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SUMMARY REPORT
of the
Workshop on Best Practices
for Concurrent
Mental Health and
Substance Use Disorders

February 21 and 22, 2002
Ottawa, Ontario

Canada

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SUMMARY REPORT of the Workshop on Best Practices for Concurrent Mental Health and Substance Use Disorders February 21 and 22, 2002 Ottawa, Ontario

BACKGROUND AND OPENING REMARKS

Health Canada invited more than 50 professionals working in the fields of mental health and/or substance use treatment to a workshop on Best Practices in Concurrent Mental Health and Substance Use Disorders. Louise Rosborough, Manager of the Treatment and Rehabilitation Division, Office of Canada's Drug Strategy, Health Canada, welcomed the participants and confirmed the objectives of the workshop:

- ▶ to disseminate knowledge based on the publication, *Best Practices – Concurrent Mental Health and Substance Use Disorders*;
- ▶ to network and exchange information on issues pertaining to concurrent mental health and substance use disorders; and
- ▶ to identify how best to apply the best practices within respective provincial/territorial programs and services.

STRUCTURE OF THE WORKSHOP

The workshop was designed to be interactive and participatory. Dr. Brian Rush, project leader for the best practices project, provided the participants with an overview of the report entitled *Best Practices – Concurrent Mental Health and Substance Use Disorders*. The report served as the basis for the workshop. Dr. Rush is Associate Director of the Health Systems Research and Consulting Unit at the Centre for Addiction and Mental Health and an Associate Professor in the Department of Psychiatry at the University of Toronto.

The structure of the workshop allowed the participants to discuss concurrent mental health and substance abuse issues around four key areas: screening; assessment; program/system integration; and treatment interventions and support services by diagnosis. More specifically, the discussions were guided by way of questions and case scenarios. This process enabled the participants to put in practice the “best practices” knowledge acquired during the workshop.

“The walls are coming down between the two systems. And you (the participants) must be the catalysts. Take this information back home and make it work!” **Dr. Brian Rush**

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**OVERVIEW OF THE BEST PRACTICES
– CONCURRENT MENTAL HEALTH
AND SUBSTANCE USE DISORDERS BY
DR. BRIAN RUSH**

a) Definition of Concurrent Disorders:

In developing the report, the consensus on how to classify concurrent disorders was a challenge. It was decided that the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, system of classification would be used as it provides a framework for diagnosis and this is essential for proper treatment planning. Concurrent disorder, then, means the co-occurrence of at least one mental disorder and at least one abuse of, or dependence on, a substance, as defined by the *DSM-IV*.

From a clinical point of view, mental health and substance abuse can be worlds apart, yet experience shows a strong overlap. For example, alcohol dependence is 21 times more likely to occur among people with antisocial personality disorder; alcohol dependence is four times more likely to occur among people with schizophrenia; and of those treated for alcohol-related disorders, up to 70 to 80 percent may have a mental disorder.

Dr. Rush pointed out the strong need for psychosocial supports, in particular for those people with severe and persistent mental illness and substance use disorders. Beyond acute treatment and medication management, long-term positive outcomes require a broad psychosocial approach, including housing, employment, income and a social support network.

b) Best Practices - Screening:

Dr. Rush noted that mental health services should apply universal screening practices for substance use disorders, while substance abuse services should apply universal screening practices for mental health disorders. He stressed that the approach and tools must be tailored to the setting, time available for the client and resources available. As stated below, screening for both substance abuse and mental health may need to take place at more than one level of effort to identify whether a problem exists.

Level of Effort I – Screening for Substance Use Problems:

- ▶ “Index of Suspicion” – problems such as violence, self-harm or non-compliance with treatment may trigger a suspicion of substance use and warrant further questioning.
- ▶ Clinicians should ask straightforward questions concerning alcohol and other drug use.
- ▶ Brief screening tools such as CAGE/CAGE-AID can be built into the interview discussion (AID incorporates alcohol and drugs).
- ▶ Case manager’s judgment can be key.

Level of Effort II – Screening for Substance Use Problems:

- ▶ Dartmouth Assessment of Lifestyle Instrument (DALI)
- ▶ Michigan Alcoholism Screening Test (MAST)
- ▶ Drug Abuse Screening Test (DAST)
- ▶ Alcohol Use Disorders Identification Test (AUDIT)

Level of Effort I – Screening for Mental Health Disorders:

- ▶ “Index of Suspicion”: ABC (Appearance, Alertness, Affect, Anxiety - Behaviour - Cognition) checklist. Refer to page 36 of the report for the complete checklist.
- ▶ Clinicians should ask simple questions (refer to page 37 of the report).

Level of Effort II – Screening for Mental Health Disorders:

- ▶ There is a need for a solid mental health screening tool for substance abuse services. Some promising tools are currently under development.

c) Best Practices - Assessment:

- ▶ The diagnosis will distinguish between the substance use and the mental illness - Structured Clinical Interview for Axis *DSM-IV* Disorders (SCID-IV).
- ▶ Clinician-rating scales, such as the Alcohol Use Scale or Drug Use Scale for the severely mentally ill, have been shown to be effective.
- ▶ The Addictions Severity Index should be used with caution, as its reliability with those with severe mental disorders is not as high as with other populations.

- ▶ Motivation and the stage of change should be assessed; however, it can be affected by the particular disorder (e.g., mania can lead to high confidence and energy levels).
- ▶ Psycho social functioning should be assessed through tools such as Person-in-Environment System (PIE) or Global Assessment of Functioning Scale (GAF).

d) Feedback from the Participants on Screening and Assessment:

Clients don't compartmentalize their problems; practitioners shouldn't either.

- ▶ The client must be intimately involved in the screening and assessment processes.
- ▶ Professional processes should be adapted to the client's culture.
- ▶ A single individual, perhaps a "wellness worker," should do intake and screening to increase coordination.
- ▶ Recognition that the screening processes may differ, depending on whether the purpose is for further assessment or to begin treatment is important.
- ▶ There needs to be cross-community agreement and education on key elements of assessment, including a harm reduction approach.
- ▶ Health care providers and employees should be engaged in cross training of both disciplines regardless of their current skills or training.
- ▶ Stigma can be decreased if assessment is part of an overall screening process.
- ▶ People should be made aware of the various levels of interventions available in the community, beyond institutionalization.
- ▶ Advocacy on behalf of clients can help to bridge the gap between the mental health and the substance abuse sectors.
- ▶ Any screening tools used should be included in the assessment, across mental health and substance abuse systems.

- ▶ Telemedicine and mobile community treatment teams may overcome the problems of rural or isolated offices.
- ▶ Collaborative assessment is important, using clinical teams, case conferencing and/or reflecting teams, across agencies and departments.
- ▶ Clearly outlining the treatment plan for concurrent disorders, with clear roles and identified responsibilities, is needed.
- ▶ The importance of the different approaches (e.g., self versus agency referral) used by the mental health and substance abuse sectors, and the needs of different communities (e.g., rural or those with few resources) should be recognized.
- ▶ Information sharing and open flow of communication between the two fields is key.
- ▶ Support from the ministry level is key for training. If front-line workers are the only ones working at integration, it won't work.

Counseling is not new – it has been around for a long time. The first Inuit counselors were elders and grandparents. Once it became a profession, it became very complicated. Systems started getting in the way. Anything new must be put in the perspective of the client.

PRESENTATION ON PROGRAM AND SYSTEM INTEGRATION BY DR. BRIAN RUSH:

Integration requires more than just a technical shift. It requires a cultural shift. Changing language, such as "intake worker" to "wellness worker", is a major change. Communities and organizations must work together. A bottom-up as well as top-down approach is needed. Enthusiasm may be decreased if there is no clear evidence of support from management and/or policies.

a) Definitions:

Integrated treatment:

Refers to mental health and substance use disorders being treated in an integrated way.

Program integration:

“Mental health treatments and substance abuse treatments are brought together by the same clinicians/support workers, or team of clinicians/support workers, *in the same program*, to ensure that the individual receives a consistent explanation of illness/problems and a coherent prescription for treatment rather than a contradictory set of messages from different providers”.

System integration:

“The development of enduring linkages between service providers or treatment units within a system, or across multiple systems, to facilitate the provision of services to individuals at the local level. Mental health treatment and substance abuse treatment are, therefore, brought together by two or more clinicians/support workers *working for different treatment units or service providers*. Various coordination and collaborative arrangements are used to develop and implement an integrated treatment plan.”

b) Best Practices - System Integration:

Planning Stage:

- ▶ A committee, or other communication mechanism, should be established for inter-agency planning. It should be resourced with one person to take the lead to provide a focal point and to champion the process. This person can speak on behalf of the organization, be it a clinician or a manager.
- ▶ Shared data systems and central access are important, as they streamline the system for the client, and provide a consistent approach and a common base of information.
- ▶ Provincial policy initiatives, such as joint demonstration projects, are important and can fuel the integration process.

Service Delivery Stage:

- ▶ Clinical case consultations can formalize and broaden the way clinicians collaborate.
- ▶ Blended service delivery teams, made up from members of mental health and substance abuse agencies, can provide more integrated services.

- ▶ Formal inter-agency partnerships can go beyond cooperation, and form service agreements or even mergers between agencies. This should be community-driven.

Training Stage:

- ▶ Cross-training is one of the most practical recommendations that can be acted upon immediately. It provides clinicians with the opportunity to see what it is like in other programs. It raises such questions such as: “Should substance abuse credentials include mental health education and vice versa?”

c) Feedback from the Participants on Program and Service Integration:

Generally, there appears to be momentum for integration, with some fully integrated services and programs available, and many less formal linkages between clinicians. Philosophical barriers continue to exist between and within the two services, for example, harm reduction versus abstinence-based approaches.

There appears to be a desire, almost a hunger, among clinicians for something to be done (regarding integration of services).

- ▶ The individual clinician can have an impact by taking the initiative to create links to other services for their clients. Building links between clinicians across services may be more efficient than trying to develop new programs.
- ▶ Substance abuse and mental health services work with justice, correctional systems, housing authorities, social services and others, and these sectors must also be integrated.
- ▶ The key for all clients is to ensure that all elements of their problems are reviewed together and an integrated plan is developed to meet their needs.

BEST PRACTICES - TREATMENT INTERVENTIONS AND SUPPORT SERVICES BY DIAGNOSIS:

Dr. Rush presented the best practices related to **integration, sequencing, and methods** used for each diagnosis described in the report. Using case scenarios provided by Health Canada, the participants were then asked to choose one of the following four diagnoses and develop a treatment plan.

- a) Co-occurring Substance Use and Mood and Anxiety Disorders
- b) Co-occurring Substance Use and Severe and Persistent Mental Disorders
- c) Co-occurring Substance Use and Personality Disorders
- d) Co-occurring Substance Use and Eating Disorders

a) Co-occurring Substance Use and Mood and Anxiety Disorders (e.g., alcohol and depression)

Integration:

Should occur at either the program or system level.

Sequencing:

Research supports addressing substance use first in the majority of people. Close monitoring is key to see the effect of treatment (e.g., does reduction in alcohol use address depression). The process will vary for different individuals and drug combinations. New medication should not be started until the substance use problems are addressed. However, if a person is on prescribed medication, it may not be advisable to stop it. Post-traumatic Stress Disorder is an exception that requires simultaneous treatment.

Methods:

A cognitive-behavioural approach is recommended and promising drug treatments also exist. Relapses are very common, so longer-term treatment is required, as is ongoing assessment.

Treatment plan developed by the participants:

Assessment:

For a client with a chronic history of substance use problems, the primary concern should be safety. A complete assessment should be carried out to

determine the severity of the depression, the potential for a personality disorder, and motivation and readiness for change through a 'stage of change' assessment. A full medical exam should be undertaken to determine the client's physical state, nutritional status and potential pain management issues. Past treatments, all medication use and past periods of sobriety should be reviewed to determine successful strategies.

Treatment:

A case conference should take place with the client and any available family members or friends who can provide support. Build the treatment plan on past successes. For example, if the substance use has ceased, treatment should focus on mental health issues. Provide education on medication and alcohol use. Consider whether a day program could provide sufficient structure for this type of client. Cognitive-behavioural therapy could be suggested, depending on the client's history.

b) Co-occurring Substance Use and Severe and Persistent Mental Disorders (e.g., alcohol and schizophrenia)

Integration:

Should occur at either the program or system level.

Sequencing:

Simultaneous treatment is recommended.

Methods:

Mental health services, crisis response, housing or hospitalization may be needed along with motivational interviewing, harm reduction approach, cognitive-behavioural counseling, self-help liaison, work with families, community treatment or less structured inpatient treatment. "Super-sensitivity" may be an issue for this population whereby small amounts of alcohol and drugs can have negative consequences. Clinicians should avoid direct confrontation, as this may affect client retention in the program.

Treatment plan developed by the participants:

Assessment:

Even though the client has been diagnosed with schizophrenia, a complete assessment and formal review of medication will be beneficial. The previous diagnosis may have been inaccurate and

could hinder future treatment. A mental health diagnosis could be difficult to make, due to the client's unstable situation regarding alcohol and drug use.

Treatment:

A simultaneous approach to treating the mental illness and substance use is recommended. It is important to address basic needs such as housing and income and also to investigate past connections, for example, with a foster family for a client who lacks a support system. Anger management or Fetal Alcohol Syndrome (FAS) support groups may be required, although difficulties in group situations could hinder this approach.

c) Co-occurring Substance Use and Personality Disorders

Integration:

Should occur at either the program or system level.

Sequencing:

Should be simultaneous for borderline personality disorder. For anti-social personality, the substance use issues should be dealt with first.

Methods:

More research is needed to determine the best approaches. Currently, the best empirically supported treatment for borderline personality and substance use disorders is dialectal behaviour therapy, which includes behavioural skills training. This is a high-needs population that is difficult to reach and often exhibits the revolving door syndrome.

Treatment plan developed by the participants:

Assessment:

A full review of the client's history and past assessments should be conducted, including forensic, mental health and substance abuse assessments; bio-psycho-social, HIV and HEP testing.

Treatment:

Jurisdiction in which clinicians operate will impact treatment options. Case conferencing is recommended, involving the client in planning the treatment. The treatment plan should involve outpatient support. Dialectic behaviour therapy

would be the recommended treatment for borderline personality; however, it would require a psychiatric assessment.

d) Co-occurring Substance Use and Eating Disorders

Integration:

Should occur at either the program or system level.

Sequencing:

Simultaneous treatment is recommended, unless there are compelling clinical reasons (e.g., life threatening) for focussing on one of the disorders first.

Methods:

Combinations of medical management, behavioural strategies and psychotherapy, to effect change in the eating and substance abuse behaviour, must take place.

No participants chose to address a treatment plan for this issue.

**BUILDING PARTNERSHIPS FOR
DISSEMINATION OF BEST
PRACTICES:**

Over the course of the workshop, participants were asked to reflect on the following two questions. The lists below are the suggestions provided by the participants.

a) How can Health Canada further develop and disseminate the knowledge discussed at the workshop?

- ▶ Distribute the report of the workshop to participants and decision-makers and make it easily accessible on the Health Canada Website.
- ▶ Enable a wider range of health professionals to learn about issues related to concurrent disorders and integrated approaches by holding best practices workshops across the provinces/territories.

- ▶ Create and support a Website to post documents, list public domain tools and encourage discussion among health professionals.
 - ▶ Create a list of the “top ten” best practices and make it easily accessible.
 - ▶ Develop tools to provide practical information on how to further integrate the mental health and substance use fields.
 - ▶ Develop specific strategies and culturally appropriate tools to address the unique needs of small and remote communities.
 - ▶ Develop a position paper on core competencies and a curriculum for training staff regarding integrated systems.
 - ▶ Strengthen mechanisms for sharing information and establish links between federal and provincial/territorial governments.
 - ▶ Raise the awareness of Health Canada funding for youth and women specific initiatives.
 - ▶ Make funding available for specific pilot projects to enhance provincial/territorial policies for integrated programs and services.
- b) What can you do in your community/jurisdiction to promote and strengthen best practices in the integration of programs and services?**
- ▶ Distribute the best practices report widely and ensure that respective provincial/territorial governments implement the best practices.
 - ▶ Provide cross-education between mental health and substance abuse staff.
 - ▶ Promote integration at all opportunities – individual, program and system.
 - ▶ Use techniques that are successful in facilitating individual change to effect system-wide changes.
 - ▶ Engage consumer advocacy groups in the change process.
 - ▶ Start discussions at the local level with both substance abuse and mental health staff and use support from networks and contacts made at the workshop to promote change in systems.
 - ▶ Build support at the ground level for public policy changes.
 - ▶ Gain political support in order to secure long-term funding.

This report is available on the Internet at <http://www.cds-sca.com>.

The full report, *Best Practices - Concurrent Mental Health and Substance Use Disorders*, on which this workshop was based on, is available on the Internet at <http://www.cds-sca.com>.