Concurrent Disorders

“Case Management: Making It Work”

Ontario Harm Reduction Distribution Conference February 2013

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This session is intended to introduce you to some new questions you may want to consider regarding working with individuals with concurrent disorders.

After this session, please continue your learning with suggested websites and resources.

My bias is grounded in the expectation that we will be working with individuals with complex issues (including CD) regardless of our setting and/or role.
Session Objectives

• To provide an opportunity for “tuning in” to the reality of Concurrent Disorders
• To review Concurrent Disorders and the important fit with Harm Reduction
• To present a model for collaborative case conferences as key to supporting recovery for individuals with complex needs and multiple service providers
• To provide answers to your burning questions
Concurrent Disorders and Your Work...

• Burning Questions?
What are CD?

- **Concurrent Disorders** refers to cases where the individual has both a substance use concern and another serious mental health or psychiatric concern (same time or in sequence)

- Other terms:
  - **Dual Diagnosis** – popular in American literature, but in Canada refers to a Mental Health disorder and a developmental disorder – obvious limits are being increasingly recognized
  - **Co-Occurring Disorders** – commonly accepted term internationally for CD
Access To Treatment

• Research comparing treatment of patients with a depressive disorder and coexisting substance use issue found that they experience greater complexity of psychosocial needs and clinical presentation than those diagnosed with depression alone and they have fewer admissions and shorter lengths of stay. Brems et al 2006, Journal Of Dual Diagnosis (Research conducted in Alaska Psychiatric Institute).

• Access to medical care, and clarity regarding diagnoses, HIV status and other health concerns are also impacted by this

• The difficulty for research to be done on complex samples (aka people with more than one presenting issue) has impacted the availability of data supporting evidence based practices for individuals with CD

Allison Potts, March 2011
Mental Health is a Universal Concept

Figure 1: The Mental Health/Illness Continuum

Source: CMHA Ontario
Factors Influencing Concurrent Disorders

- Factors influencing the development of mental health and substance use issues are similar:
  - Genetic, developmental and environmental factors interact and influence outcomes
  - They can mask, mimic, exacerbate, trigger, complicate and possibly be independent of each other
# A Four Quadrant Model of Concurrent Disorders

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<thead>
<tr>
<th>Quadrant 1</th>
<th>Quadrant 2</th>
<th>Quadrant 3</th>
<th>Quadrant 4</th>
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<tbody>
<tr>
<td>CD Capable services delivered to individuals with high severity of mental illness and low severity of both mental illness and substance use.</td>
<td>CD Capable services delivered to individuals with high severity of mental illness and low severity of substance use.</td>
<td>CD Capable services delivered to individuals with high severity of substance use issues and low severity of mental illness.</td>
<td>Coordinated CD capable and enhanced services are delivered to individuals with high severity of both substance use and mental illness.</td>
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*Consultation/Collaboration*

*Integration*

*Care is provided throughout the health care system and all points of entry should support recovery and use of consultation.*
Mental Health Care

Addiction Treatment
Evidence Based Practices for CD

• The most consistent finding across recent studies is that integrated treatment programs are highly effective.

• Ideally, integrated treatment means that the clinician weaves the treatment interventions into one coherent package.

• Several outpatient and residential studies also support the use of Stage-Wise treatments (based on the Transtheoretical Model of Change – Prochaska & DiClemente 1984), Engagement Techniques and Motivational Counselling Techniques.

Drake, R., Mueser, K., Brunette, M., & McHugo, G. 2004
Your “Collaborative” Experience?

- Barriers?
- Successes?

Themes?
Case management: What is it?

• “A collaborative, client-driven process for the provision of quality health and support services through the effective and efficient use of resources. Case management supports the clients’ achievement of safe, realistic and reasonable goals within a complex health, social, and fiscal environment”.

(National Case Management Standards Network of Canada, 2009)
Closing the Gap ~ Case Management For Concurrent Disorders: Functions and Standards

• Recognize that no one program owns the client, the system needs to serve the client
• Can no longer operate in silos
• Programs must collaborate to best meet the client needs
• Programs to coordinate services for the clients, rather than clients being asked to go to individual programs
• Reduce duplication of services due to fiscally restrained times
• Some programs had exclusionary criteria which highlighted the gaps in service for these clients, thus prevented the development of staff capacity
• By working in silos, we prevent the ability of staff to develop skills to assist clients with co-existing mental health & addiction issues.

~EVERY DOOR IS THE RIGHT DOOR~

CD Network of Durham Region
Sept 2012
We recognize...

• Some services are specialized however, clients are changing individuals and the system needs to be able to respond to the changing client

• By developing a flexible treatment team, we can meet the changing needs of the client without changing the treatment team

~ INCREASED RESPONSIVENESS!
The client “Navigator”...

• The “Lead” case manager may change within the treatment team, but not the role of case management.

• The change of the Lead will depend on the primary needs of the client.

• Even if the client’s primary service provider does not employ a case management model, they can still be the Lead (e.g. psychologist).
Collaborative Case Management...Can it Work?

• Rose is 38. She is dependent on alcohol and opiates and is a polysubstance user. She has PTSD secondary to extreme child sexual abuse and is HIV positive. She is “known” to police, EMS, Addictions services, CMHA, local hospitals and emergency housing.
• Rose has been unable to participate in PTSD treatment because she is rarely sober.
• She has intermittent involvement with community addiction treatment services.
• She tries to cope with extremely disturbing flashbacks by drinking alcohol, taking drugs, self-mutilating, binge-eating, and acting out sexually.
• Rose often does not keep appointments for HIV treatment.
• She engages in high-risk behaviors including needle-sharing and multiple sexual partners.
• She has been taken to Emergency Depts repeatedly and has had two brief hospitalizations in the last year for suicidal ideation/intention.
• Rose tells the staff at the JHS where she gets her needles that she is tired of living this way but can’t see a way out.
Questions We Can Ask

• What holds us back?
• Quadrant fit?
• What services (potential partners) are involved?
• What other partners might be helpful?
• How can we increase Rose’s willingness to let us “navigate”?
• What gives us hope?
Harm Reduction - ENGAGES

Enters into supportive relationship
Non blaming approach
Gives options
Accepts their choices
Gains awareness
Educates regarding potential harm

Tom Walker, CAMH

Systemic support for recovery    (my addition)
References

• Concurrent Disorders Network of Durham Region. Closing the Gap Case Management for Concurrent Disorders: Functions and Standards, Sept 2012
• Stoff, D.M., Mitnick, L, & Kalichman, S. Research Issues in the Multiple Diagnoses of HIV/AIDS, Mental Illness and Substance Abuse AIDS Care, 2004; 16 (Supplement 1): S1 – S5.