

Concurrent Disorders and Schizophrenia: A National Awareness Strategy  
Discussion paper



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A National Awareness Strategy**

**Discussion Paper**

Schizophrenia Society of Canada

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# Concurrent Disorders and Schizophrenia: A National Awareness Strategy

## Discussion paper

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### 1. INTRODUCTION

This draft report summarizes the research process of Year One of Concurrent Disorders: A National Awareness Strategy, a project of the Schizophrenia Society of Canada. We have learned about various promising initiatives underway across the country that are improving the lives of people with concurrent disorders, as well as the many gaps and frustrations that continue to challenge those dealing with concurrent disorders, whether as consumers, family members or professionals.

The report presents the findings of our information-gathering, including the results of the consultations, some key themes and findings from the literature, and highlights from a series of key informant interviews. Potential directions are presented to create resources and information on concurrent schizophrenia and substance abuse disorders for individuals and families affected by the illness and professionals working with people with concurrent disorders.

The draft will be circulated to the project's Advisory Panel, those who participated in the consultation process, as well as a growing national network of people who are interested in remaining involved in the project's activities. Comments on the draft will help guide us in the next stages of the project when we focus on developing public education and awareness resources.

#### 1.1 How are we defining concurrent disorders?

A concurrent disorder (CD) combines both a mental health problem and a substance use disorder. Substance use disorder involves dependence on or abuse of substances, such as alcohol, prescription and/or over-the-counter medication or illegal drugs. A person with major depression who also abuses alcohol has a concurrent disorder, for example, as does a person with schizophrenia who abuses cannabis. In the context of this project, it does not include use of nicotine.

Concurrent disorder is also known as co-morbidity. In the United States these disorders are sometimes called dual diagnosis or dual disorder. In Canada, dual diagnosis usually refers to someone with a developmental disability and mental illness.

#### 1.2 The impact of concurrent disorders

The prevalence of concurrent disorders among people with serious mental illness is higher than many people realize. Recent research indicates that between forty and sixty percent of people with substance use disorder (with addictions to alcohol and/or street drugs) also have at least one mental illness<sup>1</sup>.

People with serious mental illnesses such as schizophrenia who also have substance use problems tend to experience a wide range of serious problems. Common issues include<sup>2</sup>:

- more severe psychiatric symptoms, such as depression and hallucinations
- more dramatic effects after using substances, including a greater number of blackouts
- greater chance of not following treatment plans
- physical health problems

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<sup>1</sup> Roberts, S. "Dual Diagnosis" in Schizophrenia Digest, Winter 2003.

<sup>2</sup> Concurrent Disorders: A Resource for Families. Centre for Addiction and Mental Health, Toronto. 2006. pg. 15

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- increased experiences of stigma
- financial problems
- housing instability and homelessness
- poorer management of personal affairs
- serious relationship problems with family members
- more verbal hostility, tendency to argue, disruptive behaviour, aggression
- greater likelihood of ending up in jail
- increased suicidal feelings and behaviours

Having concurrent disorders affects not only the person experiencing the disorders, but also that person's family members and friends. As problems become more complex, family members are often confused about which problems are causes, and which are results. It is difficult for families to understand why their relative continues to use alcohol or other drugs when the consequences can be so severe.

The needs of people with serious mental illness and substance use disorder are complex; the problems posed by the severity of the symptoms of the disease, and the persistent stigma which surrounds mental illness and addictions are often compounded by the lack of integrated treatment services in the community.

### 1.3 The national context

The recently released Kirby Report<sup>3</sup> highlights the need for change in many areas of mental health and addictions treatment in Canada. The report specifically mentions the high rates of concurrent disorders, and the need to improve the way services are delivered to concurrent disorders clients.

The report cites the impact of the "culture clash" between mental health and addiction services on clients who need both services. This clash means that they are often excluded from accessing either system of care. The disconnect between the two treatment systems and their differing philosophies has created a major gap for people with concurrent disorders, so that many people who needed help "just got lost"<sup>4</sup>.

The Kirby Report and the 2001 report on Best Practices in Concurrent Mental health and Substance Use Disorders<sup>5</sup> make specific recommendations for transforming the way services are delivered to people with concurrent disorders, in terms of program and systems-level efforts to support integration between mental health and addictions sectors. Both reports also recommend cross-training for staff from both sectors, to share knowledge, perspectives, and better equip staff to meet the needs of those with concurrent disorders.

The need for tools which can transform information from the best practices report and other sources into more user-friendly advice was highlighted in an article written by Dr. Brian Rush<sup>6</sup>, the leader of the team who produced the best practices report. The article also emphasized that although implementation of the recommendations of the best practice report is essentially a provincial responsibility, the dissemination process could benefit from more focus and leadership at the national level, and that a national forum or focal point for discussion and sharing of ideas and experiences is needed.

"In the interface between addiction and mental health, the old concept was that if you deal with the mental health problem first, the addiction will go away on its own".

<sup>3</sup> Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addictions Services in Canada. Final Report of the Standing Senate Committee on Social Affairs, Science and Technology, May 2006

<sup>4</sup> Out of the Shadows at Last, pg. 215.

<sup>5</sup> Centre for Addiction and Mental Health, 2001

<sup>6</sup> Rush, Brian. Best Practices: Guidelines for the Treatment and Support of People with Concurrent Substance Use and Mental Disorders. In Visions: B.C.'s Mental Health and Addictions Journal. Vol. 2, No. 1 Winter 2004.

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### **1.4 The project**

Concurrent Disorders and Schizophrenia: A National Awareness Strategy is a three-year project, supported by the Drug Strategy Initiative Fund of Health Canada which hopes to respond to many of the needs and build on the strengths of the concurrent disorders practice in Canada. The project, which began in September of 2005, is designed to centralize expertise, resources and information on concurrent disorders specific to schizophrenia and substance use disorder. The aim of the project is to involve and benefit individuals and families affected by the illness as well as professionals within the mental health and addictions sectors.

The project is meant to serve professionals, family members of those with concurrent disorders, and consumers (both youth and adult). The general public is also a potential target audience, through the web-based component.

During the first year of the project, the focus has been on gathering information. The second and third years of the project will be dedicated to developing resources such as public education materials and a national website that will respond to the needs articulated in year one.

### **1.5 National Advisory Panel**

The project is overseen by an Advisory Panel, comprised of mental health and addictions professionals and family members. Panel members provide overall advice and direction, and support all activities of the project. The Panel includes representatives from a variety of regions across Canada. This advisory panel has offered expert advice into the structure and content of the regional consultations, and will continue to influence and direct the next steps.

For a list of Panel members, please see Appendix A.

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### **2. PROCESS**

The first year of the project has involved three key components: the literature review, the consultations, and the key informant interviews. The following is a brief description of each component. The next section presents a summary of the findings of each component.

#### **2.1 Literature review**

To provide a background for the consultations and to contextualize the project within the broader field of concurrent disorders research and treatment, a brief literature review was conducted. Areas of focus included: a) identifying established recommendations in terms of best practices for the treatment of concurrent disorders and schizophrenia; b) current areas of research; and c) existing public awareness and education tools and websites.

#### **2.2 Consultations**

To develop a clear understanding of the reality of concurrent disorders in different regions of Canada, the Schizophrenia Society of Canada, in collaboration with its regional members, local chapters and branches, held six consultations across the country in March and April 2006. These regional consultations had the following objectives.

- To identify and catalogue the most promising approaches to concurrent disorders (in terms of research, treatment, services and information) that are available in that region;
- To identify needs and major gaps (in treatment, services and information) of those dealing with or affected by concurrent disorders;
- To track emerging issues for those living with concurrent disorders, their families, and professionals working in the field;
- To gather information about how this project can best address the expressed needs and build on the strengths of different approaches to helping those who are dealing with concurrent disorders.

#### **2.3 Key Informant interviews**

Based on the results of the literature review and the consultations, several areas emerged as being either of particular significance to the project, or areas requiring further investigation. To follow up on those areas (which include early intervention, issues in rural and remote settings, issues of particular concern to family members and to those with concurrent disorders) we conducted a number of key informant interviews to ensure that we have captured and represented a balanced picture of needs in terms of treatment, research, advocacy and education/awareness. For a list of key informant interviewees, please see Appendix B.

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### 3. SUMMARY OF FINDINGS

At this point in the project, we have completed the formal information-gathering and we are moving toward translating our learnings into concrete products and resources. The findings for our three major research activities, the literature review, the consultations and the key informant interviews, will be presented in this section.

#### 3.1 Literature Review

The literature review involved a variety of different sources of information, including a Medline and internet search using the keywords 'schizophrenia, concurrent disorders, dual disorders', a review of the grey literature, and recommendations of the advisory panel and key informants on articles of particular relevance to the project.

The majority of available literature tended to focus on clinical and treatment-related aspects of concurrent disorders. There is also a branch of the literature which discusses the historical separation of mental health and addictions systems of care, the philosophical differences between the systems, and the barriers that exist to effective and comprehensive treatment for individuals with concurrent disorders.

Given that the literature on the topic of concurrent disorders and schizophrenia deals primarily with clinical and treatment-related issues, it has lesser relevance to our current project. Some grey literature – defined as “information produced on all levels of government, academics, business and industry in electronic and print formats not controlled by commercial publishing<sup>7</sup>” – is directly related to our goals. These documents are more focused on providing support and education for family members and consumers, particularly from a Canadian perspective.

##### 3.1.1 Clinical/treatment–related literature

###### *Prevalence*

Recent literature on prevalence states that between 40-60 % of individuals with severe mental illness will develop a substance use disorder at some point during their lives, and about half currently meet criteria for substance abuse or dependence<sup>8</sup>. For people with schizophrenia specifically, population surveys have consistently shown elevated rates of alcohol use disorders (about three times the risk) and drug use disorders (about five times the risk)<sup>9</sup>. Several studies show that about half of youth in the first episode of schizophrenia also have or will develop a substance use disorder<sup>10</sup>.

###### *Service implications*

There is a substantial amount of literature describing the poor coordination between mental health and addiction services, a situation that has been shown to contribute significantly to poor consumer outcomes<sup>11</sup>. A better integration between mental health and addictions services is seen as part of the solution, but there are several levels of service integration that need to be addressed: systems level and

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<sup>7</sup> See the Grey Literature Network Service (GreyNet) at <http://www.greynet.org/>.

<sup>8</sup> Meuser, K., Noordsy, D.L. Drake, R.E. & Fox, L. Integrated Treatment for Dual Disorders: Effective Intervention for Severe Mental Illness and Substance Abuse. New York: Guilford Press.

<sup>9</sup> Kessler, R.C., Nelson, C.B. McGonagle, K.A. Edmund, M.J. Frank, R.G., and Leaf, P.J. (1996) The epidemiology of co-occurring addictive and mental disorders: Implication for prevention and service utilization. American Journal of Orthopsychiatry, 66, 17-31.

<sup>10</sup> Cuffel, B.J. (1996) Comorbid substance use disorder: Prevalence, patterns of use and course. New Directions for Mental Health Services, 70, 93-105.

<sup>11</sup> Rush, B. (2004) Best Practices: Guidelines for the treatment and support of people with concurrent substance use and mental disorders. Visions: B.C.'s Mental Health and Addictions Journal. Vol. 2, No.1, 7-10.

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program level. Additionally, there is a need for upgrading the general capacity to address concurrent disorders across all service providers, not just within highly specialized services.

Substance abuse/dependence and severe mental illness can interact in several complex ways that have important implications for screening, assessment and the planning of treatment and support. The Health Canada Document *“Best Practices: Concurrent Mental Health and Substance Use Disorders”* (2001) emphasizes that those who experience overlapping severe mental illness and substance use problems require interventions that address both disorders concurrently. A concurrent disorders strategy should therefore include screening, assessment, treatment and aftercare interventions that target both types of disorders with equal emphasis and importance.

The Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States has recently produced a document titled *Overarching Principles to Address the Needs of Persons with Co-occurring Disorders* (2006). It is an overview paper which outlines 12 principles for service providers working with people with concurrent disorders. The principles are intended to help guide both systemic and clinical responses. The principles, or best practice statements, are grouped into two categories – the first to guide systems of care, and the second, for individual providers.

### *Issues specific to people with schizophrenia*

People with serious mental illness and substance use disorder are a high-need subpopulation of concurrent disorders clients, and have unique needs and issues. People with severe mental illnesses such as schizophrenia are more sensitive to the effects of alcohol and other drugs due to increased biological vulnerability and, therefore, experience more negative consequences from relatively small amounts of alcohol and other drugs<sup>12</sup>.

### **3.1.2 Non-clinical issues**

Information on the non-clinical issues that are of importance to those with concurrent disorders and their families has tended to come mainly from the grey literature, such as websites of non-governmental and support associations, with one major exception. A new resource, *Concurrent Disorders: A Resource for Families* (Centre for Addiction and Mental Health (CAMH) in production) brings together the results of a multi-site pilot study conducted by CAMH, of support and education groups for family members of people with concurrent disorders. The aim of the groups was to help family members become better informed about concurrent disorders, develop coping skills, and find ways of working collaboratively with service providers and relatives to manage their mental health and substance abuse issues.

This comprehensive resource offers practical information for family members on various aspects of concurrent disorders, providing an introduction to mental health and addiction issues, their impact on family members, treatment options, and recovery. While the guide addresses concurrent disorders in general, much of the information it contains is directly relevant to people who have schizophrenia and substance use disorder.

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<sup>12</sup> Best Practices: Concurrent Mental Health and Substance Use Disorders, Centre for Addiction and Mental Health, 2001.

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### 3.2 Consultations

In March and April of this year, six consultations were held across Canada, in Toronto, Vancouver, Calgary, Winnipeg, St. John's and Montreal. The consultations followed a focus group format and included people with concurrent disorders, family members, mental health and addictions professionals, as well as representatives from areas such as corrections, housing and legal aid.

The consultations were a huge success -- they generated rich information for the project, and did so by bringing together a variety of stakeholders who provided different kinds of experience and expertise. Working collaboratively with the provincial and local chapters of the Schizophrenia Society to recruit participants proved to be an effective way of ensuring that the right people came to each consultation. A secondary benefit of the consultation process was that it created the beginnings of a national network on schizophrenia and concurrent disorders, a network that we will continue to build through the next stages of the project.

The following is a summary of the results of the consultations.

#### 3.2.1 Critical gaps and needs across regions

Participants identified a number of important gaps and needs in each consultation. While there were some minor differences in the results of each consultation due to regional variations in provincial administration, infrastructure and resources, a number of key themes emerged that were common across all regions:

- issues related to training and knowledge
- policy
- research
- services
- primary care
- education and awareness

#### a) Training / Knowledge base

A major gap identified across all regions is the area of professional training in concurrent disorders, in terms of increasing the knowledge base and competencies of staff in a broad range of addictions, mental health and other social and support services. While some regions and provinces are further along than others in terms of mandating cross-training for addictions and mental health professionals, much work remains to educate and train those who serve people with concurrent disorders.

##### i) Training and education for professionals

- Need for cross-training for both mental health and addictions professionals – core competencies
- Professionals need more training in diagnostic skills
- Difficulty in recruiting good people to work in the field because of stigma associated with CD
- Need to have more empathy for people with CD – this starts with professional training – medical schools, nursing, nurse practitioners, social work, police, corrections and housing staff, etc.

##### ii) Philosophy / Approach

- Need to think about CD as the expectation rather than the exception
- Need to recognize and provide training about the chronic nature of both addictions and mental illnesses

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- Need common language and terminology – too many different terms being used creates confusion, (e.g. dual disorders, dual diagnosis, comorbidity, concurrent disorders, co-occurring disorders)
- Need to integrate theory on mental health and addictions – create CD intake and assessment criteria – specific to those with psychotic disorders
- Promoting a harm-reduction approach is key – there is a growing acceptance of the effectiveness of this approach in treating CD

### **b) Policy**

The federal government has a role to play in ensuring that there are consistent national standards for care in concurrent disorders. The need for federal leadership in terms of a developing national mental health strategy was mentioned in all regions. Several provinces have completed an amalgamation of mental health and addictions at the level of provincial administration, but integration of the sectors at the regional service-delivery level is ongoing.

- Federal government created Best Practices document – but how is it being implemented? How can the information be disseminated?
- Programmatic vs. systemic integration of services - integration between mental health and addictions services may be happening at the policy level, but what about in terms of implementing services?

### **c) Research**

The lack of ongoing evaluation was repeatedly mentioned as a gap in all of the regions, and in particular, the need to develop performance indicators to measure improvements in service delivery and consumer outcomes.

The need for funding for new clinical research into emergent issues was highlighted throughout the consultations.

- Need for strong and reliable prevalence data on CD
- New research shows that treating people with CD with simultaneous but not integrated approaches can have negative outcomes – need to integrate treatment to increase success rates
- Need for baseline data and performance indicators to evaluate service delivery and consumer outcomes
- New research on links between marijuana use and development of psychosis – implications for practice?

### **d) Services**

Having access to a range of consistent, integrated, community-based services was highlighted as a critical area of need in all regions. Some progress has been made in different localities in terms of providing services that address the realities of people living with concurrent disorders and severe mental illness, such as the growth of early psychosis intervention services, but many people are still having great difficulty accessing appropriate and reliable services that meet their needs in a timely manner.

#### **i) Need for an integrated and consistent approach**

- the approach to services has historically been that addictions issues must be addressed before mental health services are provided – need to reframe the ways that services are offered

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- The “presenting problem” should be the individual person, rather than either their addiction or mental health issues
- People are being denied service because of relapse, or service is interrupted
- There needs to be a “No wrong door” policy on services
- Need for continuous, comprehensive, integrated services – often times it’s the “luck of the draw”
- Need to have increased communication among professionals
- Consistency in terms of service provider is very important – e.g. case manager

#### **ii) Increasing access to community-based services**

- Assertive Community Treatment-type services are effective for people with CD, but there are too few available
- Need to provide integrated approach to treatment of individuals with CD

#### **iii) Importance of early psychosis intervention (EPI)**

- Early intervention very important, both for psychosis and substance abuse
- No man’s land exists between child and adult mental health services – many young people fall through the cracks
- Gap between first episode/early intervention services and ACT team service

#### **iv) Need for consistent assessment and intake criteria**

- Difficulty in diagnosing CD – often very hard to figure out what the issues are
- Need for integrated intake process for CD clients
- Discharge planning is a key component of effective services for people with CD

#### **v) Resource issues**

- Long wait times for addictions and mental health services
- Professionals are completely overwhelmed by workload and lack of resources
- In rural and remote areas, under-servicing is a huge issue

#### **vi) Culturally-relevant services**

- Cultural issues need to be considered – different concepts of mental health and mental illness in different ethnic and cultural communities, e.g. First Nations

### **e) Primary Care**

Across the regions, family doctors and primary health care teams are most often the gateway to accessing specialized mental health and addictions services. Primary care service providers need more information on recognizing CD and making appropriate referrals. Increasing access to primary care for people with concurrent disorders was also named as a major challenge in areas where there are a limited number of physicians available.

- Outreach to family physicians on importance of early intervention in psychosis
- Need to enhance skills of primary practitioners to deal with clients with CD
- Many people with CD do not have family doctors
- Need to increase links between primary care providers, family doctors and specialized services

### **f) Education / Awareness**

With appropriate services and support, many people with concurrent disorders are able to achieve recovery. Family members, consumers and service providers across the regions emphasized the need for

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accessible and comprehensive information on concurrent disorders for different populations and in different formats.

- Need to educate public about recovery– too much doom and gloom associated with schizophrenia
- Needs to be a greater understanding of addiction – not a question of willpower, but a disease
- Needs to be a greater focus on role of cannabis use in psychosis

### 3.2.2 Specific gaps from different perspectives

Each consultation included a number of family members and consumer participants who offered insights into the reality of living with concurrent disorders and schizophrenia. While the nature of peoples' experiences depended to some extent on the local resources that were available, there were a number of overarching issues and gaps that family members and consumers tended to face across all regions.

#### a) Family members

There is a growing recognition that the ongoing involvement and support of family members is a key component of successful recovery for people with concurrent disorders. Family members need to be supported in their role as caregivers, and their expertise and unique insights need to be recognized by service providers.

##### i) Stress

- Often people with CD withdraw from their families, or families get worn out / driven away
- Having a family member with CD can threaten the health and integrity of whole family
- Many ill people have few family members left involved – stress of the illness causes people to fall away –How can family members be supported to remain involved?

##### ii) Relationship with service providers

- Sometimes the importance of the role of the family is not acknowledged by professionals
- Need to have a partnership between staff and families, not an adversarial relationship

##### iii) Need for information and education

- Many family members have no knowledge of CD – need to be educated, need straightforward information
- Need to understand chronic nature of CD, and common relapses
- Stigma and shame of mental illness becomes “double shame” with CD

##### iv) Consent / privacy issues

- Confidentiality and privacy legislation is often an obstacle to family involvement
- Family members need to be able to access referrals without involving ill family member
- Sometimes the only way for families to get help/treatment for their ill relative is to lay charges
- Needs to be a way of accessing treatment without going through process of “Form 1”

##### v) Early access to treatment

- Families need earlier access to treatment – it shouldn't have to escalate to full-blown psychosis before people receive help
- Family members who have received Early Psychosis Intervention services are often less frustrated with the system

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- Early intervention in psychosis can mean early intervention in substance abuse as well as mental illness, with better outcomes for both

### **b) Issues for consumers**

For people living with serious mental illness and substance use disorder, having access to a wide range of treatment and support services cannot be undervalued. But consumers also need access to the types of supports that promote quality of life and recovery, such as social support, peer support, housing, employment and income.

#### **i) Social/ peer support**

- Social isolation is a big issue – socializing through substance use often reduces loneliness
- People with CD need access to recreation and leisure opportunities as well as mental health and addictions services
- Need to acknowledge importance and value of peer support
- Need to create a support network, or “inner circle” around people with CD – including family members, friends and service providers
- Many people with CD have lost contact with their family members – have very little family support

#### **ii) Access to community-based supports**

- Many people with CD end up incarcerated – in prison many essential services are provided, like integrated case management, but these services should be available in the community
- Finding meaningful employment is equally important to recovery as having access to effective services

#### **iii) Socioeconomic issues**

- Potential loss of benefits if people become employed
- Disability benefits very low, cost of medications very high, so people with CD are often doomed to poverty

#### **iv) Housing**

- People with CD are often denied proper housing
- Need a full range of housing options for people with CD - dry, damp and wet
- a harm-reduction approach is key
- housing staff need training in CD

“A few times people have come back early from a weekend pass, because they are afraid of using. They come back for support, for the non-judgmental approach of the staff.”

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### 3.2.3 Potential solutions / Promising approaches

In each consultation we asked participants to tell us about examples of initiatives or approaches in dealing with concurrent disorders they felt were working well, whether in terms of treatment, services, supports or educational materials /information. Below is a summary of ideas and approaches that were identified in different regions:

#### a) Services

There is a great deal of variation in terms of the types of services that are available in different regions. While access to services remains a major gap in many areas, several promising approaches in clinical, community-based and early intervention services were identified across the regions.

##### i) Clinical

- Motivational counselling – an approach that can help – more services providers need training in this area
- Create consistent intake and assessment criteria
- Implement best practices at service level
- Focus on improving people's quality of life rather than just eliminating symptoms

##### ii) Community-based services

- Need to create a seamless transition from hospital to the community
- Create more Assertive Community Treatment (ACT) type services – take services out of offices and into the community
- Mental health emergency outreach teams – new trials involving psychiatric nurses/social workers riding with police responding to emergency calls are showing promise

##### iii) Early intervention

- Early treatment of psychosis is creating more hope by improving people's functioning and quality of life, reducing risk of relapse
- Growing body of evidence of showing the effectiveness of early intervention
- Importance of continuity of care and family support

“How are we measuring success? You have to look at a range of measures, such as a client getting in touch before going into crisis, trying to stay away from using a needle.”

#### b) Public Education / Awareness Tools

The need for reliable, accessible and practical information for consumers and family members was a consistent theme throughout the consultations. The Schizophrenia Society as an organization has a need for tools and information that can be used by members and staff in conducting public education and awareness. Tied to the need to promote early intervention in psychosis, the need for youth-friendly information on concurrent disorders was also identified.

##### i) Family members and consumers

- Provide family members with strategies for dealing with their ill family member
- Create a “roadmap” of services and treatment options
- Provide accessible and user-friendly information on mental health and addictions – basic education for family members, checklists, FAQ's, questions to ask treatment professionals, etc.

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- Provide straightforward information on mental health legislation, e.g. Mental Health Act. How can they work within existing legislation to gain as much information and involvement as possible?
- Create a template and tools to help families advocate/ get involved in treatment, become agents of change
- Provide family members with suggestions and concrete skills on how to deal with and communicate with loved ones who are ill
- Provide basic information on CD treatment and theory – Stages of Change model
- Help people to understand that recovery is a long process and that there can be many setbacks – positive results and progress happen over the long term
- Promote capacity building for consumers and family members – peer support, information sharing, networking

#### **ii) Schizophrenia Society**

- Develop a “train-the-trainer” project on CD for Schizophrenia Society staff
- National Schizophrenia Society needs to provide branches with tools they can distribute to community members

#### **iii) Youth/Schools**

- Need to focus on youth and provide age-appropriate information
- Need to provide more information to schools about mental health and addictions issues
- Provide information emphasizing the impact on brain chemistry of substance misuse, not only the legal aspects
- Create consistent messaging for teens, e.g. that marijuana can be a trigger for psychosis

#### **iv) General public**

- Need to destigmatize CD through public education and awareness campaigns
- Create accessible public information on mental health and addictions issues and make it available in doctors’ offices, pharmacies, etc.

#### **v) Tools for professionals**

- Create a national network/forum for information sharing
- Provide networking/training opportunities and information on best practices
- Recommend tools and standards for professionals

### **c) Advocacy**

There is a role for the national organization to work proactively with other national mental health organizations to advocate for change in concurrent disorders research, education and treatment and at the federal level.

- Work for greater freedom of information – demystify privacy legislation
- Create a “Mental Health Action Day”
- Advocate for greater resourcing for concurrent disorders research and services
- Create generic advocacy strategies that can be customized provincially, because health, mental health and education are all provincial jurisdictions

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### 3.3 Key Informant interviews

The key informant interviews were designed to address specific issues that could not be covered within the context of the consultations and to bring more specialized knowledge and experience to bear on the project.

Below are some of the key points that came forward in the interviews.

#### 3.3.1 Issues specific to CD and Schizophrenia / psychotic disorders

Much of the literature on concurrent disorders addresses the issue from a general perspective, without looking at the specific issues of individuals with psychotic disorders as differentiated from other mental illnesses. People with severe and persistent mental illnesses such as schizophrenia represent a high-need subpopulation that has unique issues and concerns. Below are some of the key issues pertaining to concurrent disorders and schizophrenia:

- Complexity of problems – not many clinicians are skilled enough to handle the multiple problems presented by people with SMI and CD, including concerns over physical health.
- For people with psychosis, a lower amount of alcohol or drug consumption has greater effect and more serious consequences.
- Focus on developing assessment approaches that work, (e.g. the Payoff matrix – Dr. Kim Meuser) motivational interviewing looks at the perceived costs and benefits of substance use.
- Exclusion criteria – often shut people with SMI and CD out of treatment.

“The concurrent disorders assessment process for people with SMI shouldn’t use “normal” drinking and drug guidelines, because people with SMI much more susceptible to negative effects of substances – assessment should focus on consequences – how is the substance use impacting the person, for example, their ability to stay on meds?”

#### 3.3.2 Early Intervention

Early intervention has a very important role to play in treating both psychosis and substance abuse. New research is beginning to show the potential for early intervention to improve outcomes for both mental illness and substance use disorders. Ongoing family involvement is essential to youth remaining committed to treatment. A few more specific points are listed below:

- Role of drugs in the development of early psychosis – marijuana becoming much more potent, potential to trigger psychosis in vulnerable individuals, preparing for the impact of the coming wave of methamphetamines
- The more the family is part of the treatment process, the more likely the young person is to succeed
- Families provide vital information on youth’s substance use habits – they often provide different info to that supplied by youth, because drugs interfere with the ability to be honest about their use, and their judgment is impaired
- Families need to understand that this is a process that may take years – change won’t happen overnight

“Research is showing that early intervention in psychosis acts simultaneously as early intervention in substance abuse. Even though some youth who come to clinic haven’t been using long enough to meet criteria of substance abuse, at least 40% are using.”

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### 3.3.3 Rural perspective

In rural areas, concurrent disorders as a concept is still very new. There's a lack of awareness of CD itself, not only a lack of awareness of the types of services that are available. In many non-urban settings, there is a major shortage of family physicians, and access to specialized treatment is extremely limited.

- Only very basic training provided to staff – focusing on defining CD, assessment and keeping people in treatment, but training does not get into best practices, interviewing techniques, etc.
- Some substance abuse service partners are stuck in abstinence-only approach, harm reduction approach making some inroads, but moralistic view of addictions changing very slowly
- Training for CD professionals – should be more online training available so that people don't have to leave their communities
- Training has to reflect the reality of working in a rural area – population, geography, specific opportunities and challenges

“In practice, you have to deal with people whose addictions are ongoing – you do have to start where people are at, with a harm reduction approach. You need to get as much sobriety as you can, but you can't expect it from everyone.”

### 3.3.4 Family perspective

Family members usually bear the brunt of caring for their relatives with concurrent disorders, but are often frustrated by feelings of helplessness because of the limitations imposed by confidentiality and mental health legislation. Relationships with service providers can be antagonistic instead of collaborative.

- The ongoing active involvement of families is key to achieving recovery for many people with concurrent disorders
- Family members have often been excluded in treatment decisions, but they need to be involved at every step
- Service providers have a responsibility to help family members of their clients with concurrent disorders, and to respond to families' needs

“Just because service providers can't talk about the client doesn't mean they can't listen to the expertise of family members”

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### 4. DISCUSSION

A number of key questions were raised by the literature, the consultations and the interviews that will guide the activities of Years 2 and 3 of the project, when the focus shifts to developing resources and public education materials.

The next critical stage of the process is addressing the needs articulated in the first year of the project by creating concrete products. In order to determine how best to proceed, the following issues will need to be discussed:

*ISSUE: How can we share information on best practices in concurrent disorders at the national level?*

- *What is the most effective media to disseminate information on best practices to professionals?*
- *What national professional organizations can we work with to disseminate the information and ensure that it is current?*

The Schizophrenia Society of Canada has an opportunity to share knowledge and expertise on best practices in concurrent disorders and schizophrenia. The project needs to harness the strength of our regional networks and partnerships as well as our Advisory Panel to create a national forum or focal point for discussion and sharing of ideas and experiences.

*ISSUE: How can we identify and support promising approaches happening at the regional level?*

- *How can these findings be shared with stakeholders?*

Throughout the consultations and the interviews, we learned about a number of exciting initiatives taking place at the provincial or regional level, including efforts to integrate services and programs for concurrent disorders clients, and family support initiatives. A number of the Schizophrenia Society's own provincial chapters are on the forefront of the change process in Canada, working at the grassroots level to find innovative ways of encouraging cross-training and collaboration between community-based mental health and addictions providers.

People working in other regions of the country and outside Canada could benefit from the experience and learnings of those who have undertaken these initiatives. The project has an opportunity to support and showcase local efforts by highlighting the successes and challenges faced by those involved in the change process.

*ISSUE: How can we create user-friendly information to support families and consumers?*

- *How do we get the information into the hands of those who need it?*

While there is a considerable amount of information on concurrent disorders and schizophrenia out there, very few resources have been developed to address the concerns and realities of consumers and family members. By working with other organizations that support consumers and family members, the Schizophrenia Society has an opportunity to address this need. The project can draw upon the strength of its provincial societies and local chapters and other partners to bring forward the kinds of comprehensive information that consumers and family members need, in a number of different formats to ensure the information is accessible to as wide a range of community members as possible.

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*ISSUE: How do we address needs identified through the process that are not achievable within the scope of our project?*

- How can we work with other partners and within our own organization to make sure that all of the important issues raised through the process are brought forward?

A number of the key needs and gaps that were identified in the consultations and interviews relate to areas that lie outside the scope of this project, which will focus primarily on developing educational and public awareness materials. Addressing needs in areas such as service, treatment, training, policy and research will be critical to improving the lives of people who care for those with concurrent disorders, as family members or service providers, and those who experience concurrent disorders.

*ISSUE: What other roles and activities should be lead by the National organization and its societies in response to the findings of the consultation process?*

The Schizophrenia Society of Canada, in collaboration with its provincial chapters other national organizations, has an opportunity to advance the cause of concurrent disorders in Canada. Following on the momentum created by the release of the Kirby Report, SSC can work with other advocacy groups and coalitions to addresses some of the overarching issues raised by the project which relate to national mental health policy.

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### 5. APPENDICES

#### 5.1 Appendix A: National Advisory Panel Members

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**Cathy Croucher** – Family Counsellor – Early Psychosis Program – Waterford Hospital, Health Care Corporation Waterford Bridge Road, St. John's, NF. A1E 4J8 Canada [Cathy.Croucher@hccsj.nl.ca](mailto:Cathy.Croucher@hccsj.nl.ca)

**Barry Fogg** – Mental Health Services Development Specialist, Winnipeg Regional Health Authority, 4-189 Evanson Street, Winnipeg, MB R3G 0N9 Canada [BFogg@wrha.mb.ca](mailto:BFogg@wrha.mb.ca)

**Stan Kutcher** - Associate Dean of International Medicine, Dalhousie University, 5909 Veteran's Memorial Lane, 8th floor, Abbie J. Lane Memorial Building, QEII Health Sciences Centre, Halifax, Nova Scotia, B3H 2E2 Canada [Stan.Kutcher@Dal.Ca](mailto:Stan.Kutcher@Dal.Ca)

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**Caroline O'Grady** – Advanced Practice Nurse, Centre for Addiction and Mental Health, 33 Russell Street, Toronto, ON M5S 2S1 Canada [Caroline\\_OGrady@camh.net](mailto:Caroline_OGrady@camh.net)

**Patrick Smith** – Senior Advisor, Mental Health and Addictions, British Columbia Provincial Health Service Authority, Riverview Hospital, 2601 Lougheed Highway, Coquitlam, BC V3C 4J2 Canada [psmith2@bcmhs.bc.ca](mailto:psmith2@bcmhs.bc.ca)

**Shari McKee** – Clinical Psychologist, Concurrent Disorders Program, Georgainwood Mental Health Centre, 500 Church Street, Penetanguishene, ON. L9M 1G3 [SMCKEE@mhcp.on.ca](mailto:SMCKEE@mhcp.on.ca)

**Laura Panteluk / Arlene MacLennan** – Manitoba College of Psychiatric Nurses, 1854 Portage Ave, Winnipeg, MB R3J 0G9 Canada [lpanteluk@crpnm.mb.ca](mailto:lpanteluk@crpnm.mb.ca); [amaclennan@wrha.mb.ca](mailto:amaclennan@wrha.mb.ca)

**Greg Purvis** - President, Atlantic Association of Addictions Executives, P.O. Box 359, 199 Elliot Street, Pictou, N.S. B0K 1H0 Canada [Greg.Purvis@pcha.nshealth.ca](mailto:Greg.Purvis@pcha.nshealth.ca)

**Sharon Scott** – National Coordinator, National Network of First Episode Families, Box 395, J-1631 St. Mary's Road, Winnipeg, MB. R2N 1Z4 [sism@rainyday.ca](mailto:sism@rainyday.ca)

**Wayne Skinner** – Director of Concurrent Disorders Program, Centre for Addiction and Mental Health, 33 Russell Street, Toronto, ON M5S 2S1 Canada [Wayne\\_Skinner@camh.net](mailto:Wayne_Skinner@camh.net)

**Chris Summerville** – Executive Director, Schizophrenia Society of Manitoba [Chris@mss.mb.ca](mailto:Chris@mss.mb.ca)

**Greg Zed** – President, Schizophrenia Society of New Brunswick [greg.zed@gnb.ca](mailto:greg.zed@gnb.ca)

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## 5.2 Appendix B: Key Informant Interviews

### Family Perspective

Caroline O'Grady – *Centre for Addiction and Mental Health*  
*Organizer of Family Forums on Concurrent Disorders across Ontario in 2005–*

Ainslie Mistysyn/ Sherry Franklin (to come)  
*Eastern Regional Family Network – leaders of Family to Family Education program, Eastern Ontario*

### Rural Service Provider's perspective

Karen Bell/ Lundi Costante – *Concurrent Disorders Clinicians – Northeast mental Health Centre – North Bay / Sudbury*

Dr. Jay Warren – *Psychiatrist, Penetanguishene Mental Health Centre*

### Integration of Concurrent Disorders treatment into Primary Care

Dr. Julian Somers / Dr. Eliot Goldner - *Researchers – Integrating Concurrent Disorders treatment into Primary Care, Simon Fraser University, (to come)*

### Systems integration

Dr. Brian Rush – *Associate Director, Health Systems Research and Consulting Unit- Centre for Addiction and Mental Health*

### Adolescence / Early Intervention

John Westland – *Adolescent Substance Abuse Outreach Program – Sick Children's Hospital, Toronto*

Dr. Suzanne Archie – *Clinical Director, Cleghorn Program, First Episode and Early Intervention in Psychosis– McMaster University*

*Dr. Katherine Boydell – Researcher, Centre for Addiction and Mental Health, Toronto. (to come)*

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### Glossary

#### **Assertive Community Treatment (ACT)**

The assertive community model was developed to meet the needs of clients with severe mental illness who often experienced relapse and re-hospitalization, often due to their inability or unwillingness to go to local mental health centres. The ACT team provides around-the-clock support and services such as case management, assessment, psychiatric care, employment and housing assistance, family support and education, substance abuse treatment and other services that help a person to live in the community<sup>13</sup>.

#### **Concurrent disorder**

Concurrent disorders (CD for short) generally describes a situation in which a person experiences a psychiatric disorder and either a substance use disorder and/or a gambling disorder.

Other terms used over the years to describe the occurrence of both problems include: dual disorders, dual diagnosis, co-morbidity, and co-occurring substance abuse disorders and mental disorders. These terms will still be found in publications and on web sites. In Ontario, the term dual diagnosis applies to people with developmental disabilities and psychiatric disorders. In the United States and in the international literature, dual diagnosis and dual disorders are most commonly used; although recently the phrase "co-occurring disorders" has been used to refer to clients diagnosed with psychiatric disorders and substance use disorders.

[http://www.camh.net/About\\_Addiction\\_Mental\\_Health/Concurrent\\_Disorders/index.html](http://www.camh.net/About_Addiction_Mental_Health/Concurrent_Disorders/index.html)

#### **Early psychosis intervention**

Early psychosis intervention refers to current approaches to the treatment of psychosis that emphasize the importance of both the timing and the types of intervention provided to persons experiencing a first episode of psychosis.

'Early' means as early as possible following the onset of psychotic symptoms. The 'intervention' is comprehensive, intensive, phase-specific and individualized.

[http://www.cmha.ca/data/1/rec\\_docs/461\\_epi\\_guide.pdf](http://www.cmha.ca/data/1/rec_docs/461_epi_guide.pdf)

#### **Harm reduction**

Harm reduction is any program or policy designed to reduce drug-related harm without requiring the cessation of drug use. Interventions may be targeted at the individual, the family, community or society.

[http://www.camh.net/Public\\_policy/Public\\_policy\\_papers/harmreductionposition.html](http://www.camh.net/Public_policy/Public_policy_papers/harmreductionposition.html)

#### **Substance use disorder**

Substance use disorder involves dependence on or abuse of substances, such as alcohol, prescription and/or over-the-counter medication or illegal drugs.

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<sup>13</sup> O'Grady, C.P., Skinner, W.J. Concurrent Disorders: A Resource for Families. Centre for Addiction and Mental Health. Toronto (in production)