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1 INTRODUCTION



Shared Mental Health Care

The concept of shared mental health care is an increasingly successful approach that attempts to address the problems of access and co-ordination/continuity of care. In this approach, mental health and primary care providers work together as part of a well co-ordinated mental health care delivery system that spans both primary and specialized care.

Shared care promotes collaboration between providers from different services or disciplines who share responsibility for the care an individual receives. Working together, they will be able to pool their resources according to the needs of an individual client, service availability, and their respective skills. In doing so, they will attempt to:

- ensure patients receive the services they need when they need them
- improve communication and personal contacts between providers from different sectors
- enhance continuity of care
- provide mutual support.

Shared care models also have the potential to address resource shortages, build system capacity, and deal with mental health emergencies, as the provision of backup and support for primary care providers can enable them to handle a broader range of cases.

Such an approach recognizes that no single service or provider can deliver every service that an individual needs. While an individual may require greater involvement with a specific service at particular times or during certain stages of illness, other providers or services will remain involved and will be able to reactivate care quickly when required.

Goals of Shared Care

The overall goal of collaborative projects is to improve the outcomes for individuals with mental health problems. This can be achieved by developing new models of service delivery/training that aim to:

- increase access to mental health services
- support and enhance the role of primary care providers in delivering mental health care
- strengthen personal contacts between providers from different specialties
- strengthen links between the two sectors
- increase the skills and comfort of primary care providers in managing the mental health problems of their patients
- increase understanding of the demands and needs of primary care among mental health providers and learners
- integrate mental health services within primary care settings.

Models of Shared Care

Models of shared care need to be adapted to local resource availability (i.e., availability of particular types of care providers) and be based upon key principles. The key to successful collaborative partnerships is personal contact among providers involved who are in regular communication, treat each other with respect, and take advantage of opportunities to support each other and share resources when appropriate. These foster the sharing of care by:

- **strengthening personal contacts**, leading to improved communication and more collaborative/less fragmented care
- **creating opportunities to discuss problems/cases** that may not need a specialist consultation but where advice may have a significant impact on the outcome
- **creating personal relationships** that reduce the likelihood that territorial issues will affect service delivery.

There are many possible ways in which care can be shared. Examples include:

- making intake processes more user friendly
- improving written communication between the sectors
- developing rapid access consultation services
- holding joint clinic or educational rounds
- educational programs for primary care providers in managing mental health problems
- integrating mental health services in primary care settings.

Potential Benefits

Evidence within Canadian programs over the last five years suggest that better integrated services are effective and well received by patients, family members, and providers alike, and lead to:

- an increase in access
- decreased waiting time for services
- decreases in hospitalization rates
- decreases in the number of prescriptions being written for individuals being seen
- decreased outpatient utilization rate
- more efficient use of secondary and tertiary resources.

SHARED MENTAL HEALTH CARE

The College of Family Physicians in Canada and the Canadian Psychiatric Association Collaborative Working Group has worked diligently over the last eight years to find ways to bridge this gap and promote the concept and practice of shared mental health care across Canada. Also, the BC Medical Association and the BC College of Family Physicians have strongly supported the development of Mental Health Shared Care in British Columbia.

For more information, we encourage you to contact the regional director of mental health and addiction services within your local health authority (listed under General Resources for Patients and Families in this Guide) and access the national website on Shared Care: www.shared-care.ca



Diversity Issues

Canadian family physicians face the challenge of providing health care services to a diverse population of patients. The expression of psychopathology, risk for mental illness, symptoms of mental illness, utilization of mental health services, and responses to treatments or interventions vary depending on the individual, their gender, age, country of origin, circumstances of migration, sexual orientation, marital status, socioeconomic class, religion, and place of residence.

According to the American Psychiatric Association Position Statement on Diversity (May, 1999), awareness of cultural diversity includes awareness of issues of race, sex, language, age, country of origin, sexual orientation, religious/spiritual beliefs, social class, and physical disability. Awareness of cultural diversity also includes knowledge about cultural factors in the delivery of mental health care and in the patient's health-related behaviour. Cultural diversity is a challenge to the diagnosis and treatment of mental illness, as it can affect the experience and communication of symptoms.

The establishment of a therapeutic alliance between patient and physician is determined as much by the patient's cultural background as by the physician's values, ideas, and understanding of cultural diversity. This concept is particularly important in British Columbia. For instance, visible minorities in Vancouver in 2001 accounted for 49% of the total population.

Women's Mental Health

Women suffer higher rates of certain mental disorders than do men. Women are more often diagnosed with affective disorders (major depression and rapid cycling bipolar illness), eating disorders, post-traumatic stress disorder (PTSD), social anxiety, somatization disorder, and borderline and histrionic personality disorders. Women are more likely to be exposed to traumatic events, domestic violence, physical and sexual abuse, discrimination, inferior social class, and lack of educational/economic opportunities. Women are also more likely than men to attempt suicide. Elderly, ethnic, immigrant, incarcerated, lesbian or bisexual women, and single mothers are more likely than other women to live in poverty, experience discrimination, and have problems accessing health care services.

All aspects of a women's world, including complex biological, psychological, and social factors must be considered in understanding health care needs from a women's perspective.

Gay, Lesbian, and Bisexual Community

From January to December of 2003, 135,000 Canadians over age 12 were surveyed through the Canadian Community Health Survey Cycle 2.1. For the first time, a question about sexual orientation was included in the survey. This information was needed to understand differences in health-related issues within the homosexual, bisexual, and heterosexual populations. Among Canadians aged 18 to 59, 1% reported that they considered themselves to be homosexual and 0.7% considered themselves to be bisexual. 1.3% of men consider themselves to be homosexual, almost twice as much as women do (0.7%). The results of the survey also indicated that there were important health differences between heterosexual, bisexual, and homosexual populations. For instance, among individuals 18 to 59, 21.8% reported unmet health care needs in 2003, which is nearly double of the proportion of heterosexuals with unmet health care needs (12.7%) for the same year. Also, individuals who identified themselves as either homosexual or bisexual reported increased levels of stress in their lives when compared to heterosexual individuals. British Columbia reported the number of homosexual or bisexual people in 2003 to be 47,700 or 1.9% of the total population.

Visible Minorities

The 2004 report by Canadian Heritage ("Canadian Diversity: Respecting our Differences") states that by the year 2006, one of six Canadians will be a member of a visible minority.

The largest visible minorities groups are Chinese, South Asian, Filipino, Japanese, South East Asian, Latin American, Arab, West Asian and Korean. The most commonly spoken languages in British Columbia, other than the official languages, are Chinese (Cantonese and Mandarin), Punjabi, Vietnamese, Korean, Tagalog, Spanish, Persian, and Japanese.

Aboriginal People's Mental Health

As indicated in the Background and Purpose of this document, issues specific to the Aboriginal People's are out of scope for this Guide. However, a brief summary of epidemiology is included in this section. In addition, an Aboriginal Health Services resource list is available in the section titled Information and Supports for Individuals and Families, under Cross Cultural Resources.

First Nations, Inuit, and Métis represent about 1 million people, or 4% of the total Canadian population. There are 11 major languages with more than 58 dialects in 596 bands residing on 2284 reserves, or in cities and rural communities. Historically, Canadian Aboriginal people have suffered rapid cultural change and dislocation of their communities, causing them to live in isolated areas and under conditions of poverty. This poses challenges for the delivery of health care to these small and isolated communities.

Epidemiological studies have documented higher levels of mental health problems in many Canadian Aboriginal communities than in the population at large, including higher rates of suicide, alcoholism, and violence. Depression, anxiety, and PTSD are more prevalent in Aboriginal communities. Aboriginal people have increased rates of death among the youth caused by accidents and suicide.

Immigrant and Refugee Populations

Barriers to Accessing Services for Refugees in British Columbia

Access to Mental Health services can be a significant challenge for immigrants and refugees. Barriers to consider include:

- language/culture
 - absence of or poor English skills
 - issues regarding interpreters (e.g., availability, discomfort)
- access issues
 - finding service providers
- difficulty identifying mental health issues, especially differentiating between acculturation stress and mental illness.
- lack of transportation
- lack of childcare.

Perception of what constitutes a health issue can also be very different for immigrant or refugee groups. A BC 2004 study titled ‘Chinese and South Asian Immigrant Women — Experiences of Postpartum Depression’ revealed that these women understood their emotional difficulties as being related to their personal relationships and social networks rather than as a health issue. Therefore, they are unlikely to speak to their GPs about ‘depression’. Based on this information, it is recommended that health care providers ask women questions about the practical and emotional support they are receiving. Consider referral to community organizations and other less formal sources of support as possible avenues of treatment. For more information on this study and further recommendations, go to www.bcwomens.ca.

Cross-cultural assessment is challenging. Physicians need to be culturally sensitive and aware of variations in phenomenology from culture to culture. Cultural sensitivity is the ability to appreciate that patients may have different lifestyles, divergent views, experience different types of stress, and have unique coping skills.

Formulating Cross-cultural Patients

When formulating culturally diverse patients, consider the following:

- the cultural identity of the individual.
 - Note the individual’s ethnic or cultural reference group.
 - For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture.
 - Note language abilities, use, and preferences (including multilingualism).
- cultural explanations of the individual’s illness.
 - Note the predominant idioms of distress through which symptoms or the need for social support are communicated (e.g., “nerves”, possessing spirits, somatic complaints, inexplicable misfortune).
 - Understand the meaning and perceived severity of the illness in relation to the norms of the cultural reference group.
 - Explore the explanatory models of the illness used by the reference culture.
 - Inquire about current preferences for, and past experience with, health professionals and Western medicine.
- cultural factors related to psycho-social environment and level of functioning.
 - Note culturally relevant interpretations of social stressors.
 - Clarify available social supports and the role of religion and kin networks in providing emotional, instrumental, and informational support.
- cultural elements of the relationship between the individual and the clinician.
 - Identify cultural differences and potential pitfalls (e.g., difficulty with communication, eliciting symptoms, determining whether a behaviour is normative or pathological).
 - Understand and discuss how cultural considerations specifically influence comprehensive diagnosis and care.

Mental Health History — Taking in Immigrant and Refugee Populations

When screening immigrants or refugees for mental illness, it is critical to consider certain issues which may contribute to mental illness. Certain specific questions may be useful in screening for anxiety disorders including PTSD, adjustment disorders, depression, and suicidal ideation/behaviours:

- Where were you born?
- When did you come to Canada?
- How did you arrive?
- Who came with you? Did you come on your own or with your family?
Were they left behind?
- Were you sponsored?
- Are you currently going through an immigration process?
- What was your profession before coming to Canada?
- Were you persecuted in your country?
- Was there violence or war?
- Did you witness or were you a victim of sexual and/or physical abuse in your country or on your immigration journey?
- Were you detained or imprisoned?

- Were you tortured?
- Have you had personal losses? How did you grieve the loss?
- Describe the adjustment to Canada? Financial? Shelter? Employment?

Mood Disorders

In the specific case of depression, culture can affect the experience and communication of symptoms. Complaints of “nerves” or headaches (in Latino and Mediterranean cultures), weakness, tiredness, or “imbalance” (in Chinese and Asian cultures), and problems of the “heart” (in Middle Eastern culture) may be communications of depressive symptomatology.

Most cross-cultural studies have found a higher rate of somatization associated with depression in non-Western groups of countries; however, most research has focused on unipolar depression indicating extensive cultural patterns but also extensive similarities. According to the World Health Organization Collaborative Study of Depression, the differences beyond the core depressive syndrome are in symptom presentation, conceptualization of affect, level of severity and influence of acculturation.

Anxiety Disorders

The World Health Organization study on mental disorders found significant variation in the prevalence of anxiety disorders across countries. For example, the prevalence rate of anxiety disorders is high in Brazil (22.6%) and Chile (18.7%), compared to Shanghai, China (1.9%). These prevalence rates are difficult to interpret and they may or may not reflect the actual incidence of these disorders. For example the rates are often based on self-reports which in turn may be influenced by cultural differences in beliefs, perceptions, and willingness to report. However, at the same time, some cultural elements may contribute to stress, influence the perception of stress, and influence the ability to cope. For example, anxiety can be caused by cultural beliefs, such as breaking taboos or cultural demands in the family, intergenerational conflict between children and parents, rapid change, family separation due to war or other sociocultural situation. Anxiety often manifests itself as a mixture of anxiety, depression, and somatization.

Psychosis

Research into cross-cultural presentations and course of schizophrenia shows significant differences as well as similarities. While the core positive and negative symptoms are universal, the content of hallucinations and delusions varies significantly. Phenomenology also varies with cultural settings: catatonia is more frequent in India and agitation more frequent in Japan when compared to Western cultures. Ideas that may appear delusional, such as witchcraft or sorcery may be culturally appropriate. Certain mental status observations like disorganized speech may be difficult to assess if using an interpreter.

Substance Use Disorders

Cultural factors influence problematic substance use and prevalence varies greatly amongst cultures. The definition of substance abuse or dependence and the perception of impairment and intoxication may be specific to the local culture. The availability of alcohol, its use in religious ceremonies and social activities, and family values regarding alcohol consumption by children are all cultural factors that may influence problematic alcohol use.



Natural History of Mental Illness Trajectories

- While some individuals may only experience a single episode of the disorder, many will have a chronic illness trajectory.
- Each new episode may occur sooner, last longer and become more severe and more difficult to treat.
- Terms such as prodrome, acute presentation, remission, residual symptoms and relapse describe the various stages of the trajectory.

Prodrome

- A period marked by numerous subtle changes that precede the acute presentation of the illness
- Common changes include:
 - sleep and appetite changes
 - increased substance use
 - withdrawal from family and friends
 - feelings of irritability, anxiety or depression.

Acute Presentation

- During this period the type of illness manifests itself more clearly.
- The individual may experience distress and will usually have impaired function at work, school or home.

Remission

- A period of reduced symptom severity with a return of function and remission of impairment
- Remission is the primary goal of treatment.
- Illness which is resistant to remission after a full treatment course is considered to be *refractory*.

Residual Symptoms

- Even with effective treatment, some people may continue to experience symptoms.
- The presence of residual symptoms demands more active treatment efforts in an effort to attain remission.
- In some situations the presence of residual symptoms may increase the likelihood of relapse.
- The use of self-management strategies may lead to better control of residual symptoms for many individuals.

Relapse

- Relapse is a return of acute presentation after a period of remission.
- Relapse rates for many of the disorders are high.
- The goal of maintenance treatments is to prevent relapse.

Comorbidity

- Comorbidity is defined as the simultaneous presence of two or more physical or psychiatric disorders.
- There is a high rate of comorbidity between the disorders presented in this guide. These disorders are often comorbid with physical disorders and other mental disorders (including eating disorders and personality disorders). Comorbidity is associated with significant diagnostic and treatment challenges.
- Assess comorbid conditions (both mental and physical) initially and throughout the course of illness.
- Treatment ideally is integrated but at times must be prioritized.
- Comorbidity influences the clinical presentation and is not always easily detected. For example,
 - psychosis may obscure the presence of a co-occurring anxiety disorder
 - alcohol abuse may obscure the presence of a co-occurring depression
 - heart disease may co-occur with major depression.

- Comorbidity tends to be associated with:
 - delayed detection and diagnosis
 - incomplete treatment
 - less complete recovery
 - more chronic course
 - greater problems with functioning
 - higher rates of suicide.
- Chronic pain and chronic illness commonly present with a comorbid psychiatric illness (depression, anxiety or substance use disorders). Chronic pain itself and analgesics such as opiate medications can mask symptoms of mental illness.

Comorbidity and Trauma

- Lifetime prevalence rates for exposure to traumatic events ranges from 50% to 98% across studies.
- The experience of trauma may lead to significant comorbidity in the areas of physical and mental health.
- Individuals with a mental illness are also more likely to be exposed to traumatic events including childhood sexual or physical abuse and adulthood traumatic victimization.
- Children exposed to early traumatic experiences are at increased risk for the development of depression, anxiety disorders, personality disorders, substance use disorders and psychotic disorders later in life.
- In some cases, individuals may develop problems with substance use as they use alcohol or other drugs as method to cope with the trauma and resultant symptoms of over-arousal or avoidance.
- The lifetime prevalence of posttraumatic stress disorder (PTSD) is about 8% – 14% in the general population. Rates of comorbid PTSD in individuals with a mental illness are estimated to be as high as 43%.



Overview of Disorders

Annual rates for Major Depressive Disorder, Mania, Social Phobia, Panic Disorder and Agoraphobia as well as those for Problematic Alcohol and Substance Use are provided by the 2002 Canadian Community Health Survey: Mental health and well-being www.statcan.ca/Daily/English/030903/do30903a.htm.

“One out of every 10 Canadians aged 15 and over, about 2.6 million people, reported symptoms consistent with alcohol or illicit drug dependence, or one of the five mental disorders covered in the survey, at some time during the 12 months prior to the interview”

– 2002 Canadian Community Health Survey: Mental health and well-being

MAJOR DEPRESSIVE DISORDER

* For a complete review on issues regarding Major Depressive Disorder, please see the Guidelines and Protocol Advisory Committee: Diagnosis and Management of Major Depressive Disorder [monograph]. *BC Medical Association and BC Ministry of Health Services, Victoria, 2004, 18 pages.* www.healthservices.gov.bc.ca/msp/protoguides/gps/title.html

- A clinical depression occurs when a person experiences a major depressive episode as defined by the DSM-IV or DSM-IV-TR.
- Other mood disorders or conditions with mood components include:
 - dysthymic disorder
 - bipolar disorders 1 and 2 and cyclothymic disorder
 - bereavement
 - substance-induced mood disorder
 - adjustment disorder with depressed mood
- Subtypes of major depressive disorder include:
 - seasonal affective disorder
 - postpartum depression
 - psychotic depression
 - atypical depression
 - melancholic depression

Epidemiology

The implications of depression for both the individual and society are significant:

- In 2002, 4.5% of Canadians reported suffering from Major Depression in the previous 12 months; 4.9% reported “any mood” disorder.
- Lifetime risk of Major Depressive Disorder varies from 10 – 25% for women and 5 – 12% for men.
- About 2% of people with depression will commit suicide.
- Depression is the second leading cause of long-term disability and the fourth leading cause of global burden of disease.
- 50 – 60% of individuals with a first episode can expect to have a second while 70% of those with two episodes can expect to have a third; 90% of those with a third will go on to have a fourth.
- 5 – 10% of individuals diagnosed with MDD go on to develop bipolar disorder.
- In 2002, 0.8% of Canadians reported suffering a manic episode in the previous 12 months.
- ‘Bipolar spectrum disorders’ affect up to 8% of the population “Bipolar spectrum disorders” include bipolar disorder type 2, cyclothymia and “ultra-rapid cyclers”.
- Postpartum depression occurs in up to 10 – 20% of women.

Comorbidity

- Medical illnesses commonly presenting with comorbid depression include:
 - coronary artery disease
 - HIV/AIDS
 - cancer
 - arthritis
 - stroke
 - metabolic and endocrine disorders such as hypo or hyperthyroidism
 - diabetes
 - neurodegenerative disorders e.g., Alzheimer’s and Parkinson’s disease
- Most psychiatric disorders, including anxiety and psychotic disorders, problematic alcohol and substance use and personality disorders have high rates of comorbid depression.

Overview of Treatment

- Between 70% and 80% of depressed people get better with various forms of evidence-based therapy.
- The evidence indicates that antidepressant medication and various psychotherapies are effective treatments for many people.
- Depression is a time-limited disorder and many recover over time in the absence of treatment.

ANXIETY DISORDERS

While anxiety can be a normal and adaptive emotion, chronic and excessive anxiety can lead to significant personal suffering and substantial interference in daily functioning.

Anxiety disorders (approximate prevalence rates) include:

- panic disorder (2.4%)
- social anxiety disorder (2 – 13%)
- agoraphobia (1 – 5%)
- generalized anxiety disorder (3 – 7%)
- post-traumatic stress disorder (1 – 14%)
- specific phobias (9 – 11%)
- obsessive-compulsive disorder (1 – 2%)
- substance-induced anxiety disorder.

Note: Prevalence rates are approximate and often vary substantially across studies.

Epidemiology

- About 1 in 10 Canadians reported suffering from an anxiety disorder in the previous 12 months.
- PTSD has a prevalence rate of 9 – 10% in Western countries.
- Panic disorder, agoraphobia, post-traumatic stress disorder, generalized anxiety disorder and specific phobias occur more frequently in women.
- There are no significant gender differences for social anxiety disorder and obsessive-compulsive disorder.

Comorbidity

- More than half of individuals with an anxiety disorder receive at least one additional psychiatric diagnosis.
- Common comorbid medical conditions include:
 - osteoarthritis
 - diabetes
 - heart disease
 - obesity
 - elevated lipid levels
 - fibromyalgia
 - irritable bowel syndrome.
- Common comorbid psychiatric illness include:
 - another additional anxiety disorder
 - depression and other mood disorders
 - substance use disorders
 - personality disorders.
- Comorbidity is often associated with more severe anxiety disorder symptoms.

Overview of Treatment

- Approximately 80% of patients benefit from cognitive-behavioural therapy, medications or a combination of both.
- Cognitive-behavioural therapy and medication treatment (when appropriate) are roughly equivalent after approximately 8 to 20 weeks of treatment.
- Cognitive-behavioural therapy may be superior to medication treatments in the long-term (i.e., months and years following treatment) most likely due to the high relapse rates often associated with medication cessation.

EARLY PSYCHOSIS

- Psychosis is a state characterized by an individual's loss of contact with reality. It may involve abnormal perceptions (hallucinations in any sensory modality), delusions, disorganized speech or disorganized or catatonic behaviour.
- Psychotic Disorders include:
 - schizophrenia
 - schizophreniform disorder
 - schizoaffective disorder
 - delusional disorder
 - brief psychotic disorder
 - psychotic disorder due to a general medical condition
 - psychotic disorder not otherwise specified
 - substance-induced psychotic disorder.
- Subtypes include: paranoid, disorganized, catatonic, undifferentiated, and residual types.
- Mood disorders such as Bipolar disorder and Depression may present with psychotic features. Bipolar disorder in adolescents is often misdiagnosed as Schizophrenia and should be revisited as a possible diagnosis when mood symptoms present.
- Dementia may be accompanied by psychosis.

Epidemiology

- Psychosis has a lifetime prevalence of about 3%. Schizophrenia is the most prevalent psychotic disorder with a lifetime prevalence rate reported to be between 0.4% and 1.5%.
- The median age at onset for the first psychotic episode of schizophrenia for men is early to mid 20's and for women, late 20's.
- First-degree biological relatives of individuals with schizophrenia have a risk of schizophrenia that is 10 times that of the general population.
- Both genetic and environmental factors have been implicated in the etiology of schizophrenia.
- The rate of completed suicide in persons with schizophrenia is about 10%, a rate more than 25 times higher than in the general population. The risk of suicide is highest during the first five years of the illness.
- According to the World Health Organization, active psychosis ranks as the third most disabling condition — higher than paraplegia and blindness.

Comorbidity

- Comorbid substance abuse occurs in 20 – 30% of individuals with rates for substance misuse above 50%.
- 15% of individuals with psychosis have post-traumatic stress disorder.
- 40% of individuals with psychosis have significant depression.
- Many individuals with a psychotic disorder develop serious medical conditions leading to shortened life expectancy:
 - Diabetes and obesity
 - Conditions related to chronic tobacco/substance use
 - Nutritional deficiencies and self-neglect
 - Victimization and violence.

Methamphetamine-related Psychotic Symptoms

The use of methamphetamine has increased in recent years leading to a higher number of individuals seen with comorbid psychosis. Further research is needed to understand the association between methamphetamine use and psychosis.

Three theories have been proposed to account for the high rate of comorbid methamphetamine use and psychosis:

1. People with psychosis use methamphetamine – this causes a relapse and gives the appearance that the drug caused the psychosis.
2. Methamphetamine use may be a kind of stressor that unmasks a person's vulnerability to develop psychosis (e.g., someone with a high genetic risk may have developed schizophrenia given one of many possible physical or social stresses).
3. Methamphetamine may cause psychosis — there are increasing reports of persons with no psychiatric history whose psychosis fails to go away after the drug is out of their system.

Overview of Treatment

- With appropriate treatment up to 85% of people with a diagnosis of schizophrenia will symptomatically recover within a year.
- For schizophrenia and bipolar disorder with psychosis, the one-year relapse rates are reduced by half with appropriate medication treatment (from about 60% to 30%).

SUBSTANCE USE DISORDERS

Substance related disorders include:

- substance use disorders:
 - abuse
 - dependence
- substance-induced disorders:
 - withdrawal
 - intoxication
 - substance-induced delirium
 - substance-induced psychotic disorder
 - substance-induced mood disorder
 - substance-induced anxiety disorder
 - substance-induced sleep disorder

Epidemiology

- In the “2002 Canadian Community Health Survey: Mental health and well-being”, in the previous 12 months
 - 2.6% of Canadians reported alcohol dependence
 - 0.7% reported an illicit substance dependence
- Lifetime prevalence of alcohol dependence may be as high as 15%

Comorbidity

- Medical comorbidity may include liver disease, lung disease, emphysema, STDs, HIV, head injuries.
- There is significant overlap between substance use disorders and concurrent mental disorders.
- Substances may be used as a form of self medication for mental health problems (eg. depression, anxiety).
- Substance use may also trigger, worsen, or mask mental health problems.
- Trauma contributes to both mental health and substance use problems.
- Comorbidity of substance use disorder with a mental disorder is associated with an overall higher disease burden and higher mortality.
- **People experiencing multiple diagnoses are more likely to develop substance dependencies and less likely to benefit from stand-alone addictions services.** Such complex cases require an integrated approach that addresses substance use and mental health issues concurrently.

Overview of Treatment

- The annual rate of remission in patients completing intensive treatment is estimated to be between 45 – 60%.
- About 2% of alcohol dependent individuals achieve stable abstinence each year, with or without treatment.
- Similar figures exist for heroin and tobacco dependence.