Concurrent addiction and mental health disorders

An information guide

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Library and Archives Canada Cataloguing in Publication

Title: Concurrent addiction and mental health disorders : an information guide / W.J. Wayne Skinner, MSW, RSW; Caroline P. O'Grady, RN, MN, PhD; Christina Bartha, MSW, CSW; Carol Parker, MSW, CSW; edited by Elnaz Haddadi, RPh, PharmD; Tim Godden, MSW, RSW; Matthew Tsuda, OTD, MScOT, OT Reg. (Ont.); Niall Tamayo, RN, MN.

Other titles: Concurrent substance use and mental health disorders

Names: Skinner, W. J. Wayne, 1949- author | Centre for Addiction and Mental Health, issuing body https://id.oclc.org/worldcat/entity/E39QH7JmpBkW699fjPwPJhjc7R

Description: Previously published under title: Concurrent substance use and mental health disorders. | Includes bibliographical references.

Identifiers: Canadiana (print) 20250179083 | Canadiana (ebook) 2025017913X | ISBN 9781771144667 (softcover) | ISBN 9781771144674 (PDF) | ISBN 9781771144681 (HTML)

Subjects: LCSH: Dual diagnosis. | LCSH: Mentally ill, Alcohol use. | LCSH: Mentally ill, Drug use. | LCSH: Substance abuse. | LCSH: Mental illness. | LCSH: Substance abuse, Treatment. | LCSH: Mental illness, Treatment.

Classification: LCC RC564.68 .S55 2025 | DDC 616.86, dc23
This guide was produced by CAMH Education
Development: Alexxa Abi-Jaoudé, CAMH
Editorial: Laura Pastore, CAMH
Graphic design: Leonard Wyma, Donderdag
Print production: Sandra Booth, CAMH

Contents

Acknowledgments

The authors would like to pay special tribute to patients at CAMH and their families who, through their openness, have taught us so much. A special thanks to CAMH Education for sharing resources, educational materials and supplemental content.

Introduction

This guide is for people with concurrent disorders and their families. It is also for anyone who wants basic information about concurrent disorders, its treatment and its management. This guide should not replace treatment from a health care professional.

The term "concurrent disorders" covers many combinations of problems. This guide talks about topics that are common to most concurrent disorders, such as symptoms, causes and treatment options.

Although experiencing a concurrent disorder can be distressing for a person and their loved ones, it's important to highlight that recovery is possible. There are many evidence-based, effective treatment options for people with concurrent disorders, and the belief that recovery is possible can help promote hope, which is an important piece of the recovery process.

A NOTE ABOUT LANGUAGE

Concurrent disorders refer to the simultaneous occurrence of mental health disorders and substance use disorders (Rush et al., 2008; Skinner et al., 2010). The term "concurrent disorders" is most commonly used in Canada and is used throughout this information guide, but there are other terms (e.g., co-occurring disorders and dual diagnosis) used in different geographical areas.

In this information guide, we use the phrases "substance use problem," "addiction problem" or "mental health problem" to describe the broad range of issues, from mild to severe, that a person with concurrent disorders may experience. We use the phrases "substance use disorder" or "mental health disorder" only when referring to a specific diagnosis.

We will also use the following terms throughout the guide:

- *client*: referring to people who receive care from health care providers. It includes "patient" and related terms, such as person and individual
- *family*: referring to any person or group of people that someone identifies as belonging to their family or as a significant circle of support.

1 What are concurrent disorders?

Mental illnesses are conditions in which people's thinking, mood and behaviours may negatively affect their day-to-day functioning. Mental illnesses can affect people of any age, but they often appear in teenage years or early adulthood.

There are several types of mental illnesses. Mental health problems can include depression, anxiety, schizophrenia and many other disorders, as well as addictions (Public Health Agency of Canada, 2015a). They can range from single, short-lived episodes to chronic disorders (Public Health Agency of Canada, 2015b).

Addiction occurs along a continuum from mild to moderate to severe. In the extreme, it can be characterized by the four Cs: *craving*, loss of *control* of the amount or frequency of use, *compulsion* to use and use despite negative *consequences*.

A person with a mental health problem has a higher risk of having an addiction problem, just as a person with an addiction problem has an increased chance of having a mental health problem. When someone is diagnosed with both mental health and addiction disorders, they are said to have concurrent disorders.

Concurrent disorders can include combinations such as:

- an anxiety disorder and problematic alcohol use
- schizophrenia and cannabis use disorder
- borderline personality disorder and substance use disorder
- depression and addiction to sleeping pills.

Many other combinations are possible, because there are many types of mental health and addictive disorders. It should also be noted that people with concurrent disorders may have more than one addictive disorder and more than one mental health disorder. It is therefore important to view concurrent disorders as involving multiple factors rather than just two disorders, and that these factors are often intertwined.

HOW COMMON ARE CONCURRENT DISORDERS?

A 2020 national survey on concurrent disorders among adults aged 18 or older in the United States found that in the past year:

- 14.2 per cent (or 35.9 million people) had mental illness only
- 8.3 per cent (or 20.9 million people) had a substance use disorder only
- 6.7 per cent (or 17.0 million people) had both mental illness and a substance use disorder (SAMHSA, 2021).

People with substance use disorders are more likely to also have mental health problems than those without substance use disorders (Chan et al., 2008; Harris & Edlund, 2005). About three quarters of people with addictive disorders have pre-existing mental health issues (Rush et al., 2010). The risk of having concurrent disorders increases with the number of substances used (Cooper & Calderwood, 2004).

In 2012, an estimated 6.1 per cent of the Canadian household population aged 15 to 64 had a mood/anxiety disorder in the previous year and 3.8 per cent had a substance use disorder. An additional 1.2 per cent experienced concurrent mood/anxiety and substance use disorders (Khan, 2017).

The following sections show the prevalence of mental health and substance use disorders.

Anxiety disorders

- In 2012, almost 9 per cent of Canadians met the criteria for generalized anxiety disorder (Pelletier et al., 2017).
- In the United States, among individuals with anxiety disorders, almost 15 per cent have a substance use disorder, and among individuals with substance use disorders, almost 18 per cent experience anxiety (McHugh, 2015).
- People with anxiety disorder are twice as likely to smoke tobacco as people who do not have a disorder (Kutlu et al., 2015).

Major depression

- In general, 15 to 20 per cent of all people will have major depression in their lifetime.
- Twenty-five per cent of people diagnosed with major depression are also diagnosed with substance use disorder. Among those, the most common substance used is alcohol (20 per cent), followed by unregulated substances (11.8 per cent) and cannabis (11.7 per cent) (Hunt et al., 2020).
- Compared with people with no diagnosis, people diagnosed with concurrent major depression and substance use disorders (i.e., alcohol, cannabis or other drugs) are at least 10 times more likely to have suicidal ideation, as well as other psychiatric conditions (Onaemo et al., 2022; Davis et al., 2008).

Bipolar disorder

- In general, one to two per cent of all people will have bipolar disorder in their lifetime.
- Among people who have had bipolar disorder in their lifetime, around 90 per cent will also have a substance use disorder in their lifetime. Among those, the most common substances used are alcohol (62.3 per cent), cannabis (46 per cent), cocaine (24 per cent) and opioids (8.5 per cent) (Grunze et al., 2021).

Schizophrenia

- One per cent of Canadians live with schizophrenia (Public Health Agency of Canada, 2020).
- Among people who have had schizophrenia in their lifetime, 47 per cent will have a substance use disorder in their lifetime.

EFFECT OF COVID-19 ON CANADIANS' MENTAL HEALTH

The COVID-19 pandemic has had a significant impact on mental health and substance use. Between September 2020 to May 2021, 16 per cent of Canadians reported an increase in alcohol consumption, and five per cent reported an increase in cannabis consumption.

Nineteen to 23 per cent of the Canadian population aged 18 and older screened positive for either or both general anxiety disorder and major depressive disorder, and six to seven per cent screened positive for posttraumatic stress disorder. Compared with those who did not screen positive for generalized anxiety disorder or major depressive disorder, those who screened positive were more likely to report daily or almost daily alcohol use and daily cannabis use. When compared with people who did not screen positive for posttraumatic stress disorder, those who screened

positive were more likely to report symptoms of depression and anxiety, thoughts of suicide (in their lifetime) and increased alcohol and cannabis use since the beginning of the pandemic (Health Canada, 2022)

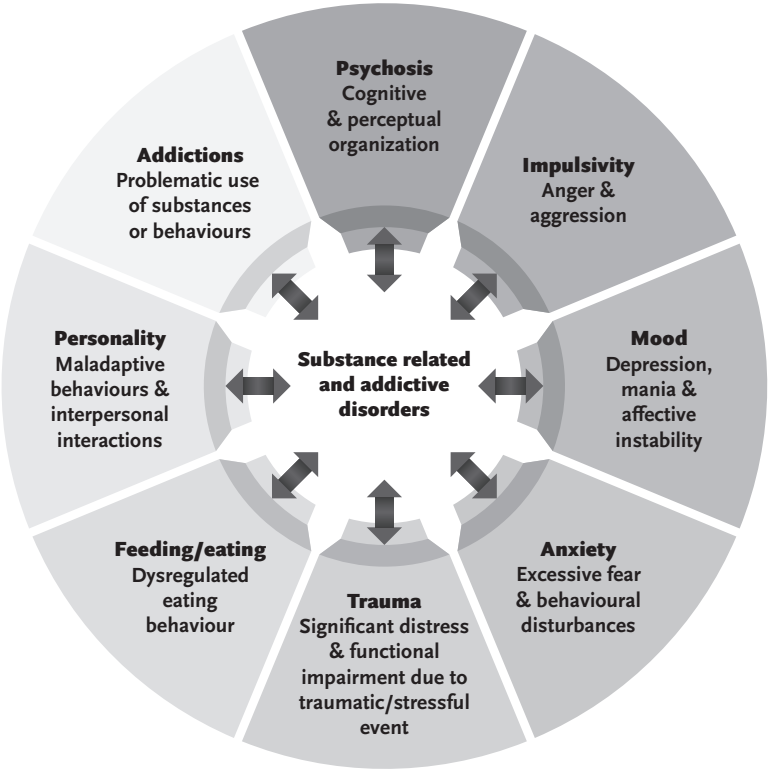
2 Understanding concurrent disorders

Concurrent disorders is a term for any combination of mental health and substance use problems. There is no symptom or group of symptoms that is common to all combinations.

The combinations of concurrent disorders can be divided into eight main groups:

1. **Substance use** and **psychotic disorders**: conditions that affect the mind, in which people have trouble distinguishing between what is real and what is not (e.g., schizophrenia).
2. **Substance use** and **impulsivity**: problems of anger and aggression, including risk of harm to self or others
3. **Substance use** and **mood disorders**: conditions involving depression and affective instability (i.e., rapid and intense mood swings) (e.g., bipolar disorder)
4. **Substance use** and **anxiety disorders**: features of excessive fear and anxiety and related behavioural disturbances
5. **Substance use** and **trauma- and stressor-related disorders**: in which exposure to a traumatic or stressful event has caused a person to develop symptoms that bring about significant distress, behavioural disturbances and/or functional impairment

6. **Substance use** and **feeding and eating disorders**: conditions involving an obsession with food, weight and/or appearance that negatively affect people's health and daily living (e.g., anorexia nervosa, bulimia nervosa, binge-eating disorder)
7. **Substance use** and **personality disorders**: conditions involving a lack of adaptability and limited coping responses that lead to negative consequences (e.g., borderline personality disorder).
8. **Substance use** and other **addictive behaviours**: problematic use of substances and other addictive behaviours (e.g., problem gambling, technology use) that cause negative consequences in several areas of a person's life



HOW DOES EACH PROBLEM AFFECT OTHER CO-OCCURRING ONES?

Some people with concurrent disorders have severe problems with both their mental health and their addictive behaviour. This makes it hard for them to function day-to-day. While other people may have milder co-occurring problems, the impact on their lives can still be quite negative.

Concurrent disorders may interact in several ways, such as:

- substance use and/or other addictive behaviours can make mental health problems worse
- substance use and other addictive behaviours can mimic or hide the symptoms of mental health problems
- sometimes people turn to substance use to "relieve" or escape the symptoms of mental health problems
- some substances can make mental health medications less effective
- using substances can make people forget to take their medications, which can make the mental health problems come back ("relapse") or worsen
- when a person relapses with one problem, it can trigger the symptoms of the other problem.

A person with concurrent disorders is at higher risk of experiencing more serious medical, social and emotional problems than if they had only one condition. The interaction between the effects of substance use and mental health symptoms can prolong treatment and make it less effective.

3 What causes concurrent disorders?

WHEN DO CONCURRENT DISORDERS BEGIN?

Mental health and substance use problems can begin at any time: from childhood to older age. When problems begin early and are severe, recovery may take longer and the person may need more support. On the other hand, if the problem is recognized and treated early, the person has a better chance of a quicker and fuller recovery.

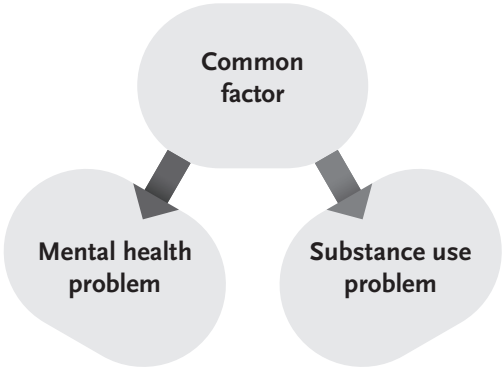
People often ask, "Which came first: the mental health problem or the substance use problem?" This is a hard question to answer. Often it is more useful to think of them as problems that interact with each other.

WHAT CAUSES CONCURRENT DISORDERS?

There is no one cause of concurrent disorders. Each person's situation is different and unique. Here are some reasons why a person might develop both a mental health and a substance use problem:

Common factor model

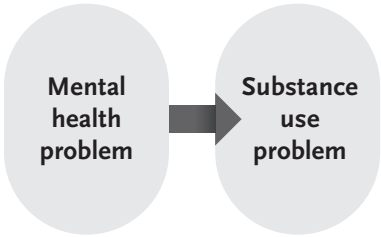
In this model, a common factor leads to both mental health and substance use problems. This factor may be biological or it may be an event, such as emotional or physical trauma.



Secondary addiction model

In this model, the mental health problem triggers the substance use problem. Some people who have a mental health problem may use substances to feel better. While substance use is risky in such cases, it can help people forget their problems or relieve symptoms, at least in the short term. People sometimes talk about using substances for "self-medication."

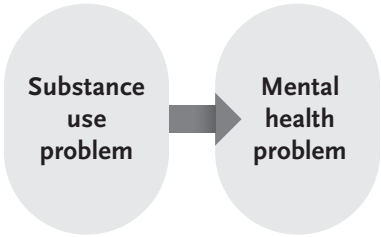
For a person who is more vulnerable to mental health issues, even moderate amounts of substance use may create problems.



Secondary mental health model

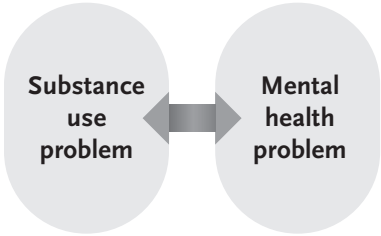
In this model, the substance use problem triggers the mental health problem. Substance use can cause harmful changes in people's lives and relationships. For example, substance use problems may cause a person to lose their job. Mental health problems may result from these indirect effects of substance use.

Some effects of substance use can mimic symptoms of a mental health problem, such as depression, anxiety, impulsivity or hallucinations. This is sometimes described as substance-induced mental health problems.



Bidirectional

In this model, each problem increases a person's vulnerability to the other. For example, if someone with depression is also misusing alcohol, the alcohol use disorder may lead to job loss, worsening the depression, and the depression may lead to relationship problems, contributing to increased alcohol use.



It is important to mention that there are also social, physical and situational factors that can affect the experience of concurrent disorders and further complicate a person's problems. Some factors include:

- chronic physical illness
- experience of trauma
- stigma
- social determinants of health
- acquired brain injury.

It can be helpful to think of causal factors in the following three ways:

1. the factors that might predispose or make someone vulnerable to a problem
2. the factors that trigger the first event
3. the factors that cause a problem to continue.

TRAUMA

"Individual trauma results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being" (SAMHSA, 2014a).

The relationship between trauma and substance use is bidirectional: people who use substances are at risk of being exposed to traumatic events and, therefore, are more vulnerable to the effects of trauma. On the other side, traumatic experiences increase the risk of substance use. Similarly, mental illness increases one's vulnerability to the effects of trauma, and trauma — such as adverse childhood experiences (ACE) — increases the risk of mental health problems (SAMHSA, 2014b).

Many people diagnosed with a mental health, substance use or other addictive disorder report exposure to trauma (Rosenberg, 2011; SAMHSA, 2014b). Additionally, people who use substances are often exposed to traumatic circumstances (e.g., compromised home setting, witnessing unintentional death by poisoned drug supply, experiencing non-fatal overdose, etc.) (SAMHSA, 2014b).

STIGMA

Stigma occurs when people avoid or look down on a person or a group that has unusual or different traits compared to the rest of society. Stigma is a complex concept that involves attitudes, feelings and behaviour; it results from and gives rise to prejudice and discrimination.

When a negative label is placed on an individual or group, it can lead to bias, misperception, myths, stereotyping, prejudice and discrimination. Individuals who face this stigma often internalize the language and attitudes of other people. This may damage a person's self-perception, decrease optimism and confidence and set up negative expectations.

SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are nonmedical factors that can influence a person's health and well-being, as well as affect their access to timely, appropriate and high-quality health care. The social determinants of health can also influence the way a person is treated while receiving care and the outcome of the care provided. Some examples of social determinants of health are:

- gender
- race
- age

- income
- education
- sexual orientation
- immigration or refugee status
- unemployment and job insecurity
- housing and food insecurity.

ACQUIRED BRAIN INJURY AND CONCURRENT DISORDERS

Acquired brain injury (ABI) is damage to the brain:

- caused by a traumatic injury (e.g., car accident, fall, assault) or a medical problem/disease (e.g., brain not getting enough oxygen, a tumour, brain aneurysm, infection or stroke).
- that occurs after birth and is not related to a congenital disorder/developmental disability (e.g., cerebral palsy) or processes that gradually damage the brain (e.g., Alzheimer's disease, Parkinson's disease).

Acquired brain injuries can occur in different areas of the brain. The relationship between ABIs and mental health and substance use disorders is bidirectional (i.e., each problem increases the person's vulnerability to the other). For example, intoxication increases the risk of having a brain injury, and each fall or overdose increases the likelihood of lingering cognitive impairment. A brain injury may cause or worsen mental health symptoms or increase one's vulnerability to substance use disorders.

Whether a person has a mental health or substance use problem, or both, the cognitive and mental health consequences of a brain injury may make it more difficult to benefit from treatment. If you or someone you support has a history of brain injury and is

seeking mental health or addiction treatment, you can increase the likelihood of a better outcome by ensuring that the health care team is informed about the person's ABI history, so it can be taken into account during the care planning process (Selby et al., 2022).

4 How are concurrent disorders treated?

People with concurrent disorders are likely to receive treatment in one of the following settings:

- primary health care (e.g., family doctors)
- mental health agencies/clinics
- substance use agencies/clinics
- specialized concurrent disorders treatment programs.

The treatment setting often depends on how severe a person's problems are and what local services are available.

Often, people who have concurrent disorders have to receive mental health treatment through one service and addiction treatment at another service. Sometimes the services are not connected at all and do not communicate with one another. This can make it very challenging for clients to navigate between the two and experience the full benefits of the available treatment. Communication and collaboration across programs serving the same person enhances care and supports recovery.

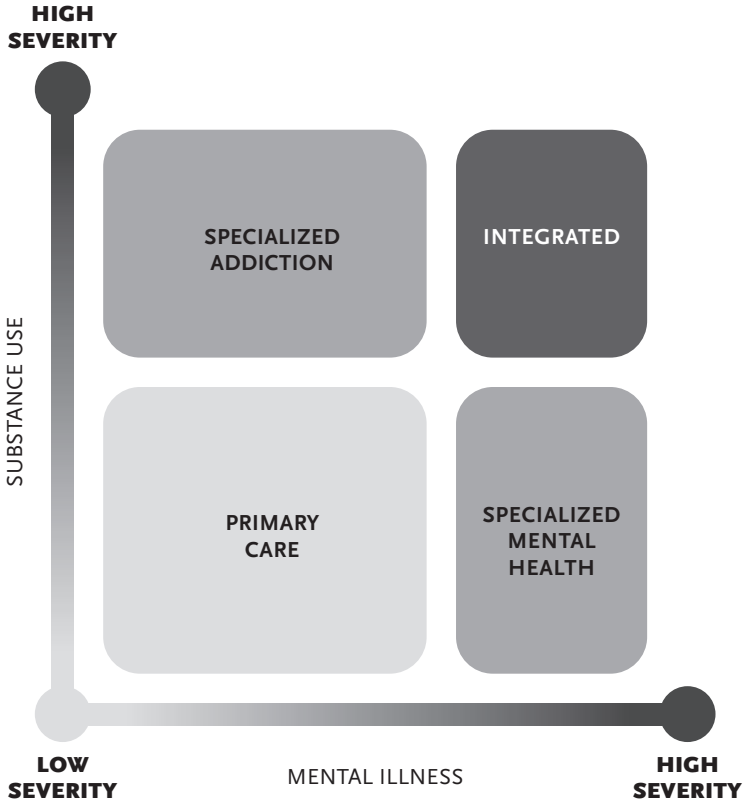


Figure 4.1: The quadrant model is commonly used to describe the different severity levels of mental health and addiction problems in individuals with concurrent disorders (NASMHPD & NASADAD, 2005). It acknowledges that a person's needs will vary and change over time and links those needs to the appropriate range of services. Source: Skinner, 2005, p. 7.

Although the overall treatment plan should consider both mental health and addiction problems, it is sometimes helpful to treat one problem first. For example, most people who have concurrent mood and alcohol disorders are likely to recover better if alcohol use is

addressed first. As another example, a person who is being treated for concurrent disorders may have an episode in which the mental health problem gets worse. In this type of situation, treatment might focus on the mental health problem, rather than on the substance use.

Typically, however, people with concurrent disorders have the best success with integrated treatment, which is when both problems are addressed at the same time, in a coordinated way.

WHAT IS INTEGRATED TREATMENT?

Integrated treatment is a way of making sure that care is coordinated and comprehensive, in ways that appear to be seamless to the client. Ideally, it ensures that the client receives help not only with their concurrent disorders, but also in other life areas. This helps to:

- maintain treatment success
- prevent relapses
- ensure the client's basic life needs are being met
- ensure access to holistic care and psychosocial support.

Integrated treatment works best if the client has a stable, trusting, long-term relationship with one case coordinator, who is typically a health care professional, such as a nurse, social worker or therapist. Even though one person is responsible for overseeing the client's treatment, the client may work with a team of professionals, including psychiatrists, social workers, pharmacists, nurses and therapists.

If treatment services are not all located in the same place, two or more programs may work together to coordinate treatment. For example, a therapist in an addiction program might ask a new client questions about potential mental health problems. If the

client does have mental health problems, the addiction program could either provide treatment or refer the client to a mental health service and work collaboratively with that service. Ideally, with the client's consent, the care team at both services would keep in touch about the client's progress and work in tandem to best address and support their needs.

WHERE DO PEOPLE GET TREATMENT?

People with concurrent disorders who are clinically stable and have social support can be treated in the community, such as through their family doctor or community clinic (e.g., addiction counselling services). People with severe problems may need specialized care for concurrent disorders.

Of note, it can be challenging to obtain access to concurrent disorders services without a doctor's referral. If the person with concurrent disorders does not have a family doctor and requires a doctor's referral to access services, they can consider attending a walk-in clinic or primary care team to request support for a referral. Community addiction services or case management services may also be able to help connect a client to a family doctor so that they can obtain a referral for more specialized concurrent disorder services/treatments.

TREATMENT GOALS

In the past, addiction and mental health treatment services have each treated problems differently. They have also had different ways of thinking about problems. Clients who received treatment from both systems may have been confused by the differences. For example, many addiction services have adopted harm reduction principles, which uses a range of strategies that include safer use,

managed use, abstinence and meeting people "where they're at" in terms of their drug use. As a result, possible client goals may include using substances in safer ways, reducing the frequency and amount of substances or stopping use entirely (for more information on harm reduction, see page 47). Mental health programs that have not adopted harm reduction principles may require clients to completely stop using substances before they can get treatment, forcing an undesired goal of abstinence.

Fortunately, staff in many mental health and substance use programs work closely together. As a result, in working towards their own goals, clients can:

- decide what a healthy future and recovery means for them
- find ways to live a healthy and meaningful life
- make gains in their recovery journey in line with their goals.

A client's treatment plan should be customized, using the most appropriate approaches for each client's particular needs and addressing both addictive behaviours and mental health problems.

TYPES OF TREATMENT

Treatment for concurrent disorders includes psychosocial treatments and medication. Clients may receive one or the other or both.

Psychosocial treatments

Psychosocial treatments include different types of psychotherapy and social and vocational training and aim to provide support, education and guidance to people with mental illness and their families (NAMI, 2024). Psychosocial treatments are an important part of treatment for concurrent disorders. They include:

- psychoeducation
- counselling and psychotherapy (individual and group therapy)
- family therapy

- case management/case coordination support and practical support with housing, employment, finances, social support, etc.
- building healthy lifestyles and engaging in leisure and other meaningful activities
- peer support and mutual aid.

PSYCHOEDUCATION

Psychoeducation is helping people learn about mental health and substance use issues. People who know about their problems are more able to make informed choices. Knowledge can help clients and their families:

- deal more effectively with their problems
- make plans to prevent or reduce problems
- build coping strategies and support recovery.

While all people should receive psychoeducation when they begin treatment for concurrent disorders, as they move through recovery they may benefit even more from psychoeducation. For people who have milder problems, psychoeducation alone may be the only treatment they need.

Psychoeducation sessions include discussions about:

- what causes addictive behaviours and mental health problems
- how the problems might be treated
- how to self-manage the problems (if possible)
- how to prevent or reduce the chance of future episodes
- how to enhance hope, build support and learn the skills that lead to recovery.

PSYCHOTHERAPY

Psychotherapy is sometimes called "talk therapy." It helps people manage their problems by looking at how they think, act, feel and interact with others.

There are many different types of psychotherapy. Some types are better for certain problems. Psychotherapy can be either short-term or long-term and can be offered in-person or virtually.

Short-term therapy has a specific focus and structure. The therapist is active and directs the process. This type of treatment is usually no longer than 10 to 20 sessions.

In long-term therapy, the therapist is generally less active, and the process is less structured. The treatment usually lasts at least one year. The aim is to help the client work through deep issues.

Successful therapy depends on a supportive, comfortable relationship with a trusted therapist. The therapist can be a:
- doctor
- social worker
- occupational therapist
- psychotherapist
- nurse
- psychologist.

Therapists are trained in different types of psychotherapy. They may work in hospitals, clinics or private practice.

Cognitive-behavioural therapy

Cognitive-behavioural therapy (CBT) is a type of short-term psychotherapy. CBT works well for a broad range of concurrent disorders.

CBT is a brief, problem-focused approach to treatment based on the cognitive (i.e., the way we think) and behavioural (i.e., the way we act) aspects of mental health disorders. Since the way a person thinks can affect how they feel and behave, the aim of CBT is to help a person develop healthier ways of thinking, which can then

lead to a change in their feelings and behaviours. Some deeply held thoughts have a strong influence on our mood and behaviour. For instance, if we are depressed and drinking too much and think no treatment will help, then we might not seek treatment. CBT helps people identify and shift such thoughts and learn new strategies to cope better in everyday life.

Dialectical behavioural therapy

Dialectical behavioural therapy (DBT) is a type of cognitive-behavioural therapy. It is used to treat a range of behaviour challenges. DBT draws on Western cognitive-behaviour techniques and Eastern mindfulness philosophies. It teaches clients how to:

- become more aware of their thoughts and actions
- tolerate distress
- manage their emotions
- improve their relationships with other people.

Insight-oriented or psychodynamic psychotherapies

Insight-oriented or psychodynamic psychotherapy tends to be longer term and less structured. These therapies reduce distress by helping people understand what makes them act the way they do.

Interpersonal therapy

Interpersonal therapy helps clients get better at communicating and interacting with others. This therapy helps people:

- look at how they interact with others
- identify issues and problems in relationships
- explore ways to make changes.

Interpersonal group therapy focuses on the interactions among group members.

GROUP THERAPY

Group therapy can help people who have concurrent disorders. Group therapy includes treatments such as:

- cognitive-behavioural therapy
- dialectical behavioural therapy
- interpersonal therapy
- psychoeducation and recovery-focused programming.

A group setting can be a safe space to discuss issues such as family relationships, medication side-effects and relapses.

FAMILY THERAPY AND FAMILY SUPPORT GROUPS

Active social support is a key ingredient in successful ongoing recovery. Family members can support the person with concurrent disorders by learning about substance use and mental health problems and participating in support groups. Family members may also engage in therapy themselves. In family therapy, therapists usually work with one family at a time and can help:

- teach families about concurrent disorders
- offer advice and support to family members.

Sometimes family therapy is offered in a group setting with other families in similar situations. Group members can share feelings and experiences with other families who can understand and support them.

It is important to remember that this guidebook defines family as "anyone who the client identifies as family." As such, a family member does not need to be a blood relative. It is also important to note that some individuals do not have people in their life that they would identify as family, and some individuals do not wish for their family to be involved in their care.

It can be challenging to make recovery gains when there is a lack of social and family support. In these situations, it is encouraged that individuals work toward building their support networks by getting involved in community programs, building trusting relationships and trying out strategies that help to broaden and deepen connections.

PEER SUPPORT GROUPS

Peer support groups can be an important part of treatment. A peer support group is a group of people who all have concurrent disorders and who can share their struggles in a safe, supportive environment. Group members accept and understand one another and may develop trusted relationships and healthy bonds. People who have recently been diagnosed with concurrent disorders can benefit from the experiences of others.

There are peer support groups for clients and for families. Some examples of peer support groups include Double Recovery Groups, SMART Recovery Meetings and 12 Step Groups.

Some addiction clinics and services offer peer support services, in which a peer support worker provides individual or group support to help with clients' recovery. The peer support worker position is a paid role for a trained individual with lived experience, who can journey with clients and provide recovery support. It is well documented that peer support is an effective strategy to promote recovery for individuals with concurrent disorders (O'Connell et al., 2017).

SPECIAL TREATMENT SITUATIONS

During recovery, people may benefit from specific interventions, such as:

- withdrawal management
- crisis management
- hospitalization.

Withdrawal management

Sometimes, people need help with withdrawal from substance use. Withdrawal management helps individuals manage symptoms that occur when they stop using a substance. This term is also known as detoxification or detox. Withdrawal management is sometimes required prior to substance use treatment and may occur with or without the use of medications, which help alleviate symptoms.

Withdrawal management can vary in intensity and can occur in several different settings, such as:

- primary care provider's office: prescribers may provide medications that can be taken at home
- substance use–specific ambulatory/outpatient services: these programs may have specialty staff that can provide support similar to primary care providers. Some places may offer extended onsite monitoring for several hours each day
- emergency departments (ED) and inpatient units: these units provide short-term withdrawal management with medications
- non-medical/community withdrawal management services: this is a facility where the person receives more intensive care and 24-hour supervision, usually staffed by non-medical trained staff. Medication may be used in these facilities
- medical withdrawal management services: this may be needed if a client has severe withdrawal symptoms, such as seizures or hallucinations. These services are staffed by medically trained personnel, such as doctors and nurses, who support the withdrawal management. Medications are often used.

Crisis management

There may be times when people who have concurrent disorders are in crisis. For example, the loss of a loved one, loss of housing, financial hardships or unforeseen violence can lead to a crisis.

It can be very hard for individuals to cope effectively with a sudden crisis. It is useful to plan some emergency strategies when the person is well. For example, before a crisis, the client could create a list of behaviours that can act as warning signs, signalling to them that they should reach out to their support system or to professional/medical support. This allows everyone to be prepared if anything does happen.

Depending on the situation, a crisis may resolve on its own or be managed at home with family, peer and professional support. Sometimes, a person may need to be hospitalized because of a crisis. After the crisis has passed, a person's treatment approach may need to change or they may need to access previous supports or treatments, such as counselling and therapy.

Hospitalization

A crisis may turn into an emergency and some people may need to be hospitalized. This can occur when clients are at risk of serious consequences, due to:

- increased aggression
- increased risk-taking behaviours/more impulsive
- overdosing
- self-harming or suicidal behaviour
- reduced ability to look after their own basic needs.

In such cases, the person may stay in the hospital for a few days up to a few weeks. In hospital, the person receives care from the interdisciplinary team and may attend daily group or individual therapy sessions. Clients should expect to leave the hospital when:

- there is improved functioning
- symptoms have improved
- their recovery goals have been achieved
- they are at a lower risk when compared to admission
- follow-up arrangements are in place.

VOLUNTARY VERSUS INVOLUNTARY ADMISSIONS

People may be admitted to hospital voluntarily. This means that they:

- agreed to enter the hospital
- are free to leave the hospital at any time.

However, the law also allows doctors to admit a person to the hospital involuntarily, even though they may not agree that they need the support and do not want to be in the hospital. Involuntary admission can happen if the doctor believes there is a serious risk that:

- the person will physically harm themselves
- the person will physically harm someone else
- the person has challenges in taking care of themselves.

Each province, state or jurisdiction has its own process for admitting people to the hospital involuntarily. For example, in Ontario, if the person doesn't have a doctor, families may ask a justice of the peace to order an examination by a physician. In the examination, the physician will decide if the person needs to be assessed in a hospital with a psychiatric facility. The physician must be able to prove that the person's illness represents a risk of harm.

There are laws that protect the rights of people who are admitted involuntarily. For example, a "rights advisor" will visit and make sure that the person has the chance to appeal the involuntary status in front of an independent board of lawyers, doctors, nurses and a non-professional.

During a crisis and depending on the scenario, it is sometimes necessary to bring the person to the nearest emergency department, call a crisis line or call 911. A mobile crisis team or the police may need to get involved to bring a person to the hospital. This experience can be very distressing for both the individual and their loved ones. Family members may worry and feel uncertain whether to involve emergency services, even if they are needed to protect the person's life. However, when a person is at risk of harming themselves or someone else, it is important to get them immediate help.

5 Medications

MEDICATIONS USED TO TREAT MENTAL HEALTH DISORDERS

Medications used to treat mental health disorders fall under various categories. They can be used to treat depression, anxiety, bipolar disorder and psychosis. Information in the following section is summarized from the Mental Illness & Addiction index on **camh.ca**. There, you'll find information on different types of medications, their side-effects and their role in treatment.

NOTE: It is important to follow your doctor's or pharmacist's instructions when taking medication, including the correct timing, how often and for how long. You should also know when and under what conditions you should stop using your medication and what to do if you miss a dose. Carefully read the product label and follow the directions closely. If you have any questions, contact your doctor or pharmacist for guidance.

Antidepressant medications

Antidepressant medications are used to treat depression. Some are also helpful for anxiety disorders. Antidepressants work by increasing the availability of one or several neurotransmitters

(i.e., the body's chemical messengers) in the brain. Key neurotransmitters that are affected, such as serotonin, norepinephrine and dopamine, play a role in regulating mood in different, distinct ways.

Antidepressant medications can take up to several weeks to be fully effective. Early signs that the medication is working include improved sleep, appetite and energy. Improvement in mood usually comes later. While all antidepressants work well overall, no drug or type of drug works equally well for everyone who takes it. Some people may be advised to try another type of antidepressant or to use a combination of antidepressants for their treatment.

Types of antidepressants include:

- **selective serotonin reuptake inhibitors (**SSRIs**)**, which increase the level of serotonin in the brain. These are usually the first choice for treatment of depression and anxiety and are known to have milder side-effects than some other antidepressants.
- **serotonin-norepinephrine reuptake inhibitors (**SNRIs**)**, which increase the levels of norepinephrine and serotonin in the brain. These are used to treat depression, anxiety and chronic pain.
- **norepinephrine and dopamine reuptake inhibitors (**NDRIs**)**, which increase the levels of norepinephrine and dopamine in the brain. It is often prescribed for its energizing effects, in combination with other antidepressants.
- **noradrenergic and specific serotonergic antidepressants (**NaSSAs**)**, which is the most sedating antidepressant, making it a good choice for people who have insomnia or who are anxious. This medication also helps to stimulate appetite.
- **serotonin modulators** affect serotonin receptors and can block serotonin absorption.
- **tricyclic antidepressants (**TCAs**)**, which increase the levels of serotonin, norepinephrine and acetylcholine in the brain. These are one of the older classes of antidepressants and tend to have

more side-effects than the other classes of antidepressants; therefore, they are not often a first choice for treatment. However, when other classes of antidepressants do not provide relief from depression, this class of medications may help. TCAs may cause heart rhythm abnormalities and it is likely your doctor will give you an electrocardiogram (ECG) before you take this medication. TCAs may also be used for chronic pain.

- **monoamine oxidase inhibitors (**MAOIs**)**, which block the action of an enzyme called monoamine oxidase, increasing the levels of norepinephrine, serotonin and dopamine in the brain. While effective, MAOIs are not often a first choice for treatment because people who take them must follow a special diet to minimize the risk of food–drug interactions. A new MAOI, moclobemide (Manerix), can be used without dietary restriction.

Table 1 lists the different classes of antidepressants, including examples of medication names and common side-effects.

The choice of antidepressant depends on the individual client's symptoms, medical history and response to previous treatments. It's important to work closely with your health care team to find the most appropriate medication and to monitor for any side-effects.

Table 1

Class of antidepressant	**Examples of medication names** *Note: Medications are listed in alphabetical order. Brand names appear in parentheses.*	**Common side-effects**
Selective serotonin reuptake inhibitors (SSRIs)	• citalopram (Celexa) • escitalopram (Cipralex) • fluoxetine (Prozac) • fluvoxamine (Luvox) • paroxetine (Paxil) • sertraline (Zoloft)	• nausea • vomiting • headache • fatigue • changes in sex drive and/or response • constipation • diarrhea • sweating • dry mouth • nervousness • difficulty sleeping • vivid dreams and nightmares

Class of antidepressant	**Examples of medication names** *Note: Medications are listed in alphabetical order. Brand names appear in parentheses.*	**Common side-effects**
Serotonin-norepinephrine reuptake inhibitors (SNRIs)	• desvenlafaxine (Pristiq) • duloxetine (Cymbalta) • levomilnacipran (Fetzima) • venlafaxine (Effexor)	• nausea • headache • changes in sex drive and/or response • constipation • sweating • dry mouth • nervousness • difficulty sleeping • dizziness • increased blood pressure with higher dosage
Norepinephrine and dopamine reuptake inhibitors (NDRIs)	• bupropion (Wellbutrin)	• insomnia • dry mouth • increased risk of seizures

Class of antidepressant	**Examples of medication names** *Note: Medications are listed in alphabetical order. Brand names appear in parentheses.*	**Common side-effects**
Noradrenergic and specific serotonergic antidepressants (NaSSAs)	• mirtazapine (Remeron)	• weight gain • sedation
Serotonin modulators	• trazodone • vilazodone (Viibryd) • vortioxetine (Trintellix)	• dizziness • nausea • diarrhea
Tricyclic antidepressants (TCAs)	• amitriptyline (Elavil) • clomipramine (Anafranil) • desipramine • imipramine • nortriptyline (Aventyl)	• dry mouth • constipation • difficulty urinating • blurred vision • dizziness • weight gain • tremors and muscle twitching • increased heart rate
Monoamine oxidase inhibitors (MAOIs)	• moclobemide (Manerix) • phenelzine (Nardil) • tranylcypromine (Parnate)	• dry mouth • nausea • dizziness • weight gain • involuntary muscle spasms • low blood pressure

Anti-anxiety and sleep medications

Many of the antidepressants mentioned in the previous section, such as SSRIs and SNRIs, are used to treat anxiety. Benzodiazepines may be used short-term to manage anxiety and insomnia and are generally avoided for long-term treatment due to the potential for abuse. Many types of benzodiazepines are available in Canada. All benzodiazepines work the same way; however, the intensity and duration of their effects vary. Possible side-effects include drowsiness, dizziness, constipation, muscle weakness, difficulties with memory, concentration and coordination.

The benzodiazepines commonly used to treat anxiety disorders include clonazepam (Rivotril), alprazolam (Xanax), lorazepam (Ativan) and diazepam (Valium). Benzodiazepines used for the treatment of insomnia include lorazepam (Ativan), nitrazepam (Mogadon), oxazepam (Serax) and temazepam (Restoril).

Another drug used for insomnia is zopiclone (Imovane). This drug is similar to benzodiazepines and has similar side-effects. Zopiclone may have less abuse potential than some benzodiazepines; however, people can still become addicted to this drug.

Mood stabilizers

Mood stabilizers are medications that help reduce mood changes and are mainly used in the treatment of bipolar disorder. They can also help prevent manic and depressive episodes. The oldest and most studied mood stabilizer is lithium, which is a simple element in the same family as sodium (table salt). Many drugs that were first developed as anticonvulsants (i.e., prescription medications that help treat and prevent seizures) to treat epilepsy also act as mood stabilizers. These include carbamazepine (Tegretol), divalproex (Epival) and lamotrigine (Lamictal). Gabapentin (Neurontin) and topiramate (Topamax) are also anticonvulsants that may act as mood stabilizers, but they

are usually only given in addition to other medications. Some people may be prescribed more than one type of mood stabilizer to take in combination.

Antipsychotic medications

Antipsychotic medications are commonly used to treat psychotic disorders (i.e., schizophrenia, schizoaffective disorder, mania with psychotic features), psychosis, bipolar disorder and severe depression. Delusions (i.e., fixed beliefs in something that's untrue) and hallucinations (i.e., sensory experiences that appear real but are not rooted in reality, such as hearing voices) are examples of symptoms of psychosis. Antipsychotic medications are generally divided into two categories: typical (first generation) and the newer atypical (second generation). The main difference between the two categories of antipsychotics is that the typical (first generation) drugs block dopamine and the atypical (second generation) drugs block dopamine and also affect serotonin levels.

Compared to typical antipsychotics, atypical antipsychotics tend to have a lower risk of movement-related side-effects, such as body rocking, feet tapping, repeated chewing motions, muscle rigidity. However, atypical antipsychotics are more likely to cause metabolic side-effects such as weight gain, changes to blood glucose (sugar) levels and changes to lipid (fat) levels. Both categories of drugs work equally well overall, although no drug or type of drug works equally well for everyone who takes it. Antipsychotics are often used in combination with other medications to treat other symptoms of mental health problems or to offset side-effects. Most people who take antipsychotics over a longer term are prescribed atypical (second generation) drugs.

Table 2 lists examples of typical and atypical antipsychotics.

Table 2

NOTE: Medications are listed in alphabetical order. Brand names appear in parentheses.

Typical (first generation) antipsychotics	Atypical (second generation) antipsychotics
• flupenthixol (Fluanxol) • haloperidol (Haldol) • loxapine (Loxapac) • zuclopenthixol (Clopixol)	• aripiprazole (Abilify) • asenapine (Saphris) • brexpiprazole (Rexulti) • cariprazine (Vraylar) • clozapine (Clozaril) • lurasidone (Latuda) • olanzapine (Zyprexa) • paliperidone (Invega) • quetiapine (Seroquel) • risperidone (Risperdal) • ziprasidone (Zeldox)

Clozapine, an atypical antipsychotic, is exceptional in that it often works even when other antipsychotic medications have not been as effective; however, because it requires monitoring of white blood cell counts, it is not the first choice for treatment.

MEDICATIONS USED TO TREAT SUBSTANCE USE DISORDERS

Medications used to treat substance use disorders are designed to help manage withdrawal symptoms, reduce cravings, and maintain long-term abstinence. Some are used in the short-term, while others may be needed for longer periods. Different drug classes are used depending on the substance involved.

Alcohol use disorder

Medications used to reduce the risk of relapse include naltrexone (Revia), which reduces cravings and blocks the receptors involved in the rewarding effects of drinking, and acamprosate (Campral), which reduces neuronal hyperexcitability (i.e., the increased likelihood that a neuron will be activated by a certain stimulus). Disulfiram (Antabuse), however, reduces the risk of relapse by causing unpleasant effects, such as nausea, vomiting and headache, if alcohol is consumed while on this medication.

Opioid use disorder

The first line treatment for moderate to severe opioid use disorder is opioid agonist therapy, along with behavioural and social supports. These supports will help address social determinants of health (e.g., employment, housing, access to health services) and other psychosocial factors (e.g., peer pressure, stress, media) influencing substance use and quality of life. Opioid agonist therapy includes buprenorphine-naloxone (Suboxone), methadone and slow-release oral morphine (SROM). These medications assist with withdrawal symptoms and cravings and have been shown to reduce the risk of overdose and death. Naloxone is an emergency treatment that rapidly reverses opioid overdose.

Tobacco use disorder

Treatment typically involves a combination of medications and behavioural therapies aimed at reducing cravings, managing withdrawal symptoms and preventing relapse. Nicotine replacement therapy (NRT) provides a low level of nicotine without the harmful chemicals found in tobacco smoke. They help reduce withdrawal symptoms and cravings. Bupropion (Zyban) helps reduce nicotine cravings and withdrawal symptoms. Bupropion can be used in combination with NRT, and it is useful for indi-

viduals with depression as it also treats depressive symptoms. Varenicline (Champix) provides a mild nicotine replacement effect while reducing the pleasurable effects of smoking.

Medications play a critical role in managing symptoms of mental health problems while also supporting recovery for substance use disorders. Individualized treatment plans, regular follow-ups with the health care team, ongoing monitoring of side-effects and adjustments to the treatment plan as needed are important for achieving best results. Discuss any questions or concerns you have about your medications with your care team, as they are there to help you.

SIDE-EFFECTS

Medications may cause unpleasant side-effects, such as nausea, constipation, diarrhea, insomnia and weight gain. Many side-effects lessen with time. If you are experiencing side-effects, it is important to talk to your doctor or pharmacist. They may recommend a dose change or to start another medication to reduce or avoid the side-effect. Remember, substance use may interfere with the therapeutic effects of medications.

Some medications may require bloodwork monitoring to measure the amount of medication in your blood and to check how body organs are affected by the medication.

With the proper precautions, the risk of serious complications from medications is usually lower than the risks of living with untreated substance use and/or mental health problems.

6 Recovery and relapse prevention

"I walked into CAMH doors six years ago, at a time when I had hit rock bottom, feeling totally useless and helpless in my struggles with concurrent substance use and rapidly deteriorating mental health disorders. Thanks (utmost gratitude) to the numerous behavioural therapies, pharmacotherapy and peer support programs that I participated in, I finally acquired the life skills and mustered the courage to embark on a transformational expedition. The transition can be painfully slow, and every step one takes in the guided direction helps in getting closer to your goals. Believe in yourself, trust your care team and please put in the hard work needed, and one day you will experience the magic that unfolds, taking you from a state of hopelessness to an aura of awesomeness. The beautiful light at the end of the tunnel is excited to welcome and usher in the new you!"

— Rohan (former CAMH patient)

Some people with concurrent disorders may feel as if they have too many difficult problems to overcome and that life will not improve. They may also feel unable to do all the things they did before. These feelings are natural and understandable. However, focusing on the negative can make us feel stuck. Instead, by focusing on

recovery as a journey that involves many small, achievable steps, we can build hope and confidence that increases our commitment to doing what we can to make things better.

WHAT IS RECOVERY?

Recovery is a unique, personal wellness journey that people with mental health or substance use problems go through. It is living a satisfying, hopeful and contributing life, even if/when there are ongoing limitations caused by mental health and substance use problems. Commonly, we may think that people are only well when they don't have any symptoms. Recovery focuses on the person's overall well-being rather than the absence of symptoms or being "cured."

WHAT DOES IT MEAN TO BE "IN RECOVERY"?

Each person has a different idea of what recovery means. Some typical goals of treatment include:

- managing mental health symptoms
- reducing or ending substance use
- reducing the risk of relapse
- improving work life, relationships and overall well-being
- addressing social and environmental factors, which can help to foster improved well-being.

Many people measure recovery by their success in meeting these goals. However, recovery is more than this. Recovery is a process that can have ups and downs; it depends as much on attitude as it does on following a treatment plan. The process of recovery can include:

- developing self-confidence
- feeling hopeful and optimistic about the future
- setting achievable goals

- feeling connected to others
- developing/maintaining a strong support network
- making changes to one's housing, lifestyle or employment situation.

A person in recovery may still experience symptoms. It's important to remember that recovery takes time, and the length of a person's care journey depends on individual needs.

WHAT ARE IMPORTANT COMPONENTS OF RECOVERY?

There are many factors that can support recovery. The following are some essential components that can be helpful in one's journey (Leamy et al., 2011):

- **connectedness** – having positive relationships or connection with others (e.g., peer support, social groups, family, professional support and community)
- **hope and optimism** – the belief that recovery is possible (e.g., demonstrating motivation to change, positive thinking, valuing successes and having dreams and aspirations)
- **identity** – regaining a sense of self and identity in the context of the mental health or substance use problem
- **meaning** – living a purposeful life as defined by the person
- **empowerment** – the increased perception of control over one's life, focusing on strengths and having personal responsibility.

SUBSTANCE USE AND HARM REDUCTION

Different people may have different goals when it comes to substance use. A common goal may be abstinence, which is when the person completely stops using substances. Another goal may be reduction. To achieve this goal, a harm reduction approach can be taken.

Harm reduction is a philosophy that aims to minimize health, social and legal impacts related to substance use, policies and laws. Harm reduction principles focus on positive change and human rights and avoids judgment, coercion, discrimination and the requirement to stop substance use. As such, people may continue to use substances and have conversations with their treatment team about preventing worse outcomes.

For example, a person may not be willing or able to discontinue intravenous drug use. Potential interventions aimed at minimizing harm include providing/using sterile equipment, substance testing and discussions about safe practices (e.g., using with people, using less for the initial dose).

Some examples of harm reduction strategies include:

- safe consumption sites
- opioid agonist therapy (e.g., methadone, buprenorphine)
- naloxone kits
- substance testing
- water consumption while drinking alcohol
- arranging for a designated driver
- safe supplies.

RELAPSE

In their most severe forms, mental health and addictive behaviours can be chronic and recurring. This means that, even after a person has received treatment, they may experience relapse and a return of symptoms.

From the perspective of chronic disease management, relapse is often a part of the recovery process, and it is not a reason to stop treatment. If a person is taking medications for a mental health

disorder, it is recommended that they keep taking them. If a person resumes substance use or other addictive behaviours, they should continue to use the strategies that helped them to previously stop.

It is important to acknowledge and discuss relapse events. Relapses can be used as a chance to learn, review the treatment plan and re-establish a plan of action.

People who have had a relapse may not need intensive medical care. A careful, supportive reassessment will help identify next steps. The relapse may be supported through medications review, individual or group therapy or the right type of informal support.

PREVENTING RELAPSE AND PROMOTING WELLNESS

The following tips may help you prevent or reduce the risk of relapse and lead to a healthy lifestyle.

1. **Become an expert on your condition**. Ask your treatment provider about your problems and treatment. Request your treatment team provide you with resources to help you learn more.
2. **Stick to your plan to manage both problems.** This includes:
   - taking medications as prescribed. Speak to the prescriber if you are planning to stop or reduce the use of medications.
   - avoiding situations or people that might trigger substance use attending treatment sessions.
3. **Live a healthy life.** Eat a healthy diet, sleep well and exercise. Regular exercise can positively affect mood. Try to follow a regular routine that includes activities in the evenings and on weekends. Use your faith, religion or cultural healing practices to support your recovery.

4. **Explore healthy ways to cope with stress.** Many people use only one coping strategy or way to deal with stress. Work with your treatment team to find effective strategies to handle day-to-day stress. Some examples might include mindfulness/meditation exercises, engaging in meaningful activities, connecting with a trusted friend/family member, using self-soothing exercises, etc.
5. **Have a support network of family, friends and peers.** A strong social network can be an important source of support. You can nurture and build this network to help protect you from situations that cause stress. Friends or family may recognize symptoms of mental health problems or situations that trigger substance use; they may be able to assist you in seeking help if necessary. Sometimes, your existing support group may provide support that is different than what you are looking for. Expanding your support network allows you to tap into a bigger group that can help you.
6. **Watch for signs of mental health problems or urges to use substances, and ask for help if you need it.** You may be able to sense early signs of an episode of illness or the urge to use substances again. Seeking help at these times may prevent a relapse. If a relapse does happen, getting help may stop things from getting worse.
7. **Try to balance your life.** Remember to do things in moderation. It is recommended to try dividing your time among:
   - work/school/volunteering
   - family
   - friends
   - leisure activities.

   A balanced and satisfying life can help you cope with stress. It may reduce your risk of relapse.

8. **Remember how and why you need to stay well.** Remind yourself of the things that help you stay well and the reasons for doing so. Reminders can include things like:
   - carrying photographs of loved ones
   - keeping a list of positive things in your life.

   It may also be helpful to carry a list of activities that support recovery, as well as emergency numbers to contact in a crisis.

7 How concurrent disorders affect families

WHAT HAPPENS WHEN SOMEONE YOU LOVE HAS CONCURRENT DISORDERS?

When someone has any chronic problem, it can affect their entire family. Family members must cope with extra stressors, which can include caring for the person with concurrent disorder's basic needs, coordinating their treatment and supporting them financially.

Many people struggle to accept that their family member has both addiction and mental health problems. Some families may accept the mental health diagnosis but think their substance use or addictive behaviour is a sign of "bad" behaviour or perceive it as a "choice." Other families may accept the substance use but find it hard to accept that their family member has a mental health problem. Some families struggle to understand that concurrent disorders are a relapsing condition and not an illness with a cure. Other families struggle to understand that making recovery gains is possible.

Family members may feel:

- guilt
- shame

- anger
- grief
- depression
- anxiety
- a sense of loss.

It can be challenging for families to recognize that the expectations they had for their family member may need to change. However, families can play a strong role in recovery. With support and understanding from families, people with concurrent disorders are more likely to have a successful and lasting recovery.

It is helpful if family members learn how to:

- communicate effectively
- help when needed
- know when to let go
- take care of themselves.

As the person with concurrent disorders undergoes treatment, family members may also feel hope and optimism. They may begin to appreciate how hard it is for the person and admire their courage. When the person has success in treatment, family members may also feel a sense of personal reward.

GETTING TREATMENT FOR YOUR FAMILY MEMBER

It may be hard to get your family member to accept help. The person may be so discouraged about their situation that they are not able to see how treatment might help and may choose not to seek treatment.

It is best to be supportive when working with your family member to accept help. Taking a confrontational or forceful approach can

often be counterproductive. One way to be supportive is to find where your family member is least resistant to the idea of changing. For example, the person may mention that drinking has a terrible effect on their mood. You could then start talking about alcohol and ask them to tell you about how it affects them. This kind of discussion can provide a platform for the person to start thinking about getting help.

When your family member is ready to seek treatment, take an active role in supporting the process through activities such as:

- finding treatment centres
- setting up an appointment
- accompanying them to the appointment.

With the consent of your family member, you may also be able to give the health care provider information that offers insight into the person's situation.

CARE FOR FAMILIES

When someone has a serious condition, family members naturally feel worried and stressed. They spend time comforting or helping their loved one. At the same time, they must also manage the usual challenges of family life. As a result:

- they may find that caring for their family member has replaced or disrupted their own routines and activities
- they may be unsure of how others will respond to the person with concurrent disorders, so they avoid having friends or other relatives visit their home
- they may lose touch with their own network of friends and feel that they have a weaker sense of community.

Recognize signs of stress

As a family member to someone with concurrent disorders, it can be helpful to recognize signs of stress in yourself. Often, people take a long time to realize how emotionally and physically drained they are. This stress can lead to:

- poor sleep
- feeling exhausted all the time
- unhealthy lifestyle (e.g., poor diet, lack of exercise, limited social and leisure activities, etc.)
- mental and physical health problems
- feeling more irritable.

Recognize your own feelings

Your own feelings are important. If you accept your own feelings, you can better help the person who has concurrent disorders. You may feel:

- sad that the person has both a substance use and a mental health problem
- angry that this has happened to your family member and seriously affects you as well
- afraid of what the future holds
- worried about how you will cope
- anxious about whether your family member will be able to recover
- guilty that somehow you caused the problem
- a deep sense of loss when your family member behaves in ways that you do not recognize
- stressed by the extra tasks you have to take on
- resentment for disruptions to the family unit.

Take care of yourself

As a caregiver, it is very important to look after your own physical and mental health. To do this, it can be helpful to:

- find and set your own limits
- create healthy boundaries

- make time for yourself. Keep up your interests outside the family and apart from the person with concurrent disorders
- think about people you might want to confide in. Substance use and mental health problems are hard for some people to understand
- aim to confide only in people who will be supportive
- acknowledge and accept that sometimes you will have negative feelings about the situation. These feelings are normal and understandable
- consider seeking support for yourself, even if your family member is not in treatment. Understanding your family member's problems and the impact they have on you will help you cope better. Local community mental health clinics, substance use treatment agencies or hospitals may offer self-help or family support programs.

Being ready for a relapse or crisis

Families often avoid talking to their family member with concurrent disorders about relapses or crises. They fear that talking about a crisis will bring one on or will upset their family member. Also, they may be hoping that the previous crisis was the last instance and will not happen again.

However, the best way to handle a crisis, or possibly avoid one, is to know how to manage it. While you focus on wellness, you should also plan for a crisis or relapse. This can help both the person with concurrent disorders and the family to feel more secure.

When your family member with concurrent disorders is well, plan what to do if problems come back. Consider the following:

- Could you both visit the doctor or treatment service to discuss your family member's condition and how to deal with a possible crisis?

- Will your family member give you advance permission to contact their doctor or care team?
- Do you have your family member's consent to take them to the hospital in a crisis? If so, which hospital has your family member chosen?
- If your family member becomes ill and cannot decide on treatment, do they agree that you can decide?
- With your family member's consent, work to build a good relationship with a therapist/clinician and have a prearranged emergency plan to avoid a crisis.

You may want to write down the terms that you and your family member have agreed on. This can help to ensure that the terms are followed.

TIPS FOR HELPING YOUR FAMILY MEMBER WITH CONCURRENT DISORDERS

1. **Learn as much as you can about the causes, signs and symptoms, and treatment of the problems your family member has.** This will help you to understand and support them in recovery.
2. **Acknowledge and accept your own feelings.** Experiencing conflicting emotions is normal. Knowing this can help you cope with these emotions, so you can support your family member throughout recovery.
3. **Encourage your family member to follow their treatment plan and attend treatment sessions regularly.** If the medication isn't helping or the side-effects are uncomfortable, encourage the person to:
   - speak to their doctor, nurse, therapist or other member of their treatment team
   - speak to a pharmacist
   - get a second opinion.

It is important to note that medications may take weeks to take effect. Ensuring the doctor and care team know what the client is experiencing will help the care team determine if the medication and dose is effective or if it needs adjusting.

4. **Go with your family member to an appointment to share your observations.** Support your family member's efforts to avoid things that may trigger substance use.
5. **Learn the warning signs of self-harm or suicide.** Some warning signs may include:
   - feeling increasing despair
   - getting their affairs in order (e.g., planning their estate and finances, writing a will, etc.)
   - talking about "When I am gone ..."

   If the person makes any threats, take them very seriously and get help immediately. Call 911 if necessary. Help your family member to see that self-harm or suicidal thinking is a symptom of the illness. Always stress how much you value the person's life.
6. **When your family member is well, discuss how to avoid relapse and how to respond to a relapse or crisis.** Prepare for how you will deal with:
   - a substance use relapse
   - an episode of mental health problems
   - other potential problems.
7. **Remember your own needs.** Try to:
   - take care of yourself
   - keep up your own support network
   - avoid isolating yourself
   - consider entering therapy for yourself
   - acknowledge the family stresses of coping with concurrent disorders
   - share the responsibility with others, if possible
   - avoid letting the problems take over family life.

8. **Recognize that recovery is slow and gradual.** Know that your family member needs to recover at their pace. You can support recovery from an episode or relapse in these ways:
   - try not to expect too much or rush the recovery process
   - try to do things with your family member rather than for them; this can help your family member slowly regain self-confidence.
9. **Think of concurrent disorders as an illness, not a character flaw.** Treat your family member with the same respect and dignity that you would treat any other family member. At the same time, watch for possible signs of relapse. If you see early symptoms, encourage them to talk with their care provider.

WHAT ABOUT PEOPLE WHO HAVE LIMITED FAMILY SUPPORT?

It is important to acknowledge that some people have limited family support or are no longer in touch with family members, for various reasons. Every situation is unique, but access to social support is an important part of recovery and having limited support can be very challenging for a person with concurrent disorders. People who are in this situation are encouraged to build new support networks, both during and after treatment.

Fortunately, many concurrent disorders programs and services can help individuals get connected to different support networks, through joining support groups, exploring hobbies and leisure activities, and getting connected with other community supports. Some examples of community groups include self-help groups, faith/church communities, clubhouse organizations, community centres, cultural centres, special interest groups, etc. Expanding support networks can play an integral role in helping with the recovery process.

8 Explaining concurrent disorders to children

Explaining a mental health or substance use problem to children can be awkward and difficult. To protect their children, parents may say nothing. They may try to continue with family routines as if nothing were wrong. This strategy may work in the short-term. Over the long-term, though, children can feel confused and worried about how their parents' behaviour has changed.

Children are sensitive and intuitive. They can quickly notice when someone in the family has changed, particularly a parent. If the family doesn't talk about the problem, children may draw their own, often wrong, conclusions.

Young children, especially those in preschool or early grades, often see the world as revolving around themselves. If something bad happens, they think they caused it. For example, a child may accidentally break something valuable. The next morning, the parent may seem very depressed. The child may then think that breaking the object caused the parent's depression.

HOW MUCH TO TELL CHILDREN

Children need to have things explained. Give them as much information as they can understand.

Toddlers and preschool children

Toddlers and preschool children understand simple, short sentences. They need concrete information and not too much technical language. It is best to explain simply and then try to make the child's life as normal as possible. After explaining the problem, you can make the child feel better by doing something special that the child enjoys.

School-aged children

School-aged children can handle more information than younger children. However, they may not understand details about medications and therapies.

Teenagers

Teenagers can generally manage most information. Often, they need to talk about their thoughts and feelings. Teenagers worry a lot about what other people, especially their peers, think of themselves and their families. They may ask about genetics. They may also wonder how much they should tell others. They may fear stigma about mental health or substance use problems. Sharing information encourages them to talk.

WHAT TO TELL CHILDREN

It is helpful to tell children about three main areas:

1. The family member has a problem called "concurrent disorders" and they behave this way because they are sick. The illness may have symptoms that cause the person's mood or behaviour to change in unpredictable ways.
2. The child did not cause the problems. Children need reassurance that they did not make the family member sad, angry or happy. They need to be told that their behaviour did not cause the family member's emotions or behaviour. Children

think in concrete terms. If a family member is sad or angry, children can easily feel they did something to cause this and then feel guilty.

3. It is not the child's responsibility to make the ill person well. Children need to know that the adults in the family, and other people, such as doctors, are working to help the person. It is the adults' job to look after their family member.

Children need the well family members and/or other trusted adults to shield them from the effects of the person's symptoms. It is very hard for children to see their family distressed or in emotional pain. Talking with someone who understands the situation can help sort out the child's confused feelings.

OUTSIDE THE HOME

Many children are scared by the changes they see in a family member with concurrent disorders. They miss the time they used to spend with this person. Having activities outside the home helps, because children are exposed to other healthy relationships. As the person recovers, they will likely be able to gradually return to family activities. This can then help mend the relationship between the children and the family member.

Family members should talk with their children about what to say to people outside the family. Support from friends is important. However, concurrent disorders can be hard to explain, and some families are concerned that:

- other people will not understand
- other people may act in a way that is stigmatizing toward the person with concurrent disorders.

Each family must choose how open it wants to be and how much information they want to share.

DURING ILLNESS

Children's everyday activities can be high energy and noisy. Some people who have concurrent disorders may find it difficult to tolerate children's noise and behaviour. Family members may need to protect an ill person from situations that may lead them to be irritable and abrupt with the children. At times, children may need to play outside the home. Or the person may need to rest for part of the day in a quiet area of the house.

DURING RECOVERY

When the family member is farther along in their recovery journey, they can explain their behaviour to the children. They may benefit from planning some special outings with the children, which can help to re-establish their relationship. They should also reassure the children that they are once again available and able to spend time with them and engage with them.

Closing words of encouragement

We hope that the content in this information guide has been helpful and that this book will be a useful reference in the future. That being said, it wouldn't be surprising if you have lingering questions.

Everyone's circumstances are unique, which means that reaching out to someone directly to ask your remaining questions could be a logical next step. If something is holding you back from taking a step like this — for instance, worry about being judged — please use our encouragement and know that you deserve all the help you can get. Don't let stigma silence you. Choose a promising resource or strategy that you've found in these pages and explore it more fully.

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Resources

Crisis hotline

- Canada's 9-8-8: Suicide Crisis Helpline: https://988.ca

Mental health resources

- Centre for Addiction and Mental Health (CAMH): www.camh.ca
- RBC Patient and Family Learning Space: https://www.camh.ca/en/patients-and-families/programs-and-services/patient-and-family-learning-space
- Canadian Mental Health Association (CMHA): https://cmha.ca/
- Internet Mental Health: https://www.mentalhealth.com/
- Dual Recovery Anonymous: https://www.draonline.org
- Substance Abuse and Mental Health Services Administration (SAMHSA): https://www.samhsa.gov/
- National Mental Health Information Center (U.S.): https://www.mentalhealth.org/

Depression

- Hope+Me: https://hopeandme.org/
- Depression and Bipolar Support Alliance: https://www.dbsalliance.org

Anxiety

- Anxiety Disorders Association of Canada: https://www.anxietycanada.ca

Schizophrenia

- Schizophrenia Society of Canada: https://www.schizophrenia.ca

Eating disorders

- National Eating Disorder Information Centre: https://www.nedic.ca

Substance use

- Al-Anon: https://www.al-anon.org
- Alcoholics Anonymous: https://www.aa.org
- Narcotics Anonymous: https://www.na.org
- Canadian Centre on Substance Abuse: https://www.ccsa.ca

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Bipolar Disorder

Cognitive-Behavioural Therapy

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Depression

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This guide is for people with concurrent addiction and mental health disorders, and their families. It is also for anyone who wants basic information about concurrent disorders, its treatment and its management.

Topics include symptoms, treatment options, recovery and relapse prevention, strategies to prevent problems and building a positive action plan.

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ISBN 978-1-77114-466-7

7004a / 01-2024 / PM121