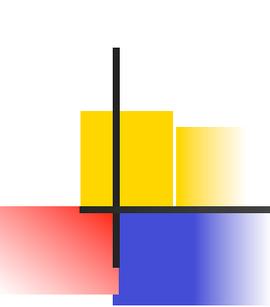
Impact of Substance Abuse on Psychiatric Illness

Effects are additive...

- Relapse and re-hospitalizations
- Severity of depression symptoms related to alcohol consumption
- Suicide risk
- Family / interpersonal conflict
- Financial problems
- Risk of violence/aggression (perpetrator and/or victim)
- Risk of homelessness/housing problems
- Legal problems
- Risk of severe physical health problems
- Worsens psychiatric outcomes and social functions



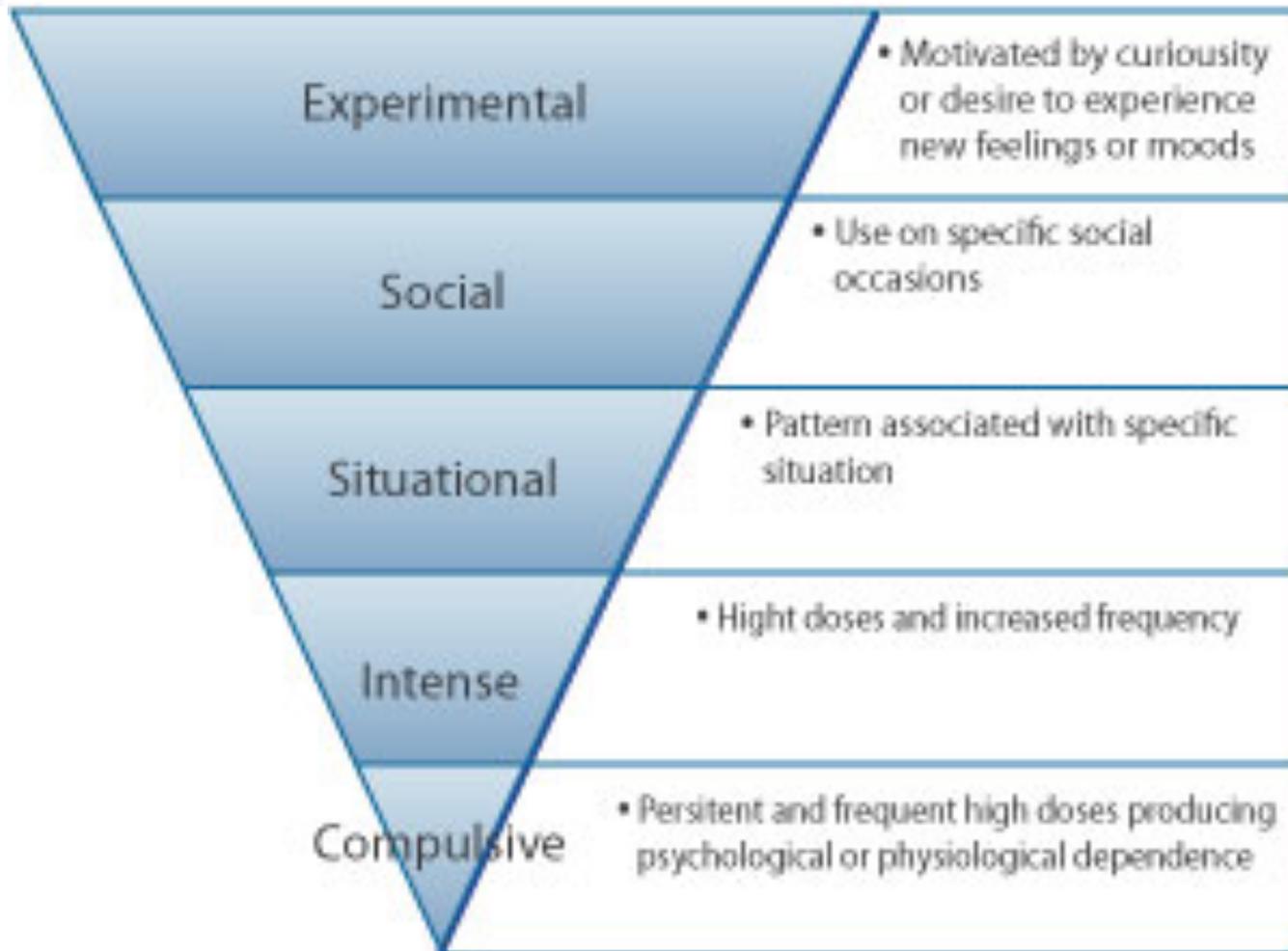
How do you define Addiction?



Addiction: The three C's

- Loss of **C**ontrol (*can't stop*)
Inability to control usage
- Increased **C**ompulsion (*need more*)
Psychological compulsion (preoccupation)
- Use despite adverse **C**onsequences
(*harm*) *Self & Others*

Continuum of Substance Use



Substance Abuse/Dependence

DSM-IV Criteria

ABUSE

1 out of 4

-- over a 12 month period

Can abuse substances but may not be dependent

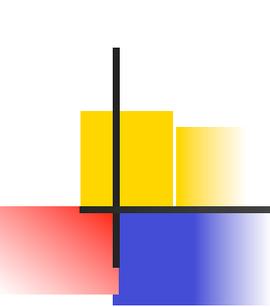
- Fail perform roles
- Physical hazards
- Legal problems
- Social/interpersonal problems

DEPENDENCY

3 out of 7

-- over a 12 month period

- ↑ tolerance
- Withdrawal symptoms
- ↑ Amounts or longer period
- Can't stop or decrease use
- ↑ time getting, using, and recovering from use
- ↓ social, occupational, or recreational activities
- Use despite negative consequences



Pathways of Addiction

Addiction

= cope with emotional pain

= maladaptive self soothing

“self medicating”

Attachment

- Crucial importance of early caregiver-child bonding in mental, physical, emotional health.
- Mental health in adulthood is dependent upon a secure base in childhood where children are “nourished physically and emotionally, comforted if distressed, reassured if frightened” (Saakvitne et al., 2000:18).
- Secure, anxious, avoidant, disorganized type of attachment.

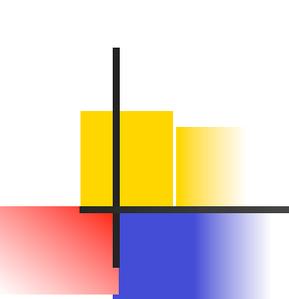
Attachment

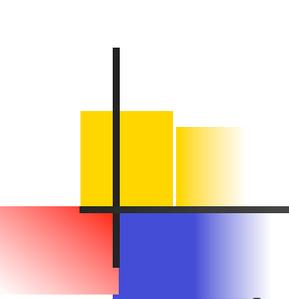
Poor attachment may result in:

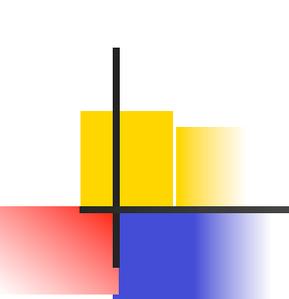
- coping with distress by self-punishment or attempts to stop any feelings at all;
- inability to self-soothe in healthy ways;
- inability to develop relationships based on mutual trust; and
- avoidance of help-seeking behaviours

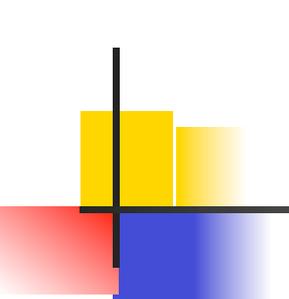
Complex Trauma

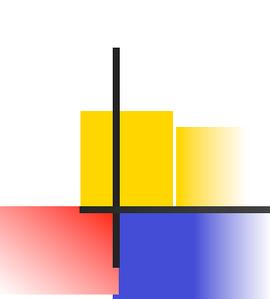
“Survivors of childhood trauma have the dilemma of having experienced both the overwhelming arousal of abuse, and the absence of adequate soothing and comforting. Thus, survivors are both often in a state of hyperarousal and particularly unskilled at self-soothing” (Saakvitne et al., 2000:18).

- 
- A study by the National Native Addictions Partnership Foundation Inc. (NNAPF) (2000) found that the primary addiction or substance abuse problem for clients in NNADAP treatment centres is
 - Alcohol (58.4%).
 - Other drugs, such as narcotics (12.2 %) and hallucinogens (8.6%), were identified by more than 20 per cent of NNADAP clients.

- 
- The cause of death due to alcohol use is 43.7 per 100,000 in the Aboriginal population, almost twice the rate of the general population (23.6 per 100,000); and death due to illicit drugs is approximately three times than the rate of the general population (NNAPF, 2000).
 - Health Canada (2003) reports suicide and self-injury accounted for 38 per cent of deaths among youth and 23 per cent among adults aged 20 to 44.
 - Aboriginal women are three times more likely to be victims of spousal violence than non-Aboriginal women.

- 
- Aboriginal youth are at two to six times greater risk for every alcohol-related problem than their non-Aboriginal counterparts. They are more likely to use all types of illicit drugs than non-Aboriginal youth, and they will begin using substances (tobacco, solvents, alcohol, and cannabis) at a much younger age than non-Aboriginal youth (Currie, 2001).
 - Major factors in the sexual practices of Aboriginal youth are the use of alcohol and drugs, and there is a high rate of teen pregnancy among this group (Anderson, 2002).

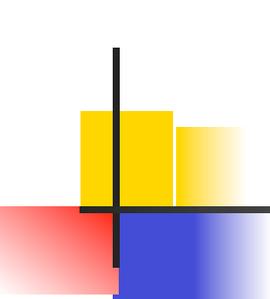
- 
- The prevalence of prescription drug abuse accounts for 48 per cent of Aboriginal people using addiction treatment services; of these, 74 per cent use benzodiazepines and over 60 per cent are poly-prescription drug users. During a one-year period in 2000, there were 1 in 3 status Aboriginal women over the age of 40 in western Canada who were prescribed benzodiazepines (Currie, 2003).



Aboriginal Clients

Attachment + Complex Trauma

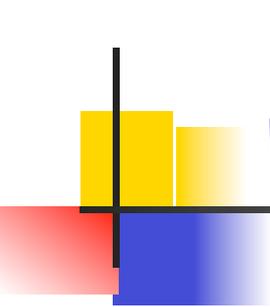
- Legacy of Residential Schools.
- Indian Act.
- Forced relocation / “Dislocation”
- Cycle of generational trauma. “Historic Trauma Transmission” (HTT) refers to a series of traumatic events occurring over time with no opportunity for recovery and rebalance between these events.



Aboriginal Clients

Attachment + Complex Trauma

- Poverty.
- Oppression / Racism.
- “Soul loss” .
- Foster home / Removal of children.
- Systems harm.



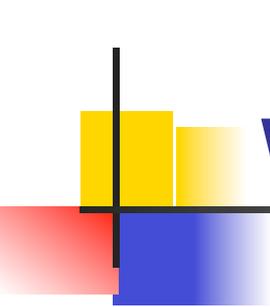
When do concurrent disorders begin?

Examples in...

Childhood?

Adult?

Older Adult?

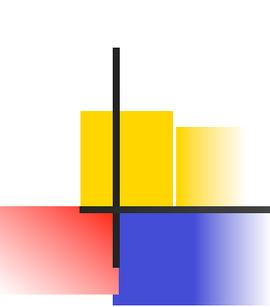


When do concurrent disorders begin?

Childhood – Oppositional behaviour & MJ or ETOH; ADD & meth; Trauma & ketamine

Adult – Anxiety & MJ, SCZ & MJ, Bipolar & ETOH, Trauma & Crack, ABI & ETOH...

Older Adult – Depression & ETOH, Multiple Losses/Bereavement & Benzos...



Classes of Psychoactive Drugs

Cannabis – hashish, MJ

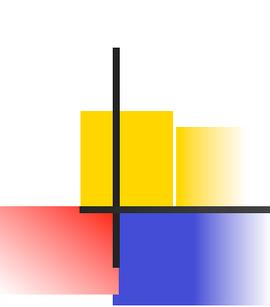
Depressants – alcohol, benzo's, GHB, barbituates

Hallucinogens – LSD, psilocybin, ketamine,

Opioids – heroin, morphine, oxycodone, codeine,

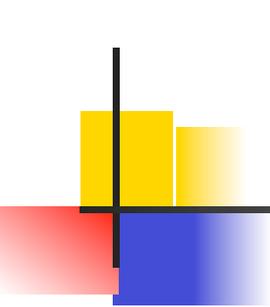
Stimulants – amphetamine, cocaine,
methamphetamine (ecstasy), caffeine, nicotine

Inhalants – solvents, laughing gas, poppers



Concurrent Disorders manifest itself in several different ways:

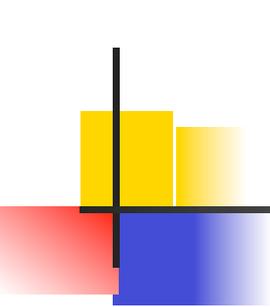
- Substance abuse and psychiatric disorders may co-occur by coincidence.
- Substance use may cause psychiatric conditions or increase the severity of psychiatric symptoms.
- Psychiatric disorders may cause or increase the severity of substance use disorders.



Concurrent Disorders manifest itself in several different ways:

- Both disorders may cause a third condition.
- Substance use and withdrawal may produce symptoms that mimic those of a psychiatric disorder

Meyer 1989, from Addictions and Mental Health, Irene Ralph, R.P.N., 2001



Vulnerabilities for Concurrent Disorders

- Increased brain vulnerability to harmful effects of substances.
- Mental illness may interfere with learning from an adverse drug experience.
- Frequent presence of trauma-related effects adding to existing problems.
- Fewer alternatives to healthier coping resources.

History of Recognizing Concurrent Disorders

SEQUENTIAL SYSTEM:

- Split between Addiction Services and Psychiatry in the past.
- Treatment for the problem that is more acute and then begin tx for the other problem.



History of Recognizing Concurrent Disorders

PARALLEL SYSTEM:

- Simultaneous but separate treatment in mental health & addiction systems.



History of Recognizing Concurrent Disorders

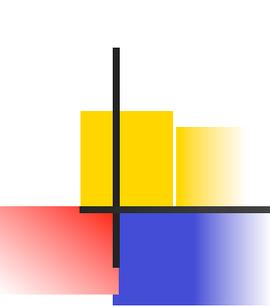
INTEGRATED SYSTEM:

- Current best practice – treatment for both illnesses from the same staff in the same setting.

“NO WRONG DOOR” (Minkoff)

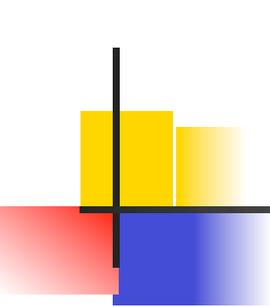


- **Welcoming environment**
- **Access**
- **Safety**
- **Support**



Take away message

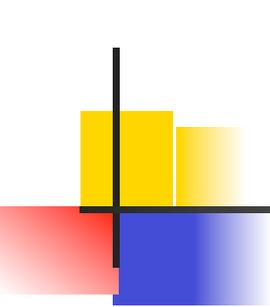
- Both psychiatric and substance use diagnoses are primary.
- These disorders ***interact*** not just co-occur.



Why Integrated Treatment

Among those with co-occurring disorders:

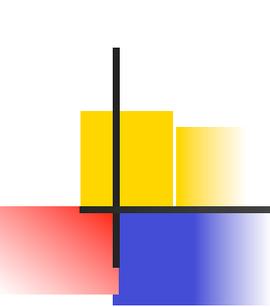
- The commonest cause of psychiatric relapse is resumption of alcohol or drug USE, not necessarily abuse.
- The commonest cause of relapse to alcohol or drug use is untreated psychiatric disorders, especially depression and anxiety.



Take away message

Failure to address CD in either substance abuse treatment or mental health programs is tantamount to not responding to the needs of the majority of program participants

US Substance Abuse and Mental Health Services Administration (SAMHSA)



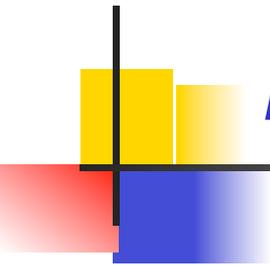
Take away message

Out of the Shadows At Last Recommendation #45

That the Canadian Mental Health Commission actively partner with national addiction organizations, and work toward the eventual goal of integration of the addiction and mental health sectors.

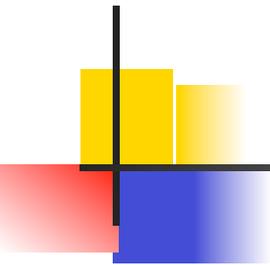
Challenges

Addictions	Mental Health	Aboriginal
<ul style="list-style-type: none">–Client–Disease–Recovery–Abstinence–Self help groups	<ul style="list-style-type: none">–Patient–Disorders–Stabilization–Prescriptions–Consumer Support and advocacy groups	<ul style="list-style-type: none">–Circle / Interrelations–Cultural Teachings–Cultural Healing–Historical Trauma Transmission–Community



Discussion

***What would you need to
provide Concurrent
Treatment in your program?***

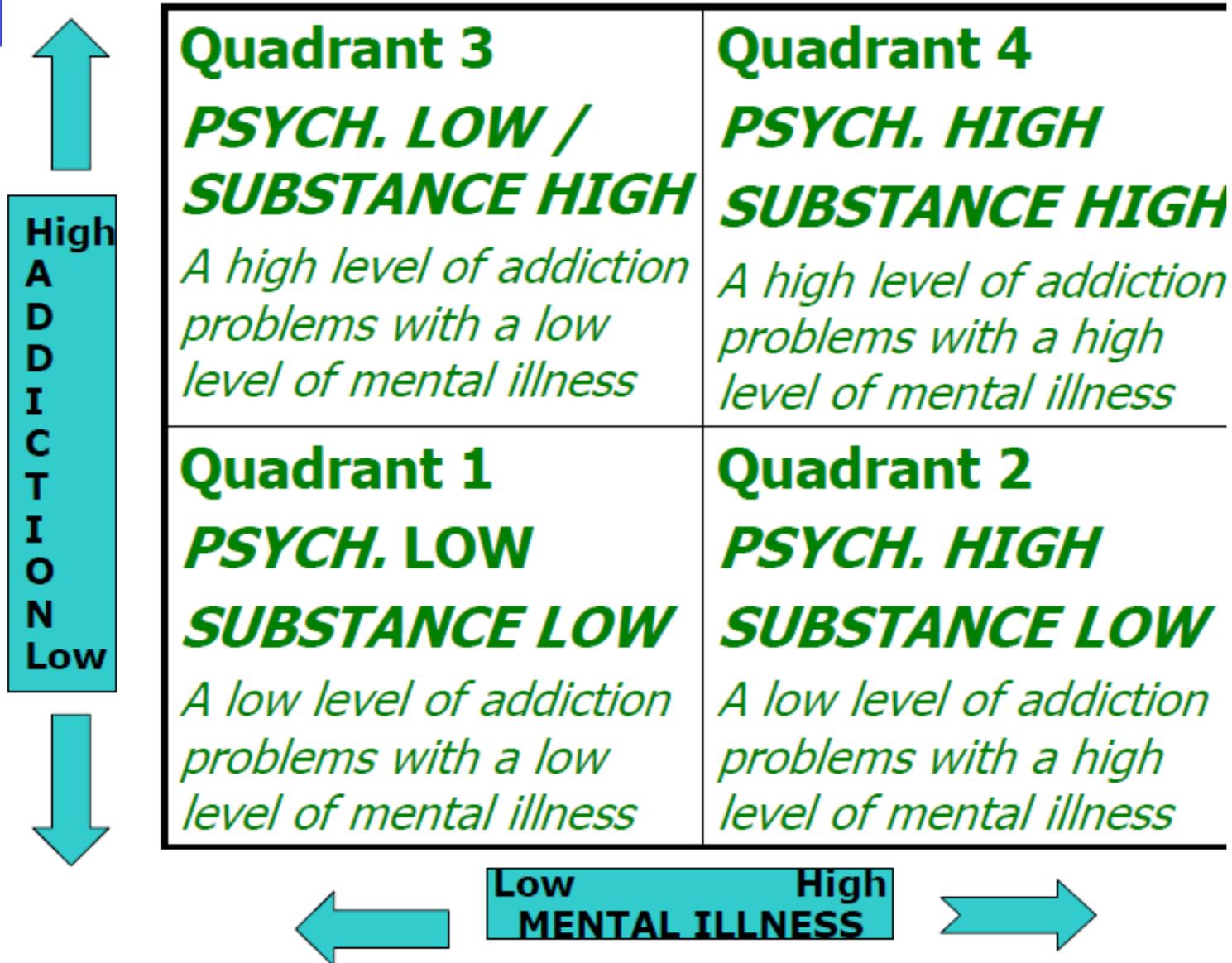


Treatment Model

Harm Reduction versus Abstinence?

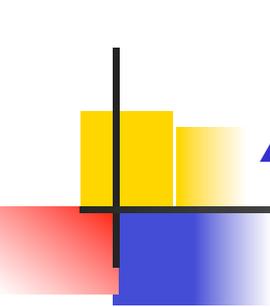
(Pro' s and con' s)

Typical Early Recovery Group



Typical Dimensions of Assessment in Substance Use Disorder

1. Patterns of Use
2. Consequences of Use
3. Subjective Distress
4. Dependence Syndrome



Assessment

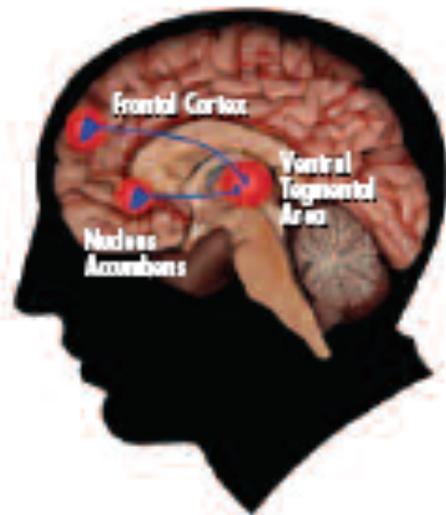
Common Assessment Problems

- Failure to take a proper history
- Denial and minimization
- Confusion about the effects of substance use
- Primary-secondary distinction
- Cognitive, psychotic, mood related
- History of sanctions
- Pre-motivational state
- Different norms for substance use disorder

Reward

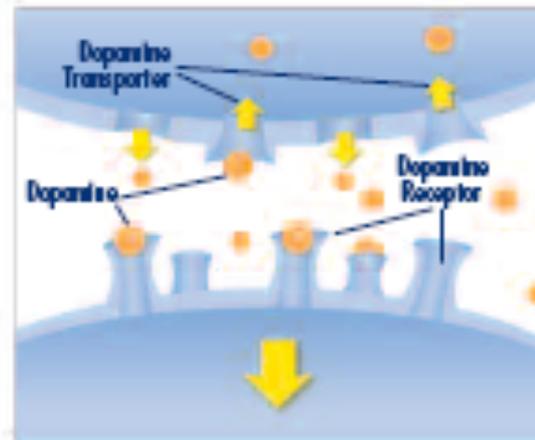
ALL DRUGS OF ABUSE TARGET THE BRAIN'S PLEASURE CENTER

Brain reward (dopamine) pathways

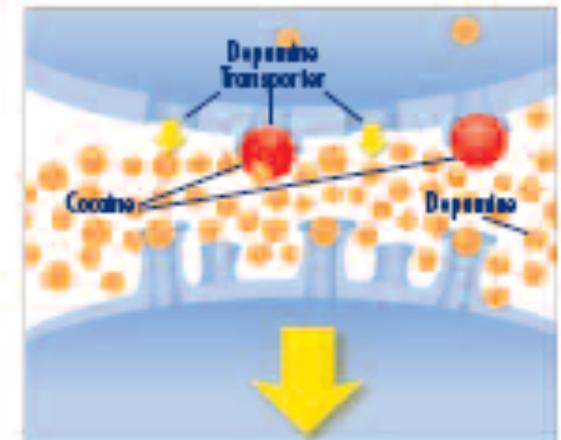


These brain circuits are important for natural rewards such as food, music, and art.

All drugs of abuse increase dopamine

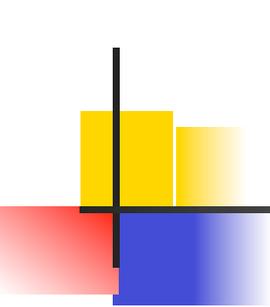


FOOD



COCAINE

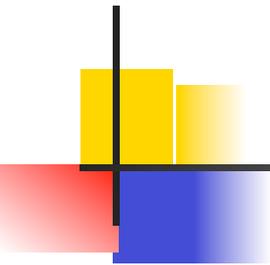
Typically, dopamine increases in response to natural rewards such as food. When cocaine is taken, dopamine increases are exaggerated, and communication is altered.



Trauma Informed Practice

Trauma

- Studies have found a higher incidence of substance abuse among women who were victims of childhood sexual abuse and sexual assault (Ryan and Popour, 1983; Reed, 1985).
- The rate of PTSD among people with substance use disorders is 12 to 34 percent. For women with substance use disorders, it is 30 to 59 percent.
- Abstinence may exacerbate PTSD symptoms.

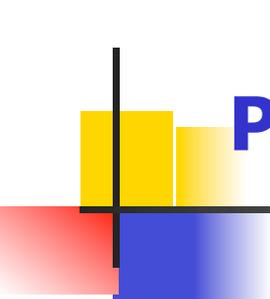


Trauma Informed Practice

ASK...

“Not what is wrong with you but what happened to you?”

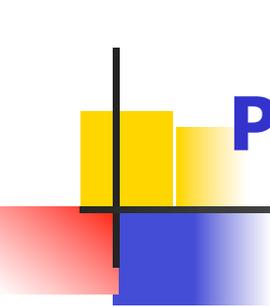
Symptoms as adaptations (survival) to trauma incld substance abuse



Phases of Treatment

Phase 1 – Engagement & Stabilization

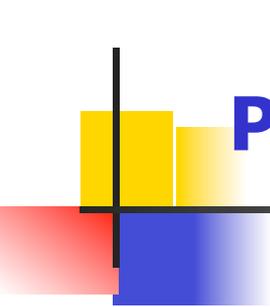
- Goal to stabilize acute symptoms.
- Address ambivalence and/or denial.
- Motivate for continued treatment.
- Detox from substances – may require medical management.
- Treat mental illness.



Phases of Treatment

Phase 2 – Early Recovery

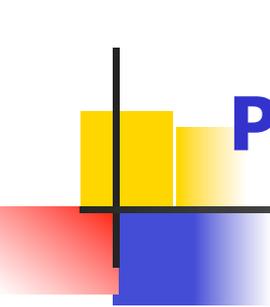
- Address environmental factors that contribute to destabilization:
 - Inadequate/unsafe housing
 - High risk people & places
 - Poor social support
- Address psychological/psychiatric symptoms
- Create recovery networks & access needed services.



Phases of Treatment

Phase 2 – Early Recovery

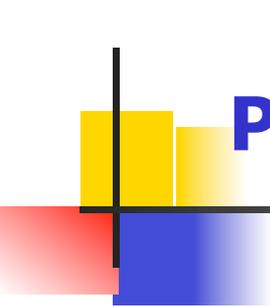
- Psycho-education & life-skills to cope with:
 - Cravings
 - Persistent psychiatric symptoms
 - Interpersonal problems
 - Lifestyle problems



Phases of Treatment

Phase 3 – Middle Recovery

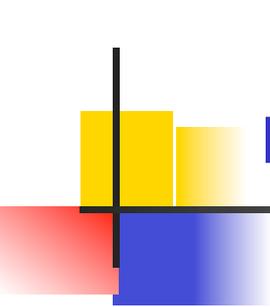
- Continued learning & application of interpersonal and problem-solving skills to address ongoing life and relationship issues.
- Strong connection to support systems including self-help resources.
- Dealing with issues of shame, guilt, stigma.



Phases of Treatment

Phase 4 – Late Recovery (Maintenance)

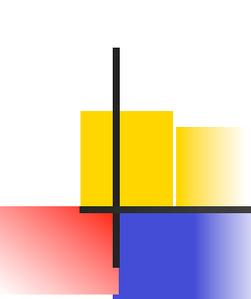
- Maintenance pharmacotherapy for some.
- Increasing control of one's life with potential for growth and contribution.
- Return to work or retraining.
- Ongoing recovery.



Recovery from Addiction

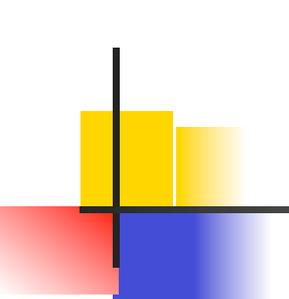
- Majority of clients (up to 70%) are eventually able to stop compulsive use of abused substances or have only brief episodes that do not lead to significant deterioration
- 15-20% experience chronic relapse
- almost 90% of those who remain abstinent for two years will be substance free at 10 years

(Vaillant et al., 1988)



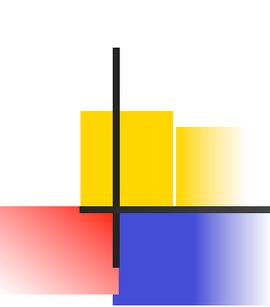
Recovery from Addiction

- Approx 60% of people meeting criteria for SUD at some time in their lives eventually achieved sustained recovery (no dependence or abuse symptoms for past yr).
- Longitudinal studies show that people reach sustained abstinence only after **three to four episodes of different kinds of treatment** over a **number of years** (Dennis & Scott, 2007)



Harm Reduction as treatment:

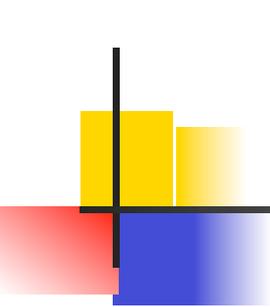
- Harm reduction meet clients “where they are” in terms of readiness to change and attempt to reduce harmful consequences of all their interrelated problems – first via stabilization of basic needs.
- Focuses on improvement in the client’s overall psychosocial functioning, well being, as well as the cessation, reduction or moderation of substance use.
- Goal is to reduce **risk & harm**. Goal setting is a collaborative process. ***Stages of change**



Engagement/Persuasion Clients

Client profile:

- Marginalized men & women in turmoil
- Homeless or at risk of losing housing
- Sex Work
- History of repeated Abuse and Trauma
- In and out of custody
- HIV, Hep C
- Heavy users; crack, cocaine, IV use, opiates, alcohol
- SMI' s-Mood disorders, Schizophrenia, Personality Disorders



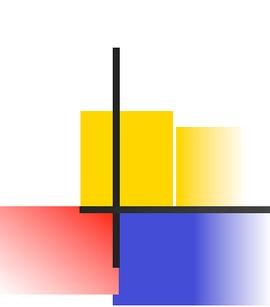
Engagement/Persuasion Goals

Engagement:

- To engage clients into integrated service. To establish a therapeutic working alliance based on trust with group facilitators and group members.

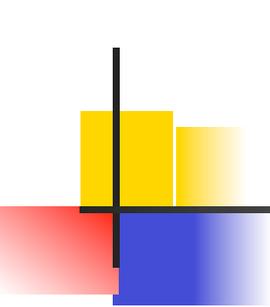
Persuasion:

- To help clients develop an understanding of how substance use has affected their lives, to become motivated to work on reducing their use of substances, and, if desired, to achieve abstinence.



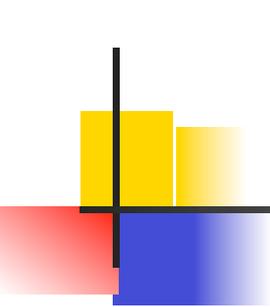
Challenges of Engagement/Persuasion

- Inconsistent attendance
- Client's experience of chaos
- Forming positive connections
- Exploring ambivalence
- One step forward; three steps back
- Containment vs. flooding
- Setting group norms



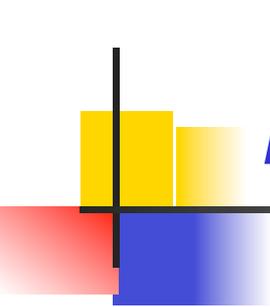
Active Treatment: Common issues

- Developing a Relapse Prevention Plan
- Developing Social Skills
- Increasing Pleasant Activities
- Exploring Community Self Help Groups
- Goal Plans



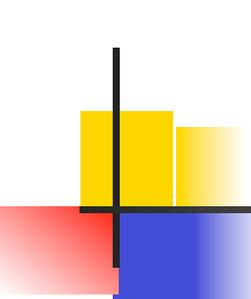
Active Treatment: Common issues

- Managing Cravings
- Problems with Sleep
- Coping with difficult feelings
- Trauma
- Dealing with Relapses



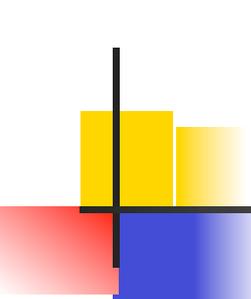
Effective Integration Strategies

- Normalize an expectation of concurrent disorder.
- Treat both conditions as primary. Every intervention for care needs to take into account how it may impact the other primary condition.



Effective Integration Strategies

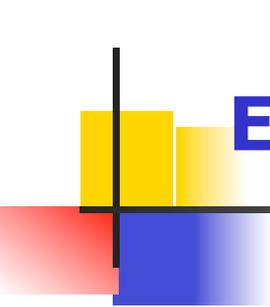
- Adopt complementary treatment philosophies if possible. Recovery philosophy is an excellent example.
- Where philosophies differ, acknowledge and work to mediate the differences with the individual and other care providers.
- Communicate. Communicate. Communicate.



Common Elements in Integrated Tx

Both mental health and addictions frequently promote the benefits of

- Cognitive behavioural therapy
- Self-help programs
- Leisure recreational activities
- Exercise and healthy lifestyles sleep/nutrition
- Developing structure in daily life
- Supportive professional and non-professional contacts

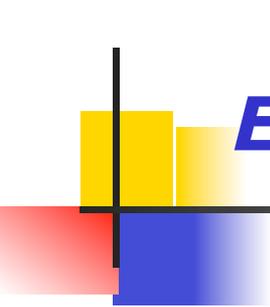


Essential Ingredients

How do people obtain remission from concurrent disorders?

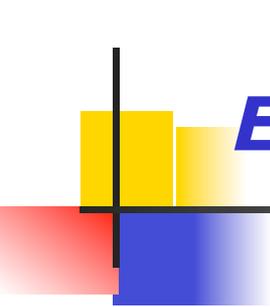
- Stable housing
- Sober support network/family
- Regular meaningful activity
- Trusting clinical relationship

(Alverson et al, Com MHJ, 2000)



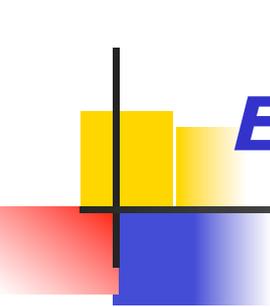
Essential Attitudes & Values

- Desire and willingness to work with people who have concurrent disorders.
- Appreciation of the complexity of CD.
- Openness to new information.
- Awareness of personal reactions and feelings.
- Recognition of the limitations of one's own personal knowledge and expertise.
- Flexibility of approach.



Essential Attitudes & Values

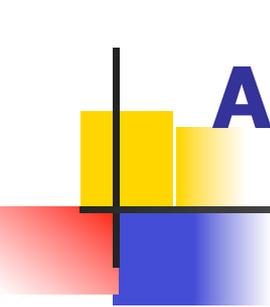
- Recognition of the value of client input into treatment goals and receptivity to client feedback.
- Patience, perseverance, and therapeutic optimism.
- Ability to employ diverse theories, concepts, models, and methods.
- Cultural competence.
- “Talking about the hard stuff...”



Essential Attitudes & Values

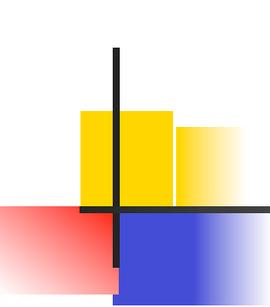
- Belief that all individuals have strengths and are capable of growth and development.
- Recognition of the rights of clients with CD, including the right and need to understand assessment results and the treatment plan.

Adapted from Substance Abuse Treatment for Persons with Co-occurring Disorders: A Treatment Improvement Protocol TIP # 42 US Department of Health and Human Services (SAMHSA) 2005



Avoiding Burnout & Demoralization

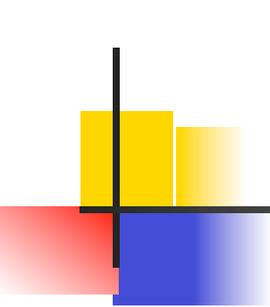
- Avoid blame of clients.
- Remember challenging clients **NEED THE MOST HELP.**
- Acknowledge clients are doing the best they can.
- Assume the best solution is not obvious.
- Remember the importance of the Functional Analysis.
- **TAKE A LONG TERM PERSPECTIVE.**



REFERENCES

Reflective of best practice in the field:

- **Best Practices Concurrent Mental Health and Substance Use Disorders (2001)** Prepared by the Centre for Addiction and Mental Health for Health Canada. This publication is available on line at the following address:
www.cds-sca.com
- Mueser, K. T., Noodsy, D.L., Drake, R.E., & Fox, L., (2003). **Integrated Treatment for Dual Disorders: A Guide to Effective Practice.** New York: Guilford Press.



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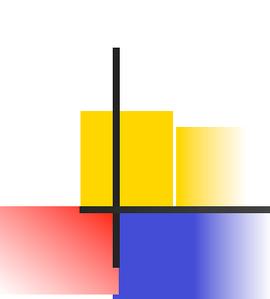
Treatment Improvement Protocol series

TIP #42 Substance Abuse Treatment for Persons with Co-occurring Disorders

<http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.74073>

- Best Practices Treatment and Rehabilitation for Women with Substance Use Problems (2001) Health Canada.

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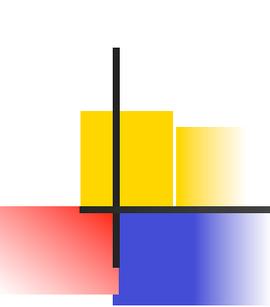
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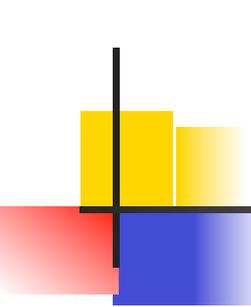
- Kenneth Minkoff, MD

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PLANNING GUIDELINES CO-OCCURRING PSYCHIATRIC AND
SUBSTANCE DISORDERS (2001)

<http://www.bhrm.org/guidelines/Minkoff.pdf>

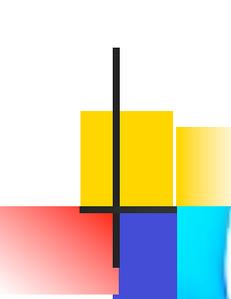
- **Concurrent Disorders Treatment:
Models for Treating Varied Populations,**
J. Puddicombe, B. Rush, C. Bois, CAMH.

[www.camh.net/about_addiction_Mental_Health/
Concurrent_Disorders/
ca_treatment_models04.pdf](http://www.camh.net/about_addiction_Mental_Health/Concurrent_Disorders/ca_treatment_models04.pdf)



Aboriginal Web Resources

- Aboriginal Healing Foundation: www.ahf.ca
- Alberta Alcohol and Drug Abuse Commission: www.aadac.com
- Assembly of First Nations: www.afn.ca
- Canadian Centre on Substance Abuse: www.ccsa.ca
- Centre for Addiction and Mental Health: www.camh.net
- First Nations and Inuit Health: www.hc-sc.gc.ca
- Information Centre on Aboriginal Health: www.ica.h.ca
- Inuit Tapirii t Kanatami: www.itk.ca
- Métis Nation of Ontario: www.metisnation.org
- Métis National Council: www.metisnation.ca
- Métis National Council of Women: www.metiswomen.ca
- National Aboriginal Health Organization: www.naho.ca
- National Inuit Youth Council: www.niyc.ca
- National Native Addictions Partnership Foundation: www.nnapf.org
- Native Women's Association of Canada: www.nwac-hq.org
- Nechi Training, Research and Health Promotion Institute: www.nечи.com
- Pauktuutit Inuit Women's Association: www.pauktuutit.ca



Berman Communities of Practice



David Berman Memorial Conference

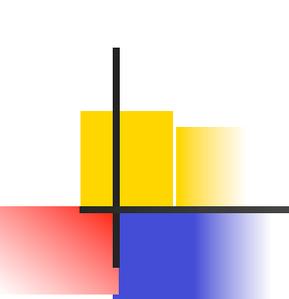
Communities of Practice
On Concurrent Disorders

May 25-26, 2011
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Roundhouse Community Hall
Exhibition Hall
181 Roundhouse Mews

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