Enhancing concurrent capability:
A toolkit for managers and staff

Comprehensive interventions

Contents

Alberta Health Services

Addiction & Mental Health
Concurrent Capable Practice Supports
Updated 2018

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Introduction

How was this toolkit chapter created?

The content for this chapter was developed following a literature review and discussions within the organization to establish what resources were available and what needed to be included for Addiction and Mental Health (AMH) related to comprehensive interventions. This chapter is one of eight in the Enhanced Concurrent Capability (ECC) Toolkit. A number of relevant websites were reviewed related to specific addiction and mental health associations and organizations. Content was validated with a variety of stakeholders who were part of a provincial working group and AMH clinical network. Representation on these committees was inclusive of the various zones and sectors representing Addiction and Mental Health in Alberta Health Services.

We would like to acknowledge the work of the participants who helped create this resource and are grateful for their valuable contributions.

We are committed to matching the toolkit content to the needs of the people who will be using it. We welcome any feedback, questions, or suggestions for content additions or revisions. We wish to learn from the experiences at the front line, so please let us know how well this toolkit works for you by emailing us at concurrent.disorders@ahs.ca

Acknowledgements and special thanks

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What you will learn in this chapter

This chapter will highlight and discuss the numerous types of interventions that exist to assist individuals in their recovery when they have been diagnosed with a concurrent disorder. Interventions will be presented in terms of type of intervention, how it might best be used or applied, and tips on how to select the best combination of interventions with the individual taking into consideration their goals, motivation, stage of change and treatment and other factors.

As with other chapters in this toolkit, we have tried to keep the main part of the chapter brief. There is detailed information available in the appendices where you can read about topics of further interest to you. Throughout the chapter and in the appendices you will find additional information on resources on comprehensive interventions.

The following topics are covered in this chapter

- What are comprehensive interventions
- How to engage individuals and families to choose interventions
- Stage-matched interventions
- Intervention factors and formats, including:
  - Individual or group therapies
  - Formal or informal
  - Personal motivation
  - Treatment settings, formats and milieu
  - Duration and amount of intervention
  - Use and timing of interventions
- Overview of select interventions and approaches
- Considerations for selecting interventions, including:
- Evaluation of interventions
- Successful engagement and selection of comprehensive interventions

NOTE: This chapter is not able to describe all interventions used in psychology, counselling, and psychiatry, but highlights the most common evidence informed approaches for persons with co-occurring mental illness and substance use and problem gambling. Moreover this chapter lists the interventions that are currently used and some emerging interventions within AHS AMH inpatient, outpatient, residential and community treatment areas.

Terms and definitions

For the purposes of this chapter, the following terms and definitions will be used as follows:

Care team: team of people who work collaboratively with the individual, their family and other health providers to ensure the individual receives the support needed to achieve goals in their recovery journey (may include family physician, elder, community counsellor, probation officer, psychiatrist, addiction worker, mental health clinician, peer support worker, housing support worker, outreach worker, teachers, etc.)

Comprehensive interventions: the combination of treatments, therapies and strategies that are part of an integrated treatment plan for a person with a concurrent disorder.

Co-occurring disorders/concurrent disorders: a combination of mental health disorders and either substance use disorders or problem gambling.

Family: for the purposes of this document, "family" refers to persons who the individual considers as being part of their support system, including immediate relatives, extended family, partners, friends, advocates, cultural supports, guardians, etc.

Individual or person: "individual" or "person" refers to the person, patient, or client in question who has a concurrent disorder and is working with clinicians, family and/or others on recovery, treatment or care. These two terms will be used interchangeably.

Informed consent: consent provided by the individual, or their family as appropriate, to allow their provider to release information and/or agree to treatment after the individual, the family as appropriate, and their care team understand the benefits and risks of all options.

Integrated treatment planning: recovery planning that includes the individual, their family and the care team to support them in setting goals for their recovery, and where there is shared responsibility to develop a single recovery plan addressing both addiction and mental health issues.

Service coordination: services are focused on the individuals needs and strengths and may include basic needs (housing, food, financial, legal, medications, crisis, etc.), as well as addiction and mental health issues by advocating for the individual and/or their family.

Treatment/intervention: specific strategies or therapeutic techniques for concurrent disorders, diagnoses or symptoms of the diagnoses. Synonyms for the term treatment include therapy, intervention, help, counselling and care. Treatments can be acute interventions to establish safety, short or long term interventions towards recovery goals, and strategies to support socio-economic factors that impact the recovery journey. For the purposes of this document we will also use the term 'intervention' interchangeably with treatment.

Recovery: recovery is an individual journey and the goals of the individual may include living a satisfying, hopeful, and contributing life, even when health problems and illnesses cause ongoing limitations. Implementing recovery-oriented practices that will enhance health outcomes and quality of life for people with lived experience and their families (Mental Health Commission of Canada, 2015).

Recovery journey: a process of change through which and individual can improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Comprehensive interventions

What are comprehensive interventions?

Interventions are the therapies, medications, treatments and other strategies used to help an individual with co-occurring issues on their recovery journey.

What is meant by comprehensive interventions is the set of interventions that are used to help the person reach their recovery goals.

Multiple interventions have been shown to be effective in the treatment of concurrent disorders, however, the best way to match the type and intensity of treatment with the individual person is not always clear. An understanding of all of the different types of interventions that exist and their typical use is important so that you and the individual can help select a comprehensive set of interventions to meet the person's needs at any point in time.

Integrated treatment plans may involve a variety of holistic treatment options as well as a range of services that include case management and addressing other social determinants of health or other factors, like housing and transportation.

Key messages

Ensure the individual and their family, as appropriate, is at the centre of the decision-making for selecting interventions.

Understanding the numerous types of interventions available will assist you in working with the person to help determine which interventions best suits their needs.

Selecting comprehensive interventions with and for a person requires consideration of numerous factors related to the interventions including availability, duration, timing with other interventions, and treatment setting.

The degree of collaboration and interest in selecting interventions may differ for each person depending on their diagnosis, intentions, strengths, diagnosis, recovery goals and treatment strategies etc.

Selection of interventions needs to be inclusive and respectful of the person seeking treatment, clinician and/or treatment team, and family members.

Comprehensive interventions and Alberta Health Services

Alberta Health Services *Patient First Strategy* (2015) can be applied to working with individuals with concurrent disorders. The strategy is about strengthening AHS' culture and practices to fully embrace patient-and-family centred care (PFCC) at AHS.

Promoting respect is one of the sub-themes of the strategy where "respect is promoted with the goal of creating a culture of safe and collaborative patient-provider interactions where goals of care can be shared, opinions respected without judgment, expectations articulated in a clear and timely way, concerns recognized and addressed from the moment they are expressed, and expectations of care are reasonable and agreed upon by all parties" (Alberta Health Services, 2015, p. 10).

More in depth information about the *Patient First Strategy* can be found here: http://www.ahs.ca/assets/info/pf/first/if-pf-1-pf-strategy.pdf

Some examples of comprehensive interventions for concurrent disorders include:

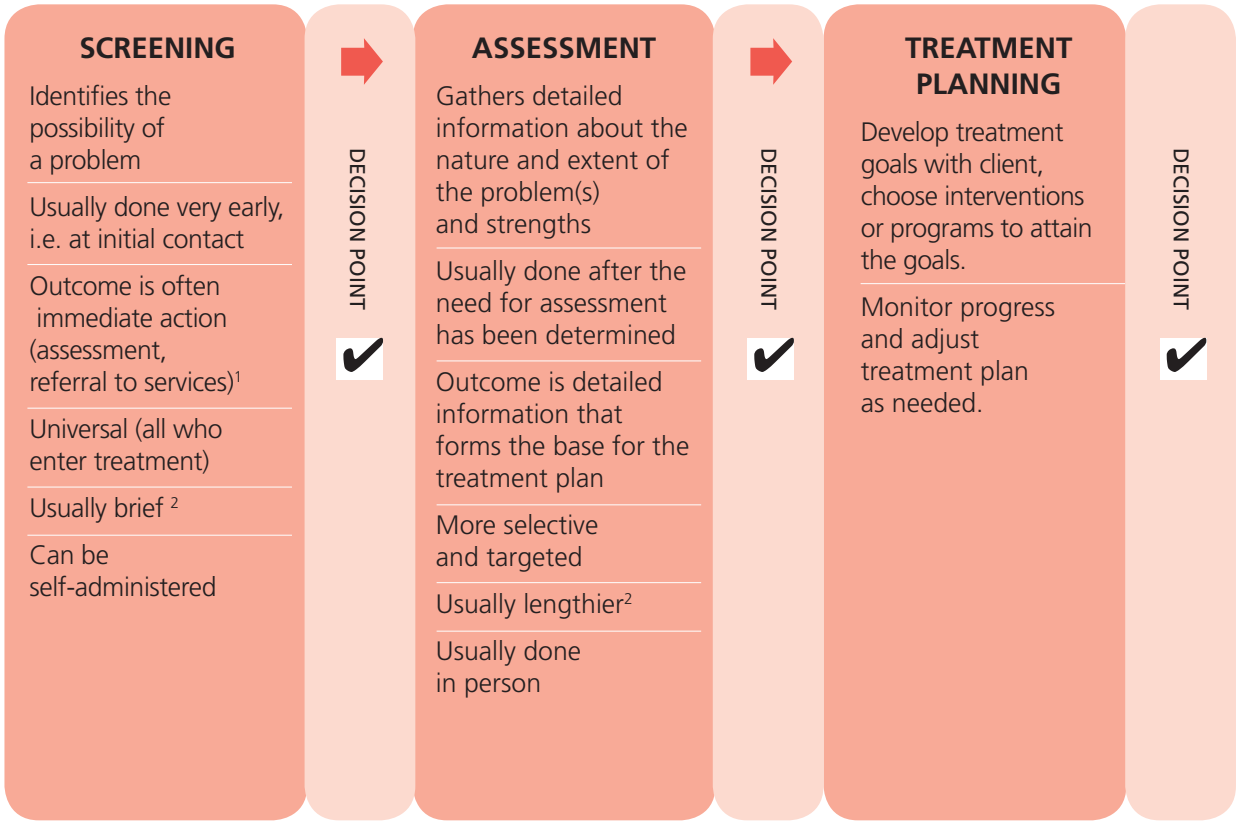
- A person with co-occurring chronic pain, depression and opioid use disorder and taking an opioid replacement therapy like methadone, and who wants to maintain their full time job, can arrange for "early dispensing" at the methadone clinic to receive their dose as early as seven o'clock in the morning.
- A person experiencing homelessness, bipolar affective disorder and alcohol use disorder is helped to attend an Assured Income for the Severely Handicapped (AISH) and Housing First application appointment with a Peer Support Worker (PSW). The PSW picks them up, attends the appointment with them and then takes them for coffee after.

Clinical decision making: Comprehensive interventions

As discussed in previous chapters, screening, assessment and treatment planning can overlap, yet they have unique qualities and follow a progressive timeline. The sequencing of the three activities makes sense – each process builds on the other process as shown below. Between each process is a decision point where the clinician, in collaboration with the individual, and/or family, decides what to do next.

Collaborative treatment planning with a client and his/her family requires understanding what treatment options are available and what the best fit is for the individual based on factors like duration of the intervention, location of the intervention, and more.

Clinical Decision-Making Process



[1] While assessment may identify immediate needs, it is usually more concerned with longer-term treatment planning and service co-ordination.

[2] Some assessment tools may actually be briefer than some screening tools if the assessment tool focuses only on specific disorders, and the screening tool is multidimensional in its coverage.

The standard approach to concurrent capable practice

While this chapter will focus on the types of interventions that may be used to ensure person and family centered, recovery-focused and trauma informed care, it is a good time to review the overall process of Concurrent Capable Practice as a whole. As discussed in previous chapters, The Standard Approach to Concurrent Capable Practice algorithm outlines a process for concurrent capable practice as outlined in the Figure below. Collaborative treatment planning with a client and his/her family involves selecting the right combination of interventions. It is important to recognize that even though the process has certain steps, it is also cyclical in nature and is a process of ongoing re-assessment and continuous care that changes as goals are met and priorities shift.

A Standard Approach to Concurrent Capable Practice

First contact with person

EVERY DOOR IS THE RIGHT DOOR…

Concurrent Capable Addiction Services

Concurrent Enhanced Programs Integrated AMH Teams

Concurrent Capable Mental Health Services

WELCOME AND ENGAGE

Observe and gather information on appearance, behaviour and cognition (ABC) and review history, while establishing rapport and engaging individual/family

SCREEN FOR CONCURRENT DISORDERS

Using a reliable tool (GAIN-SS, DSM-V CC, etc.) identify the presence of a mental health, addiction or concurrent disorder

BRIEF INTERVENTION

- Solution focused
- Single session or more (5-10)
- Crisis intervention

KEEP AND CONSULT

Consultation, collaboration and coordination with other service (addiction or mental health) and other involved service providers

WARM HANDOFF

- Mental Health
- Addictions
- Concurrent Enhanced Service
- Community supports

COMPREHENSIVE ASSESSMENT

- Recovery oriented, collaborative process that is person-centred, trauma informed and strengths based
- Involves person/family and other services providers in care coordination
- Reassessment is ongoing throughout the recovery journey with shifts in treatment planning as needed

INTEGRATED TREATMENT PLANNING

COMPREHENSIVE INTERVENTIONS

TRANSITIONS IN CARE

Comprehensive interventions: An integral part of your practice

Comprehensive interventions are the combination of treatments, therapies and strategies that are part of an integrated treatment plan for a person with a concurrent disorder.

This chapter will help you reflect on what kinds of Comprehensive Interventions you are using and how can you expand your toolbox, the tools you can offer when working with individuals.

As you learn more about the individual, their goals, their motivation, and their experiences you can work with them to ensure that the comprehensive set of interventions used to help them recover are the best fit for them.

As the person's goals and needs are identified through a collaborative process, you have already begun to think about how you can best support them through their recovery journey. You may begin to identify what stage-matched interventions might work for them based on availability, duration, timing, intervention location or setting, and personal recovery plan. Matching interventions to the stage in which the individual is at regarding their behaviour change and their treatment best helps to support their recovery goals.

Example:

1. A person with anxiety, prescription drug misuse and alcohol use disorder, who works full time during the day and is offered the option to attend the evening anxiety support group so he can maintain employment
2. A person with schizophrenia and cannabis use disorder smokes one pack of cigarettes per day and is receiving clozapine therapy and therefore may experience morning somnolence and is given the option to attend an afternoon concurrent disorders group.

Engaging individuals and families to choose interventions

Selection of comprehensive interventions should be done from a person and family centred lens, engaging with the individual, and their family whenever possible, to receive treatment and understanding their needs, goals, concurrent disorder diagnosis and more. Introducing intervention options to an individual should be carried out in a recovery-oriented way and allow for personal input and involvement, empowerment and choices.

There are several techniques one can use to engage with the individual: person and family centred, recovery-oriented and trauma informed approaches are outlined in the previous chapter *Integrated Treatment Planning*.

Some basic approaches include:

- Engaging with individuals in a calm manner
- Working with individuals in a holistic manner
- Using effective and positive communication
- Understanding the individual's world and goals
- Providing acceptance and empathy
- Using active and reflective listening
- Asking permission to discuss aspects of their concurrent disorder issues and symptoms

What is known is that evidence suggests that

> [person] factors account for more variance in treatment outcome than any other factor, such as the person's participation

(Addiction and Mental Health Collaborative Project Steering Committee, 2014, p. 34).

Another important factor in successful recovery for individuals is the alliance that develops between the individual and the therapist or care team members. This is known as the therapeutic alliance.

Therapeutic alliance

Therapeutic alliances can have great influence on patient outcomes and is often referred to as the therapist-client relationship, and is typically built over time.

Hope and expectancy are two of the most powerful predictors of treatment outcome (accounting for over 30% of treatment outcome).

The capabilities of the therapist/counsellor or care provider to be honest, empathetic and to establish a trusting relationship with individuals in a short time are key elements of the alliance.

A therapeutic alliance supports individuals to be empowered and hopeful, and allows an individual to move forward in their recovery journey.

Recovery oriented care

Recovery oriented care of individuals with concurrent disorders includes empowering the person to address a wide range of needs outside of their diagnosis, including supports for housing, employment, education, family, healthy eating and basic health promotion in order to building a meaningful, hopeful and successful life.

> Recovery-oriented services do not address addictions and mental health problems sequentially, do not use exclusion criteria or impose treatments. Recovery-oriented practitioners and providers work with people at whatever happens to be their current state and respect the choices, autonomy, dignity and self-determination of service users. They see to people's safety and offer support for harm reduction, positive risk-taking and continual personal growth

(Addiction and Mental Health Collaborative Project Steering Committee, 2014, as cited in Mental Health Commission of Canada, 2015, p. 13).

The relationship between mental illnesses and problematic substance use is complex. For some people, mental health problems can be risk factors for problematic substance use; for others, problematic substance use contributes to the development of mental health problems.

Despite some differences in approaches to providing support and treatment, the vision and principles for recovery in addictions and mental health are complementary and overlapping. They both:

- Acknowledge the multidimensional nature and complexity of issues
- Appreciate that recovery is a personal journey, with goals defined by the individual
- Recognize the significance of family, peers, workplaces and a community of support
- Understand the need for collaboration across sectors, particularly in relation to social determinants
- Are founded upon hopeful, strengths-based approaches in pursuit of well-being, quality of life and full citizenship

> Integrating mental health and addictions services at both the systems and practice levels provides the most helpful support for recovery

(Addiction and Mental Health Collaborative Project Steering Committee, 2014, as cited in Mental Health Commission of Canada, 2015, p. 13).

As a member of the care team–this comprehensive aspect of care means that you need to be thinking about the individual as a whole and asking them what interventions they are using or need to address social determinants of health in their lives.

For example:

- Do you have the support of friends of family?
- Do you have the opportunity for leisure activities and what are you doing?
- What are your living conditions like?
- Do you need help with budgeting your finances?
- How are your children doing?
- Do you need any parenting resources?

For more information about the Social Determinants of Health, check out previous chapters in the Enhanced Concurrent Capability Toolkit.

Here is one model that outlines recovery-oriented components:

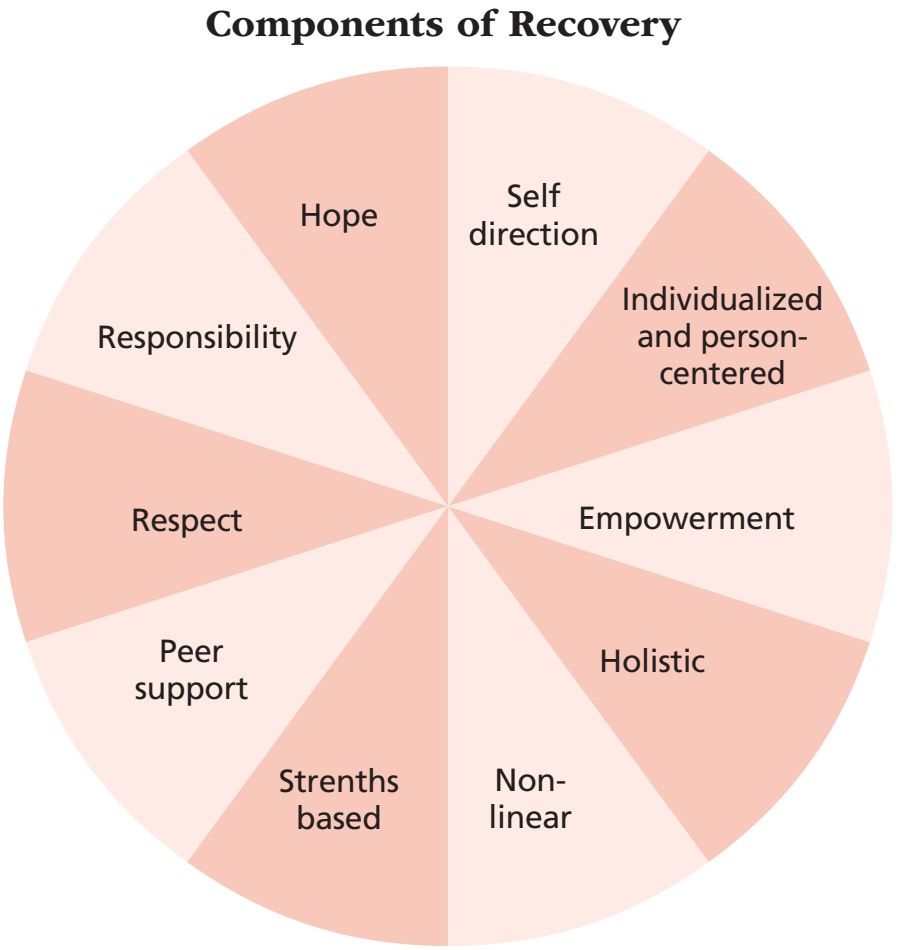


Figure 1. Components of Recovery. Reprinted from American Psychological Association. Retrieved February 13, 2017 at http://apa.org/pi/mfp/psychology/recovery-to-practice/index.aspx

Other components considered in recovery may include:

- Past addiction related issues
- Occupational, school and financial responsibilities
- Spirituality and support groups
- Recreational and leisure activities
- Interpersonal relationships
- Physical wellness
- Self-management
- Emotional and mental wellness
- Goals and aspirations
- Empowerment
- Social inclusion
- Culture

Recovery oriented interventions are shaped around many factors, unique to each individual and dependent on their stage of treatment. Examples of interventions that address aspects of recovery are:

- Supported housing
- Supported employment
- Continuing education
- Collective kitchens
- Art therapy
- Music therapy
- Pet therapy

Promoting full citizenship

Key to recovery-oriented practice are efforts to remove barriers to social inclusion and support for people to live fully engaged lives within their communities. Participation as full and equal citizens in meaningful social and economic roles is not seen as something reserved for when people "get well," but rather as a fundamental pathway to recovery.

> Promoting recovery shifts the focus of service beyond exclusively managing symptoms to supporting positive evolution in all aspects of people's lives – social, psychological, cultural, sexual and spiritual.

Recovery-oriented practice strives to ensure that people have choice in accessing a full range of service options, including specialized psychiatric services, psychosocial rehabilitation, cognitive and behavioral therapies, substance abuse treatment and trained peer support workers. Psychosocial rehabilitation, for example, is an evidence-based practice that uses tools recognized for promoting recovery that should be made available as early as possible.

Treatment options and strategies can include various types of approaches and target different types of individuals, including families. Comprehensive interventions for persons with concurrent disorders needs to offer options for both mental health and substance use issues.

Along with understanding where an individual is at on their recovery journey, the stage of change and treatment they are at, it is equally important to understand the other aspects of interventions that should be considered.

The complement of factors that make up how an intervention is delivered, by whom it is delivered, where it is delivered, and what the intervention is targeting can factor in to how well it would meet an individual's recovery goals.

The delivery mode, locations and settings of interventions comes in many forms and can include:

- Individual or group therapies, including family therapy
- Professional/clinician-led or peer-led
- Privately or publicly managed funded
- Formal or informal
- Wellness or treatment focused
- Prevention or action focused
- Cultural interventions

Other aspects of interventions to consider with an individual's recovery goals, stage of change and stage of treatment include:

- Personal motivation
- Personal goals
- Cultural sensitivities
- Concurrent issues and the severity of the issues
- Availability of services i.e. rural or urban setting
- Access to services i.e. transportation, mobility, cognition to navigate
- Social environment or milieu i.e. services provided in schools, inpatient or outpatient settings
- Family involvement or support
- Community or cultural settings i.e. friendship centres for Indigenous persons or families, or community organizations
- Setting i.e. residential, community, inpatient, or outpatient, and
- Social determinants of health i.e. age, gender, sexual orientation

You will get a better sense of these factors as you work with the individual through screening, assessment and treatment planning and by understanding the health system and service options available.

> The most important point to remember when considering interventions, is that it occurs in collaboration with the individual and family that will be treated, and that it fits with their recovery plan and needs.

Review: Understanding stages of change & stages of treatment

Interventions are most effective when they are consistent with and determined by each individual's stage of treatment and stage of change. Recognizing what stage an individual is at can help determine which interventions are most likely to be successful at a particular point in treatment and recovery.

Two models help with this:

- The Stages of Change Model – which describes the process of behavioural change
- The Stages of Treatment Model – which describes the phases of treatment

For more information about these models check out the Integrated Treatment Planning chapter.

Intervention factors and formats

The best way to collaborate with the individual to develop the most successful recovery journey is to ensure they understand all available interventions and supports open to them and the benefits and risks of each.

The next part of this chapter will explore the various modes of delivery, factors and formats for consideration when selecting an intervention, including intervention settings, duration, environment and delivery mode. Examples of how these interventions are used will also be provided.

> Recovery oriented practice acknowledges the unique nature of each person's journey of wellness and everyone's right to find their own way to living a life of value and purpose in the community of their choice

(Mental Health Commission of Canada, 2015, p. 24).

Setting

1. Settings can influence the type, priority and timing of interventions that can be done because settings may also correlate to an individual's stage of treatment. Identifying which setting is best may also depend on proximity to the person requiring treatment, availability of services, their co-occurring issues, and need.
2. For example, if an individual is acutely psychotic and is admitted to a psychiatric intensive care unit, the priority would be to ensure the individual is stabilized and a Safety Plan guides close observation, the use of appropriate intervention approaches, and pharmacological interventions i.e. injectable medication as needed, and rapid medication changes (Quadrant IV, Tier 5).
3. The setting in which the individual is in, or where they are able to receive treatment, is often influenced by the acuity of individual or the stage of change.

Comprehensive interventions are available to family members and individuals and there are a number of settings in which treatment interventions take place, including, but not limited to:

Type of Setting	Description
Residential or Inpatient	This setting could be a residential treatment centre or hospital setting.
Community or Outpatient	This might include community clinic, agency service providers, outpatient services, assertive community treatment teams, and outreach i.e. meeting people at their residence or local coffee-shop.
Supportive/group housing	This is a home where individuals live in homes with support workers and may include regular contact with informal peer support workers and community clinicians

Other examples include:

- **Hospital settings** may be appropriate for persons who cannot be treated safely as an outpatient because of factors like risk of suicide or harming others; or detox settings for medically complicated withdrawal needs.
- **Inpatient or residential settings** may be useful for persons who require a structured and supportive environment to enable them to participate in treatment. Hospital settings also allow for more intensive treatments like daily individual and group counselling, rapid medication changes, recreation/occupation therapy and/or Electroconvulsive Therapy.
- **Outpatient settings** may provide better opportunities to challenge a person's ability to live in community with others and learning and recovery can take place where support from carers, family and friends may be available to a greater extent.

For more information on treatment settings, refer to the following article:

Tiet, Q.Q., Schutte, K.K., (2012). Treatment Setting and Outcomes of Patients with Co-Occurring Disorders. Journal of Groups in Addiction & Recovery. 7, 53-76.

Environment or milieu

A milieu is defined as a 'person's social environment'. This factor needs to be taking into consideration when selecting interventions because the environment in which a person spends their time may enhance or inhibit their treatment.

Duration and amount of intervention

The duration, or length of time of a treatment, along with the amount of treatment required or needed should be considered. Some questions to consider when planning treatment, and depending on availability of treatment options, include:

- Should the intervention be daily, weekly, monthly?
- Is this a one-time or recurring treatment? Establish the number of weeks/months to participate in intervention for most benefit as part of individuals recovery oriented short and long term goals

Timing and use of interventions

Similar to above, the timing and use of interventions need to be considered when selecting treatment options. Key to this is understanding how a combination of interventions selected for comprehensive treatment for concurrent disorders work together in terms of effectiveness, timing and use.

Examples:

1. A person starting on clozapine therapy wants to reduce or quit smoking, the clinical team needs to consider how fluctuating nicotine levels will affect clozapine levels. Because nicotine cessation is a short term recovery goal along with medication therapy as long term treatment for thought disorders, it is necessary to consider if treatment of one should be focused on first, or simultaneously; and how the use of one intervention may impact another.
2. A person with anxiety and who works full time during the day can enroll in the evening anxiety group to maintain their employment.

Individual or group interventions

Consideration and respect for the person's needs, social tolerance, their ability to participate, and interests/preferences should be used as a guide to help choose the individual or group intervention format.

Individual therapies or interventions

Individual therapies can be provided in the public health system or privately, and are typically done with psychologists, doctors, nurses, addiction specialists, mental health workers or other care team members.

Individual therapy:

- Typically has an intake process.
- Is typically delivered in 45-60 minute timeslots and for a set number of sessions.
- Can be run by a variety of clinicians or counsellors.
- Is offered both in the public health system and privately.

Advantages of individual therapy include:

- Allows the therapist to focus his/her attention solely on the individual
- The ability for treatment to be individualized based on stage of change, motivation and individual goals.
- Good option for persons to work on issues that they believe are too sensitive to discuss in a group setting.
- Allows for the development of close working relationships and therapeutic alliances.
- Good method for exploring personal motivation and personal goals.
- "Individual psychotherapy has been shown to be somewhat effective when motivational interviewing and cognitive-behavioural treatment are used" (Burnett, 2011, p. 851).

Individual therapy case example:

A person with social anxiety, depressive disorder and cannabis use disorder has indicated anxiety in group settings and works day shifts. She might best benefit from interventions available in the evenings and weekends and that are structured for individual one-to-one sessions with a therapist.

Group therapies or interventions

Group therapy can be a primary therapeutic modality or an adjunct to individual therapy. Psychodynamic group therapy is an example of using groups as a primary intervention where guided by Yalom's group theory, the group process leads to change and wellness for the person. This type of group psychotherapy is used with specialized populations, such as

- family violence prevention evening programs,
- sex offender treatment within in remand centres, or
- Dialectical Behaviour Therapy day programs for persons experiencing borderline personality disorder.

Group therapy used most often for concurrent disorders would be where it is in addition to individual therapy and is support focused, skill building and providing psychoeducation. The group setting is designed to provide persons with a safe environment to share their feelings, thoughts and actions; and to learn and gain hope from peers who may have had a similar journey/experience. A group setting can be a comfortable place to discuss issues such as family relationships, medication side-effects and relapses.

Groups can be:

1. Support groups
2. Skills training groups
3. Psychoeducation groups

Group therapy:

- Can be offered publicly or privately by trained professionals or peer support workers.
- Usually consists of up to 10 people in professional settings and more in peer-led or community settings.
- Can be offered as open or closed groups – where membership is required for closed groups and open groups often allow for drop-in participants.
- Can be diagnosis or concurrent disorder specific. E.g. anxiety support group, concurrent disorder group

Advantages of group therapy:

- It is cost-effective as counsellors or therapists can see more people at one time.
- Most persons experiencing concurrent disorders benefit from this treatment.
- Almost all persons, regardless of diagnosis, can participate in this treatment when grouped accordingly.
- Peer support can be provided in a group setting and individuals can be challenged in a safe environment.
- Supportive counselling for other stressors of social and economic factors can be provided
- Positive peer support is provided and allows individuals to witness how others are dealing with the same issue.
- It can reduce the sense of isolation people may feel when dealing with issues.
- Hope and empathy to and from group members is often experienced.

Group therapy can include intentional use of approaches such as cognitive behavioural therapy, interpersonal therapy and psychoeducation.

Group therapy case example:

A person experiencing bipolar 1 disorder, who is pre-contemplative about the cocaine use may prefer a drop in group that would be welcoming, open and accepting each time she is able to attend.

Group therapy resources

The Centre for Addiction and Mental Health's (CAMH) 'A Family Guide to Concurrent Disorders' is an excellent resource to use for group or family therapy. There are worksheets and exercises included in the document that may be used. Check it out at: http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/concurrent_disorders/Documents/partnering_families_famguide.pdf

Check out Appendix A for an excerpt about 'Ground Rules for Support Groups' and an 'Outline for Running a Group', or more detailed information about groups in Mueser, K.T., Noordsy, D.L., Drake, R.E., Fox, L. (2003). Integrated treatment for dual disorders a guide to effective practice. New York, NY: The Guilford Press.

Overview

Along with an individual's personal motivation, recovery goals, co-occurring issues, when considering intervention factors and formats, one should also consider the stages of treatment and stage of change of an individual.

Interventions are designed to address different aspects of treatment through a variety of strategies, and many are available in an assortment of settings, varying durations, times of day or week or month, and amounts i.e. daily, weekly, in the community, and as individual or group therapies. Ideally, individuals would be stage-matched to all of their needs, including setting, timing, duration of interventions – however, realistically, intervention factors and formats are often based on availability of resources, an individual's situation, and other factors.

Key messages

Selecting a set of comprehensive interventions must take into consideration not only personal willingness and personal goals, but treatment settings, format, duration and amount, and timing and use of the interventions.

Interventions should be based on the individual's motivation for treatment.

Ideally, stage-wise interventions should be considered based on where an individual is at with stages of change and stages of treatment; realistically interventions may also be selected on other factors such as accessibility.

Group and individual intervention modalities should be selected on a variety of factors, including the patient's ability to participate and benefit from either setting.

Comprehensive interventions and treatment focus not only on the individual's concurrent disorder diagnosis but all other aspects that impact their world, including housing, employment, general health, outreach etc.

When working with children, family support and involvement is imperative and should be considered in selecting comprehensive interventions.

Comprehensive interventions should support all aspects relevant to an individual's recovery goals in a respectful, non-judgemental way.

Approaches and interventions

The goal here is not to describe each and every type of approach or intervention in detail, but to know they exist and have a brief understanding of them so that you can think about what options are available for individuals on their recovery journey.

Approaches

Approaches guide the way you interact with an individual in such ways as setting the tone of the interaction, how time is spent with an individual, the types of questions you may ask, whether you are actively participating in the discussion or just listening, and whether you are taking notes or providing advice. Important to note that with any one approach there are limitations - one modality doesn't treat all. The need to understand the individual, their concurrent disorder, their family system, their stage of treatment and change, their goals and other circumstances are all a part of identifying what approach may be best.

NOTE: This chapter is not able to describe all approaches interventions used in psychology, counselling, and psychiatry, but highlights the most common evidence informed approaches for persons with co-occurring mental illness and substance use and problem gambling. Moreover this chapter lists the interventions that are currently used and some emerging interventions within AHS AMH inpatient, outpatient, residential and community treatment areas.

The following common approaches will be described below:

1. Brief Solution-Focused Therapy
2. Cognitive Behavioural Therapy (CBT)
3. Collaborative Problem-Solving
4. Dialectical Behavioural Therapy (DBT)
5. Motivational Interviewing (MI)
6. Narrative Therapy
7. Psychodynamic Therapy
8. Systems Counselling

1. Brief Solution-Focused Therapy

Brief solution-focused therapy is a strengths-based, therapy that can be beneficial for individuals with concurrent disorders as it

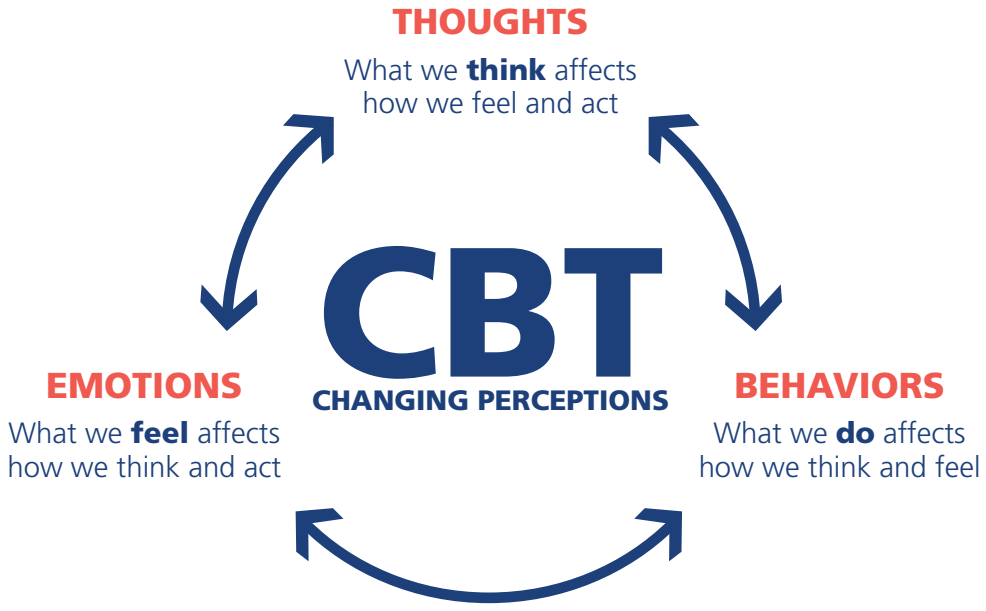
focuses on building solutions to reach desired goals. This can be conducted in an individual or group setting. This is typically a short-term therapy lasting a few weeks to a few months. **These sessions usually focus on a specific, current issues or problem such as death, divorce, parenting issues, or a specific phobia; or working on a specific goal.** Solution-focused therapy uses language and social interactions to construct new psychological meanings and behaviours, emphasizing what the individual wants to achieve, instead of focusing on the individuals problems.

2. Cognitive Behavioural Therapy (CBT)

Cognitive Behavioural Therapy (CBT) is a brief, short-term, problem-oriented approach and helps persons focus on problems that come up in day-to-day life. CBT is an umbrella term that describes therapies that focus on thought and beliefs as the solution to emotional regulation. **It is a talk therapy that focuses on modifying thought patterns to being about immediate understanding of the relationship between one's thoughts, behaviours and feelings or emotions.** CBT is often used when individuals are in planning and maintenance stages of change and can be offered as individual or group therapies.

CBT is often used to treat issues of anxiety, depression, stress, substance abuse and eating disorders.

The following diagram depicts CBT models:



More detailed information about CBT can be found in the document: Rector, N. (2010). Cognitive-behavioural therapy: an information guide. Centre for Addiction and Mental Health. https://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/Acute-Stress-Disorder/Documents/cbt_guide_en.pdf

3. Collaborative Problem-Solving

Collaborative Problem Solving (CPS) is an approach to treatment which was initially designed to be used with children with challenging behaviours. However, it has now been adapted to suit any individual, regardless of age, with challenging behaviours. **It can also be used in any area of life to resolve conflict and work through the most basic problems.** One study found that it focuses on individuals having a lack of skills to adaptively respond to demands and "that maladaptive behaviour (defiance, outbursts, etc.) will instead arise" (Pollastri, Epstein, Heath, & Ablon, 2013, p. 190).

4. Dialectical Behavioural Therapy (DBT)

Dialectical behavior therapy (DBT) treatment is a cognitive-behavioral approach that emphasizes the psychosocial aspects of treatment. The theory behind the approach is that some people are prone to react in a more intense and out-of-the-ordinary manner toward certain emotional situations, primarily those found in romantic, family and friend relationships.

Grohol (2018) describes how DBT theory suggests that some people's arousal levels in such situations:

- can increase far more quickly than the average person's
- attain a higher level of emotional stimulation
- take a significant amount of time to return to baseline arousal levels

Dialectical Behavioural Therapy (DBT) focuses on:

- the awareness of problems and choices
- mood regulation techniques
- coping skills

DBT is considered a useful treatment approach for persons with some concurrent disorders, especially co-occurring Bulimia Nervosa and Substance Use Disorder

(Carbaugh, 2010, p. 131).

DBT was originally developed to address the needs of suicidal women, and evolved into a treatment for suicidal patients who also met the criteria for borderline personality disorder (BPD). DBT has grown and been used to treat a variety of problems, including binge eating and bulimia, dissociative disorders, and substance abuse. It has been adapted for use in inpatient services and partial programs as well as for use with adolescents, elderly people, and couples.

DBT is usually done in a closed group setting and often as day treatment.

Generally, DBT has:

1. an individual weekly psychotherapy session focused on problem-solving behaviour for the past week's issues in the individual's life
2. weekly group therapy sessions where people learn skills from different modules such as:
   - interpersonal effectiveness
   - distress tolerance/reality acceptance skills
   - emotion regulation
   - mindfulness skills

> **Both between and during sessions, the therapist actively teaches and reinforces adaptive behaviors, especially as they occur within the therapeutic relationship. . .**
> **The emphasis is on teaching patients how to manage emotional trauma rather than reducing or taking them out of crises. . . .**
> **Telephone contact with the individual therapist between sessions is part of DBT procedures**

(Linehan, 1993, as cited in Grohol, 2018).

5. Motivational Interviewing (MI)

Motivational Interviewing (MI) shares similarities to a person centered approach in that it combines elements of warmth, empathy and acceptance that helps people prepare for behavior change. **It is designed to help individuals explore and resolve their ambivalence, enhance their intrinsic motivation and build confidence in identifying their own reasons for change.** It is most often used with individuals that are in the pre-contemplation/ contemplation stage of change.

Using motivational interviewing as a communications method when engaging with an individual helps you to:

- Express empathy
- Develop discrepancy
- Use sustained talk – and avoid argumentation
- Support self-efficacy

The basic skills of motivational interviewing include the following, known as OARS:

- **O**pen-ended questions
- **A**ffirm
- **R**eflective listening
- **S**ummarizing

Motivational interviewing skills	Examples of how to apply skills
Open-ended questions	Use this: I understand you have concerns about your concurrent disorder. Can you tell me about your substance use and how this has been affecting your mental health? Tell me what you like about your _____ (insert: drinking, drug use, risky/problem behavior). In what ways does your situation with substances concern you? In what ways does this situation impact your overall mental health? What is one thing that you might do for your mental health in this area? How would you like things to be different? Not this: Are you concerned about your substance use and how it is affecting your mental health?
Make affirmations	You must have a lot of strength/courage/resolve to come today despite your strong reservations about treatment. Or I appreciate this is not an easy topic for you to discuss. Thanks for hanging in there.
Use reflections	What I hear you saying is that your substance use is really not much of a problem right now. What do you think it might take for you to change in the future?
Summarize	If it's ok with you, let me check out that I understand everything we've discussed today. You've been worried about your substance use in recent months because it's impacting your relationship with your family and may be contributing to some health issues you are having. But the few times you have tried to stop using haven't been easy and you are worried you can't stop? How am I doing? Does this sound right?

Resources on Motivational Interviewing

Canadian Centre on Substance Use and Addiction (2017). The Essentials of… Series. Motivational Interviewing. Canadian Centre on Substance Abuse (CCSA). ISBN 978-1-77178-419-7. Retrieved January 23, 2018 at http://www.ccsa.ca/Resource%20Library/CCSA-Motivational-Interviewing-Summary-2017-en.pdf#search=all%28essentials%20of%29

> Motivational interventions are used to treat persons in all stages of change, but especially in the persuasion stage. For instance, substance abuse counselling, using a cognitive-behavioural approach, is used to treat consumers in the active treatment and relapse prevention stages

(U.S. Department of Health and Human Services).

6. Narrative Therapy

Narrative Therapy is an approach that allows an individual to tell their story, usually in a written format, and then separating themselves from it, and trying to take on a more positive version of the story. Essentially the individual is the narrator, and gets to 're-author' his or her life stories by focusing on positive interpretations, and emotion-focused therapy, which enables the person to realize his/her emotions. **Thus, narrative therapy can be a useful approach in the treatment of depression and is widely used in counselling, family therapy and social work.**

Narrative therapists take the role of supporting patients in order to help them find positive identities. They begin with the premise that the problem is not the person, but is the problem itself. Narrative therapists listen to the negative stories of people with depression and search for unique outcomes and experiences in which patients successfully solved problems in the past.

Principles of narrative therapy are that (Freedman & Combs, 1996, as cited in Christenson & Merritts, 2017, p. 33):

- there is not one universal reality but reality is socially constructed;
- language constructs reality;
- reality is maintained through narratives; and
- not all narratives are equal

More information on Narrative Therapy can be found in DeMille & Montgomery, 2015, and Seo, Kang, Lee & Chae, 2015.

7. Psychodynamic Therapy

Psychodynamic therapy involves exploring the client's beliefs and inner states, even when the client may not be completely conscious of them. **This therapy is usually done in a group setting and allows for individuals to have immediate experience of collaborating and contending with others.** Feedback comes from people responding primarily subjectively. Group members receive candid and multifaceted views of how they are experienced by others. Members also see how other group members deal with specific kinds of interactions; new behaviours are modeled, and multiple techniques are demonstrated. If a model seems useful, the patient can then experiment with the model and, if the experiments are successful, practice the new behaviour within the group. This leads to an increase in coping skills.

Psychodynamic Therapy is typically used for depression, mood and borderline personality disorders, but not for severe thought disorders.

"Five basic psychodynamic principles form the foundation of all psycho-dynamic psychotherapies (Alonso, 1989, as cited in Swiller, 2009):

1. Psychological determinism (i.e., psychic states have psychic causes)
2. Existence of unconscious processes
3. Dynamic motivation (i.e., thoughts, feelings, and behavior are driven by the desire to gratify a variety of basic instincts)
4. Epigenetic development (i.e., new psychological developments do not displace old ones but are layered on top of them, and the old patterns and complexes continue to exist)
5. Existence of persistent mental structures with aspects of thoughts, feelings, and behaviour that tend to be mobilized in their entirety"

Five norms of psychodynamic therapy groups

To establish a psychotherapy group – these five norms are of particular importance (Alonso 1989; Alonso and Swiller 1993, as cited in Swiller, 2009):

- **Honesty.** Group members assume the obligation to respond to one another with maximum candor, and the consequent discussions are spontaneous and emotionally rich.
- **Respect.** The honest expression of feelings does not mean self-indulgence; civility has its place. Communication is exclusively verbal, and impulses to act are expressed verbally, never enacted.

  Discussing the recent death of her father, Ms. E began to weep. Ms. F, seated next to her, reached over to take her hand. Ms. F was encouraged to put her feelings into words rather than action, and this led, for the first time, to her expression of loss when her father, following her parents' divorce when she was 7, lost contact with the family.
- **Industry.** Industry involves doing the work of therapy in the psychotherapy group itself. The expression of thoughts and feelings is not an end in itself but forms the data set for meaningful and probing inspection.
- **Responsibility.** Each member must do his or her fair share. Every member has the responsibility to participate with appropriate frequency and to interact with every other group member.
- **Application.** The gains acquired in the group experience must be used outside the group in one's everyday life. Although the process of group discussion is most fruitful when focused on the here and now of group, some report of the effect of new knowledge and skills in one's outside life can enhance the relevance of the work.

8. Systems Counselling

Systems Counselling is focused on the family system and how the family responds to and handles problems, and thus how this impacts individuals. As a basic worldview, a systems perspective includes attention to:

- Individuals, problems, and resources in family and sociocultural contexts
- Transactional processes in the couple relationship, family unit, and kin network
- Patterns, critical events, phases, and transitions across multigenerational family life cycles

Despite differences in particular strategies and techniques employed in various systemic therapy models, all approaches focus on direct assessment and change to improve functioning, adaptation, and relationships, rather than a narrow, deficit-focus on reducing pathology of the individual symptom bearer. This is perhaps the major distinction of a family systems orientation from traditional individual psychotherapy models.

In systemic intervention models, the therapist aims to promote change directly with significant family members. Also, the focus is broadened from dyadic to triangular and larger systemic patterns and their influence in problems and change.

It is important to consider all key relationships in the evaluation, to clarify treatment objectives, and to decide whom to include in subsequent sessions. This approach will clarify diagnostic questions, treatment objectives, and the choice of therapeutic intervention. With conditions such as schizophrenia and substance abuse, family members can provide more accurate information regarding symptoms and behavior" (Gabbard, 2009, p. 516).

Check out Appendix B for more examples of references that discuss specific treatment options for specific concurrent disorders.

Exercises: Approach

>| exercise |<

Motivational interviewing I

With a partner, practice the basic skills of motivational interviewing using open-ended questions, affirmation, reflective listening and summarizing.

1. Select a partner
2. Sit across from each other and choose one person to be the individual seeking treatment, and the other to be the clinician.
3. Select a topic to discuss and practice motivational interviewing for five minutes i.e. your vacation, your alcohol use, your job OR use a case example from Appendix F.
4. Switch roles and select a new topic to discuss and practice motivational interviewing.

Questions:

Each person should answer the following questions:

1. What was your experience as the interviewer using the skills for motivational interviewing?

   _____

   _____

   _____

2. How did it feel to be the person being asked the open-ended questions?

   _____

   _____

   _____

Motivational interviewing II

Take a few minutes to review the questions below and determine whether or not they are open-ended questions. If they are not, how would you re-write them to make them open-ended?

>| exercise |<

Question	Open-ended (Yes or No)	If not open-ended, how would you rewrite the question to make it open-ended?
Do you drink often?		
Tell me about your relationship with your spouse.		
Do you have other concerns about your health?		
How did you feel when that happened?		
What did you do when she said that?		
How do you feel?		
Do you exercise?		
What are your reasons for saying that?		
Tell me about your family while you were growing up?		
Are you scared?		
How are you?		
Is your relationship with your spouse a good one?		
What do you think you might do if the test results are positive?		

Interventions

Interventions are the actions taken to improve a situation or that help work towards recovery such as taking medication, participating in groups or individual therapy sessions, using an app to help track your mood etc.

The following interventions will be highlighted below:

1. Computer assisted therapy (CAT)
2. Counselling
3. De-escalation techniques
4. Electroconvulsive therapy
5. Expressive therapy
6. Family interventions
7. Mindfulness exercises
8. Peer support
9. Psychoeducation
10. Psychopharmacological therapy (medication therapy)
11. Recreation therapy
12. Relapse prevention
13. Repetitive transcranial magnetic stimulation (rTMS)
14. Self-help groups
15. Trauma therapies

Remember that each intervention can be offered with a variety of approaches, and in a variety of ways including:

- In a public or private setting or clinic
- By community agencies, government based organizations, primary care networks etc.
- As inpatients or outpatients
- In-person or online through apps
- As individual or group therapies, and
- At all or various stages of change and treatment

1. Computer Assisted Therapy (CAT)

Computer assisted therapy supports the use of technology for treatment and interventions including online counselling, self-help resources, peer-support through social media and other technologies, wearable computing and monitoring through apps, virtual reality, diary keeping and even text messaging. This emerging field is trending in all areas of health and promising research suggests that CAT used alongside individual therapies are having effective results.

For example:

- Skype or other linked technology with the individual, family and counsellor.
- Mood tracking apps used daily by individuals, allow for a summary of their moods emailed to their therapist each week before their session.
- DBT skill toolbox app can be used daily for self-calming and emotional regulation strategies. Weekly reports are sent to the therapist or member of the care team.

> One study found that "computer-based treatment, targeting both depression and substance abuse simultaneously, resulted in at least equivalent 12-month outcomes relative to in-person interventions with a therapist"

(Kay-Lambkin, Baker, Lewin & Carr 2009).

The following diagram outlines some of the current and most popular computer assisted technologies that are supporting e-Mental health services and resources in Canada.

Figure 2. e-Mental Health Services and Resources in Canada. Reprinted from Mental Health Commission of Canada. Retrieved January 23, 2018 at http://www.mentalhealthcommission.ca/sites/default/files/MHCC_E-Mental_Health-Briefing_Document_ENG_0.pdf

2. Counselling

Counselling is a form of psychotherapy where trained professionals provide help and work with individuals to find the most effective means for the individual to address his or her concurrent disorder, drawing on a flexible range of strategies for change. Counselling understands an individual exists within a unique personal environment which includes relationships, places, institutions, organizations and more. A key aspect of counselling is active listening on the part of the professional; letting the individual tell their story and points of view.

As an active listener, you are there to meet the individual's needs and are focused on all aspects of the speaker including their tone of voice, body language and their words.

> For active listening to be really effective it is important that the other person can tell that you are listening carefully. It is important that the individual can sense your undivided attention. This means good eye contact, open body language, tone of voice and receptive verbal cues.

(Wilson, 2014, p. 89).

Summarizing, paraphrasing and making use of silences are all aspects of active listening techniques.

3. De-escalation techniques

De-escalating or managing crisis situations should be focused on minimizing the use of seclusion rooms and physical restraints.

An example of a way to engage the individual and de-escalate potentially aggressive or violent situations is through psychoeducation about emotional regulation. A crisis plan can be developed with the person including:

- how to approach them when they are upset
- what crisis interventions they most and least prefer

This trauma informed and recovery oriented approach empowers the individual to use self-calming skills and strategies when escalating and staff who have a positive connection to the person can also engage them using a firm quiet voice and walking away from stimuli with them.

Inpatient units in particular, should consider the use of quiet space as an alternative to seclusion rooms to de-escalate individuals who are potentially violent. It is important for individuals to have a primary relationship with staff as therapeutic alliance is the strongest outcome influencer.

Comfort Rooms

Comfort Rooms are an example of a prevention tool to reduce the use of restraint and seclusion. For more information on comfort rooms refer to the document Comfort Rooms: A Preventative Tool Used to Reduce the Use of Restraint and Seclusion in Facilities that Serve Individuals with Mental Illness http://www.omh.ny.gov/omhweb/resources/publications/comfort_room/

4. Electroconvulsive Therapy (ECT)

"Electroconvulsive therapy (ECT), formerly known as electroshock therapy, is the application of electrical current to the human brain with the goal of alleviating specific mental health symptoms. It is a deliberately induced seizure that is medically controlled. ECT is used for various psychiatric disorders including mania, schizophrenia, catatonia, and acute suicidal thoughts. This treatment however, is most often used for individuals with a major depressive disorder that does not seem to be responding to medication therapy" (Alberta Health Services Self Study Module ECT, 2017).

5. Expressive Therapy

Expressive therapy is where the use of music, painting, drama, dance, writing, poetry, storytelling or other creative activities are typically used for the management of pain, depression and disability.

One study found that, for creative activity to have therapeutic benefit "it must have purpose, value and meaning to the individual" (Griffiths 2008, p. 50), hence, offering a diverse range of creative projects (e.g. painting, beading, sewing, clay work, paper craft and so on) to participants is desirable, though not always possible.

6. Family interventions

Families are helpful to persons by offering support and learning more about the specific concurrent disorder. Family interventions also support family members in understanding that they are not responsible for causing the disorder.

The Family Guide to Dual Diagnosis by the Centre for Addiction and Mental Health (CAMH) (Lunsky, Weiss, O'Grady, & Skinner, 2013) provides an overall understanding of key ideas and of the challenges and opportunities that are part of supporting a family member who has a concurrent disorder.

Some therapies involve the family members with the individual who is seeking treatment, and may include family consultation, family psychoeducation, family support, couple therapy, family therapy.

7 . Mindfulness exercises

Mindfulness has been popularly defined as "the awareness that emerges through paying attention, on purpose, in the present moment, and nonjudgmentally to the unfolding of experience" (Kabat-Zinn, 2003, p. 145).

> Mindfulness-based interventions have been shown to have "positive effects in patients with anxiety disorders, posttraumatic stress disorder, substance abuse, eating disorders, depression and personality disorders"
>
> (Grecucci, 2015, p. 3).

Mindfulness therapy "may be helpful across a range of conditions, leading to improvements in such outcomes as anxiety, depression, pain, stress, coping styles, sleep quality, and quality of life" (Baer, 2003; Grossman, Niemann, Schmidt, & Walach, 2004, as cited in Brown, 2010, p. 225).

"Mindfulness classes, or meditation exercises train participants to focus awareness on a specific target, such as breathing or routine activities (e.g., eating or walking). Mindfulness meditation also develops the ability to shift awareness intentionally from one target to another; for example, individuals may shift awareness from a distressing thought or emotion to their breath or to sensations in the body. Through these practices, mindfulness meditation may assist individuals to more readily disengage from excessive reactivity and learn more effective ways of responding to distressing cognitive and emotional experiences" (Brown, 2010, p. 226).

An example of mindfulness practice is being mindful of one's breathing. This might include paying attention to inhalation and exhalation. Attention is focused on the breathing and being present in the moment even when emotions or other thoughts come about.

"Breathing meditation is a common mindfulness practice, especially with novices". (Robins, Kiken, Holt & McCain, 2013, p. 512).

Positive reported outcomes associated with meditation include:

- symptom reduction i.e. from anxiety, worry, pain
- cognitive changes (e.g., "better ways of thinking," and "new thoughts and ideas")
- ability to focus on the present
- learning to relax or calm oneself
- lessening depression, anxiety and worry

Mindfulness-based relapse prevention (MBRP) has been extensively studied in individuals with substance-use disorders. "The mindfulness meditation component of MBRP affects numerous brain systems associated with decreased craving, negative affect, and relapse, and improved impulse control, and it may repair the neural changes associated with addiction and relapse" (Khusid & Vythilingam, 2016, p. 971).

8. Peer support

> Peer support is a supportive relationship between people who have a lived experience in common, whether it be related to their own mental health or that of a loved one

(Sunderland, 2013, p7).

Peer support refers to the help and support that people with lived experiences are able to give to one another. Peer support can take the form of emotional, social or practical support and is meant to provide support and mentoring without directing an individual's recovery journey. Peer support workers are not case managers, clinicians or therapists. There is a growing body of evidence demonstrating the positive outcomes associated with peer support provided in conjunction with clinical supports in mental health.

Peer support can be provided in both group and one-to-one relationships, and can take place in community groups, clinical settings, and workplaces. This range of accessibility is important as it can influence a person's day-to-day interactions in their communities, clinics, workplaces and more.

For instance, one might incorporate a Peer Support Worker (PSW) into the care team or link to an accredited Peer Support Worker program; or, peer-support can be informally provided by informal groups of peers who have experienced similar issues in their recovery.

Peer Support can range from informal friendship to more formal clinical care, including:

1. Informal Peer Support
    - Clubhouse/Walk-in Centre
    - Self-help/Mutual Peer Support
2. Formalized/Intentional Peer Support
    - Workplace Peer Support
    - Community/Clinical Peer Support
    - Clinical/Conventional or Mental Health System Peer Support

For more details on each of these types of Peer Support, see Appendix C for a diagram that outlines the Spectrum of Types of Peer Support.

Examples of peer-support include:

- Employing a Peer Support Worker on Assertive Community Treatment team
- Peers share their experience of substance use treatment and recovery with a group currently in residential addition treatment

More detailed information and guidelines on peer support check out the document: Sunderland, K., Mishkin, Wendy. Peer Leadership Group, Mental Health Commission of Canada. (2013). Guidelines for the Practice and Training of Peer Support. Calgary, AB: Mental Health Commission of Canada.

> Peer support is rooted in the knowledge that hope is the starting point from which a journey of recovery must begin

(Mental Health Commission of Canada, 2009, p.28).

9. Psychoeducation

Psychoeducation programs aim to have the person increase their knowledge about their concurrent disorder using evidence-based information, to change false beliefs about their disorder and motivate behaviour change.

> The term psychoeducation refers to the provision of information about psychiatric and substance use disorders, using didactic and interactive methods to ensure comprehension of relevant material

(Mueser, 2003, p.91).

Providing education in a respectful way to the person and their family about their disorder informs them about their disorder and helps with decision-making.

A blend of didactic and experiential, interactive learning is the best and essential way for individuals to learn at each stage of their treatment. This could be about symptoms, treatments, side-effects, emotions, techniques to deal with side-effects or other aspects of treatment and their recovery journey.

10. Psychopharmacological therapy

Medication or pharmacological interventions provide medications that may be used to treat persons with mood, thoughts and personality disorders, and/or be provided to support substance withdrawal/ dependence i.e. for opioid replacement.

This type of intervention may require that individuals check in regularly with their care team to receive medication by injection, monitor blood medication levels, adjust dosages, adjust or change medications, receive medication teaching, and/or discuss side effects experienced and management.

> Using medication is an active process that involves complex decision making and a chance to work through decisional conflicts. It requires a partnership between two experts: the [individual] and the practitioner. Shared decision making provides a model for them to assess a treatment's advantages and disadvantages within the context of recovering a life after a diagnosis of a major mental disorder

(Deegan, 2006, p. 1636).

Psychopharmacology therapy helps to stabilize the major symptoms of mental illness, and to avert or reduce the likelihood of symptom relapse. This is important through all stages of treatment. Psychopharmacological agents can also play a role in care planning for substance use disorder by aiding individual's in the reduction or replacement of substances.

Tips for connecting about medication

Some of the practical ways in which the prescriber and/or administrator of medications can connect with the individual is to:

- Empower the individual to be involved in their medication decisions and knowledge
- Build a therapeutic alliance around medication use and how to effectively take the medication
- Use it as an opportunity to consult with the individual i.e. talk about side effects, how it makes the individual feel, whether or not the individual is using the right dose and connect how taking medications fits with achieving their personal recovery goals
- Provide education to the individual about the medication they are taking using credible online sources such as CPS (Compendium of Pharmaceuticals and Specialties), Micromedex and Lexi-comp.
- Help to manage side-effects the individual may be having
- Long acting injections may be a criteria for individuals on Community Treatment Disorders and are administered through regular contact with the Assertive Community Treatment team members

Check out Appendix D for direct links to specific medication documents from the Centre for Addiction and Mental Health (CAMH) and the Canadian Mental Health and Addiction Network at Porticonetwork.ca.

See Appendix E for pharmacologic treatment recommendations for mood disorders comorbid with substance use disorders from the Canadian Network for Mood and Anxiety Treatments (CANMAT).

> Ideally, both pharmacological and behavioural treatments should be combined for the treatment of concurrent substance abuse and psychotic disorders

(Canadian Centre on Substance Abuse, 2010, p. 4).

11. Recreation therapy

Recreation therapy is focused on interventions pertaining to leisure education and participation opportunities to support individuals in maximizing their independence in leisure, optimal health and the best quality of life. It can include recovery supports around fitness, leisure, wellness, social skills, life skills, vocational preparation, volunteering, and community integration.

Also known as **Therapeutic Recreation**, it can help people with physical, social, emotional, and mental challenges that affect their leisure activity by assessing their needs and strengths, developing, following and evaluating a therapy plan. Teaches how to use resources and take part in recreation and leisure activities by:

- improving coping and reasoning skills
- supporting new learning
- supporting greater independence and quality of life
- increasing self-efficacy
- reducing stress, depression, and anxiety
- promoting a positive attitude
- teaching how to reduce the risk of falls
- improved memory and cognitive functioning

12. Relapse prevention

Relapse prevention is also known as symptom management and is most often associated with substance use but can also be related to mental health concerns.

> The goal of relapse prevention is to provide the skills and knowledge necessary to effectively manage a disorder's ongoing or recurring symptoms. "All relapse prevention programs use psychoeducation and skill training

(AADAC, 2007, p. 35).1

13. Repetitive Transcranial Magnetic Stimulation (rTMS)

"Repetitive Transcranial Magnetic Stimulation" (rTMS) uses a magnetic field to change electrical activity in the surface of the brain. By repeating this over time, the function of the targeted area can improve, which can reduce the symptoms of depression.

Over 30 randomized clinical trials have demonstrated the efficacy of rTMS in clinical populations.

> rTMS is not a replacement for existing therapies but will provide an additional method to use for Treatment Resistant Depression (TRD).

Individuals with TRD are at high risk for global impairment and depression is a major risk factor for suicide. In Alberta, it is estimated that between 3,600 and 11,000 patients could receive rTMS. Currently, the Centennial Centre in Ponoka houses the only AHS program that offers rTMS" (Alberta Health Services, 2017).

For more information on this initiative in Alberta contact the AMH Strategic Clinical Network (SCN): Addictionmentalhealth.scn@ahs.ca

14. Self-help groups

Self-help groups are typically peer-led, informal and community-based. Mentorship and leadership is provided by peers who are on the recovery journey. Examples of self-help groups include:

- ADHD Support Group
- Depression/Anxiety Support Group
- Domestic Violence Support Group
- Post-Traumatic Stress Group
- Parenting Support Group

Some self-help groups are organized around a twelve-step program model where individuals are encouraged to learn from the experiences of other members of the group who are also dealing with the same issue.

Examples of 12-step programs are:

- Alcoholics Anonymous (AA)
- Narcotics Anonymous (NA)
- Cocaine Anonymous (CA)
- Al-Anon & Al-Ateen
- Co-dependents Anonymous
- Emotions Anonymous
- Anorexics and Bulimics Anonymous (ABA)

15. Trauma therapies

Trauma is a distressing event in which a person feels severely threatened emotionally, psychologically, or physically. Post-traumatic stress disorder (PTSD) is a well-known trauma-related condition that can impact a person's everyday life. Therapy for specific trauma, such as PTSD, often requires the support, guidance and assistance of mental health professionals. Some therapies for dealing with trauma are listed below:

a) Eye movement desensitization and reprocessing (EMDR) therapy

"Eye Movement Desensitization and Reprocessing (EMDR) therapy is a set of standard protocols that incorporates elements from many different treatment approaches and may only be done by a trained

clinician. EMDR appears to be similar to what occurs naturally during dreaming or REM (rapid eye movement) sleep and can help a person to see disturbing material in a new and less distressing way. EMDR uses the patient's own rapid rhythmic eye movements to dampen the power of emotionally charged memories of past events. An EMDR session can be up to 90 minutes and the therapist will move their fingers back and forth in front of the patient's face and ask them to follow these hand motions with their eyes; at the same time the patient will be asked to recall the disturbing event, and then shift your thoughts to more pleasant ones.

> The goal of EMDR therapy is to leave you with the emotions, understanding, and perspectives that will lead to healthy and useful behaviors and interactions.

(EMDR International Association, 2017)

b) Cognitive processing therapy

Cognitive processing therapy (CPT) is a treatment for Post-Traumatic Stress Disorder (PTSD) and can be used to reduce symptoms related to a variety of traumatic events such as child abuse, sexual abuse, and natural disasters. CPT is typically run as a 12-session course in either group or individual formats and is a specific type of Cognitive Behavioural Therapy (CBT).

CPT teaches patients how to evaluate and change upsetting thoughts they have had since their traumatic event. By changing thoughts, one can change how they feel.

This therapy focuses on:

- Educating the patient about the specific post-traumatic stress disorder (PTSD) symptoms and the way the treatment will help them.
- Informing the patient about their thoughts and feelings.
- Helping and providing skills to the patient to develop skills to challenge or question their own thoughts.

2 Internal documents derived from personal communication (not publicly available) of Alberta Health Services.

c) Exposure therapy

Exposure therapy is a specific type of cognitive behavioural therapy often used to treat anxiety disorder, PTSD and phobias.

Exposure therapy involves the exposure of the patient to the feared object or context without any danger, in order to overcome their anxiety and/or distress.

This can take place over time, where people repeatedly engage in exposure and find that their reactions and fears decrease; can show the client that they are able to confront their fears; and learn how to attach new, realistic beliefs about the situation.

Confronting their fears in a safe environment can help to reduce fear and decrease avoidance.

There are several variations of exposure therapy to the feared object, situation or activity, including:

- **Direct exposure.** For example, someone with a fear of snakes might be instructed to handle a snake, or someone with social anxiety might be instructed to give a speech in front of an audience.
- **Vivid imagining.** For example, someone with PTSD might be asked to recall and describe their traumatic experience in order to reduce feelings of fear.
- **Virtual exposure.** Where direct exposure is not possible, some virtual reality technology can help. For example, someone with a fear of flying might take a virtual flight using equipment that provides the sights, sounds and smells of an airplane.

Exercises: Intervention

> exercise <

Computer Assisted Therapy

For this exercise the facilitator will provide participants with a list of apps from the directory mentioned below:

Addiction and mental health mobile application directory

AHS has an Addiction and Mental Health Mobile Application Directory that can be found on InSite. Look under Resources for AMH Mobile Application (APPS) Directory. The directory lists apps or electronic resource for different mobile platforms, and by diagnosis, which may be used as therapeutic aids for individuals with co-occurring issues.

Computer Assisted Therapy (CAT) or mobile apps as an intervention.

Consider trialling with an individual who has a smartphone and is able to download and use an app.

1. Review the list of apps available for Computer Assisted Therapy (CAT)
2. Select an app or a few apps that would suit the purpose of your work and individuals you are working with.
3. Introduce a suitable app to the individual you are working with.
4. Request that the individual use the app daily or weekly as appropriate to reflect on a certain aspect of their recovery.
5. Use the app data to check in on the individual's progress.
6. Review the findings with the individual at an in-person session.

Questions:

1. What insights did you gain from the apps daily/weekly input or data?
2. How did it contribute to your in-person visit or session with the individual using the app?
3. What therapeutic benefits were found from the individual's perspective in terms of achieving outcomes or goals? Mood or understanding?

1. Reflect on the benefits of using the app from your perspective.

Evaluation of interventions

Treatment plans with interventions need to be reviewed regularly to:

- ensure that goals are being met or changed as appropriate;
- celebrate successes and steps toward recovery;
- review and adjust short and long term goals;
- check that interventions being used are appropriate or if they need to be changed as new skills are acquired, or factors or conditions change.

For detailed information on evaluating interventions, check out the *Integrated Treatment Planning* chapter.

Successful engagement and selection of comprehensive interventions

Building a treatment plan and selecting comprehensive interventions can be successfully achieved by engaging the individual and helping them with selecting a set of comprehensive interventions that meet their needs, personal goals and that will address the concurrent disorder diagnosis.

Taking into consideration personal, environmental and availability and accessibility factors, you can now work with individuals to select the most helpful interventions for their needs.

Different types of interventions will be used at different times in a person's recovery depending upon their stage of change.

- **Introductory** interventions may be inclusive, drop-in, informal
- **Action** interventions may be focused, treatment oriented, therapeutic and require committed participation
- **Maintenance** interventions may involve relapse prevention, and peers as leaders.

Think of the variety of interventions like a MENU! Knowing about all the ingredients available on the menu is a good place to start, then consider preferences, likes and dislikes, availability and need to build the best comprehensive set of interventions for each individual.

The handout below on the next two pages outlines an idea of a list of options that could be presented to individuals to help work through identifying the right interventions for their recovery journey.

What matters to you?

Here are some ways our team can help you in your recovery journey.

We can review these with you and explain what they mean, to help you select the best options for your recovery.

There are many factors to consider when selecting the right interventions for you – including:

- Your diagnosis
- Your commitment and interest
- Location and availability of services and resources
- Your time
- And, your recovery goals

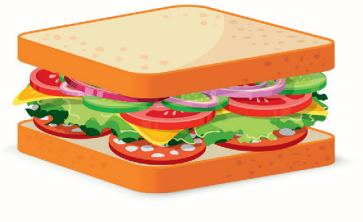
Check off the ones you think are best for you:

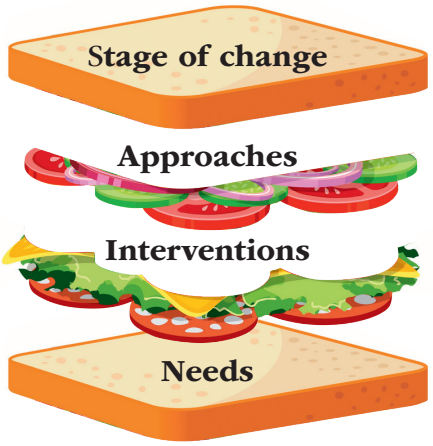
- ☐ Individual Counselling
- ☐ Support groups
- ☐ Creative activities: art, drama, music
- ☐ Family counselling
- ☐ Substance cravings strategies
- ☐ Employment or volunteer work
- ☐ Recreation: gym, outings, activities
- ☐ Mental health apps: how to use
- ☐ Breathing & meditation exercises
- ☐ Connect with a peer
- ☐ Mental health and/or medications information
- ☐ Medications to help my thoughts/mood
- ☐ Housing help
- ☐ Finances: budget, AISH

Let's get started!

Menu board of interventions and approaches

There are lots of ingredients and layers that go into a great sandwich, and there are lots of ingredients that go into a set of comprehensive interventions and approaches for each person. Selecting the best combination of ingredients, in the right order, for the right duration of time for and with the person, will depend on the diagnosis, their goals, and availability of interventions; and the need to be flexible and move ingredients around is key.





Think of selecting interventions and approaches like the layers of a sandwich - while there are different layers, some also repeat themselves when appropriate! Much like the ingredients in a sandwich, selecting the best combination of **interventions** and **approaches** for the time, **stage** and **needs** and in the best order for the individual and their family, needs to be carefully considered to provide the person with the best set of comprehensive interventions for their recovery.

> | examples | <

Case example:

A person experiencing drug induced psychosis from many months of crystal methamphetamine use may be brought to hospital. There he would receive supportive care of encouraged nutrition, sleep and hygiene the first few days as he withdraws from street drugs. Psychopharmacology would be commenced on admission also “prn” or as needed for withdrawal symptoms. Addiction recovery group therapy, Recreation therapy and Art therapy would be offered after one week or when patient is interested or more stable psychiatrically.

Exercise: Building an 'intervention' sandwich

>| *exercise* |<

This exercise will help you practice selecting a comprehensive set of interventions – taking into consideration all the factors and formats that influence helping an individual choose the interventions that will help them achieve their recovery goals.

1. Divide into groups of 3-4 and select a case study from Appendix F.
2. Based on the case study profile, and the individual's preferences, build your 'intervention' sandwich from the list of interventions and approaches listed on page 63 – think of it as a 'menu board' of interventions and approaches. Role play as the patient and care team working together to build an intervention sandwich.

Questions:

1. Discuss why you selected the interventions and approaches that you did.
2. Review the selections and reflect on what order you put them in and why.
3. How did working with the individual to choose interventions affect the final options chosen? (e.g., empowerment, buy-in, successful recovery-oriented goal setting)

Key messages

Ensuring the following can help make for selecting comprehensive interventions:

Selecting comprehensive interventions take into consideration all facets of the individual's needs, desires, goals and personal preferences.

It is important to understand the numerous intervention options and the use and effectiveness of each intervention to be able to make recommendations to an individual on the best options that might fit their needs.

Ensure the individual and their family, as appropriate, is at the centre of the decision-making for selecting interventions.

Interventions may be layered, repeated, or deleted when necessary to ensure the set of comprehensive interventions is meeting the individual's needs.

Using tools and techniques like motivational interviewing and de-escalation techniques will help to ensure a recovery-focused, solution-based approach to working with the individual.

Conclusion

We hope you have found this chapter to be helpful. If you have any questions, comments or stories to share, please contact concurrent.disorders@ahs.ca.

Want more information on comprehensive interventions?

While this chapter highlights interventions in general, here are some resources that provide more specific overviews of treatment of general and specific concurrent disorder diagnoses:

Ekleberry, S.C. (2009). Integrated Treatment of Co-Occurring Disorders: Personality Disorders and Addiction. Routledge. New York, NY.

This book provides specific examples of integrated treatment options for persons with concurrent personality disorders and addiction as examples of how to work with the specific diagnoses i.e. dependent personality disorder and substance abuse disorder; Schizoid personality disorder and substance abuse disorders.

Canadian Centre on Substance Abuse (CCSA). (2009). *Concurrent disorders substance abuse in Canada*. Ottawa, ON. Canadian Centre on Substance Abuse. http://www.ccsa.ca/Resource%20Library/ccsa-011811-2010.pdf

This book provides an overview of the different co-morbid disorders i.e. substance abuse and impulsivity, psychosis, mental health disorders, stress and trauma, anxiety etc. and emerging approaches to treatment at the time of publication.

AADAC. (2007). Concurrent disorders treatment approaches: literature review. AADAC.

This resource lists treatment considerations for numerous concurrent disorders i.e. treatment for co-occurring substance abuse and disruptive behaviour disorders; treatment for co-occurring substance abuse and disruptive personality disorders.

Skinner, W.J.W., (Ed.). (2005). Treating concurrent disorders a guide for counsellors. Centre for Addiction and Mental Health Canada.

This book provides inclusion and exclusion criteria examples for specific types of therapy groups.

Here to Help

Mental health and substance use information is provided on this website http://www.heretohelp.bc.ca/

note section

note section

APPENDIX 1

Ground rules for support groups

Ground Rules for Support Groups

This is a mutual self-help group, not a therapy group. Hopefully, this group will provide emotional, psychological, and moral support for its members. Each of us is encouraged to participate to whatever extent we feel comfortable. The following ground rules facilitate the development of trust in the group and enable us to share our thoughts and feelings with each other.

1. Because confidentiality is essential, we expect that each person will respect and maintain the confidentiality of the group. What is said in the group is not to be repeated or discussed at any other time or place.
2. We are here to share our own feelings and experiences: we try not to give advice.
3. We each share the responsibility for making this group work.
4. We try to accept people, just as they are, and we avoid making judgments.
5. We try to give everyone an opportunity to share.
6. We have the right to speak and the right to remain silent.
7. We give supportive attention to the person who is speaking and avoid side conversations.
8. We avoid interrupting. If we do break in, we return the conversation to the person who was speaking.
9. We have the right to ask questions and the right to refuse to answer.
10. We try to be aware of our own feelings and talk about what is present to us now, rather than what life was like for us in the past.
11. We do not discuss group members who are not present.
12. We begin and end our meetings on time.

Note: Even though our goal is to support each person, this particular group may not meet your needs. Before deciding this group is not for you, however, we hope you will attend at least two meetings.

Peer Support Group Facilitator Training – Student Manual, by Sharon Mahre.
Available from the Catholic Charities' Counseling Services Support for Separated and Divorced.
Archdiocese of St. Paul, Minneapolis, 1276 University Ave., St. Paul, MN 55104.
Telephone: 651-647-3126

Outline for running a group

Structuring the first meeting of a group helps to set the tone, inform participants about the rationale and/or rules for the group, and introduce members. Here is an outline to use for organizing a group:

Room set up: Chairs and couches set in a circle, coffee set up on a table behind the chairs.

Supplies: Pen and paper to record attendance, white board with questions written on it, erasable felts, eraser.

Outline of group

Introduce group: "Welcome everyone to discussion group. The purpose of this group is to discuss topics related to wellness. When people are in the hospital, they are often in a process of recovery from mental illness. Sometimes people are also in recovery from substance use. This group is open to everyone who is interested in getting better. Today's topic is_____."

Group guidelines: We cover three guidelines: (a) confidentiality (i.e., what is said in the room stays in the room), (b) respect (i.e., not speaking when others are; allowing differences of opinion), and (c) staying on topic.

Introduction/ice breaker question: Go around the room and ask people to share their first name and answer an ice breaker question (e.g., favourite movie, colour, hobby, food).

Structure of the group: The questions from each topic are written on the white board. Try to solicit participation from all group members and call on staff to offer their input at your discretion.

Challenging behaviour:

- *Over-participation:* Thank the participant for their comment and say: (a) "let's hear from some people we haven't heard from yet…" (b) "I appreciate your comments but let's give others a chance to speak," or, (c) "why don't we chat more about that after the group."
- *Silence:* Elicit participation directly by asking each group member: "(patient name), what do you think about (topic)?" Closed questions are helpful for patients who have difficulty comprehending complex sentences (e.g., "do you think drug use is good or bad?")

- *Leaving during group:* The purpose of this group is to engage clients at all stages of wellness. Therefore, we are tolerant of patients leaving during the group. If a group member becomes particularly disruptive, approach them after the group and discuss ways to help them stay in the room (e.g., writing notes during the group).
- *Disagreement between members:* This rarely occurs, but reminding patients of the expectation of respect can be helpful: "remember when we spoke about respect at the beginning of the group? It's okay to disagree with other members but it's important to also respect what they have to say."

For disruptive behaviours that are persistent, meet with the patient after group to discuss strategies for improvement. Some examples: ask the patient to write down questions and discuss them after group, or ask the patient to focus on listening instead of speaking. Positive reinforcement is helpful when group members improve their behaviour.

APPENDIX 2

References on treatment options for specific concurrent disorders

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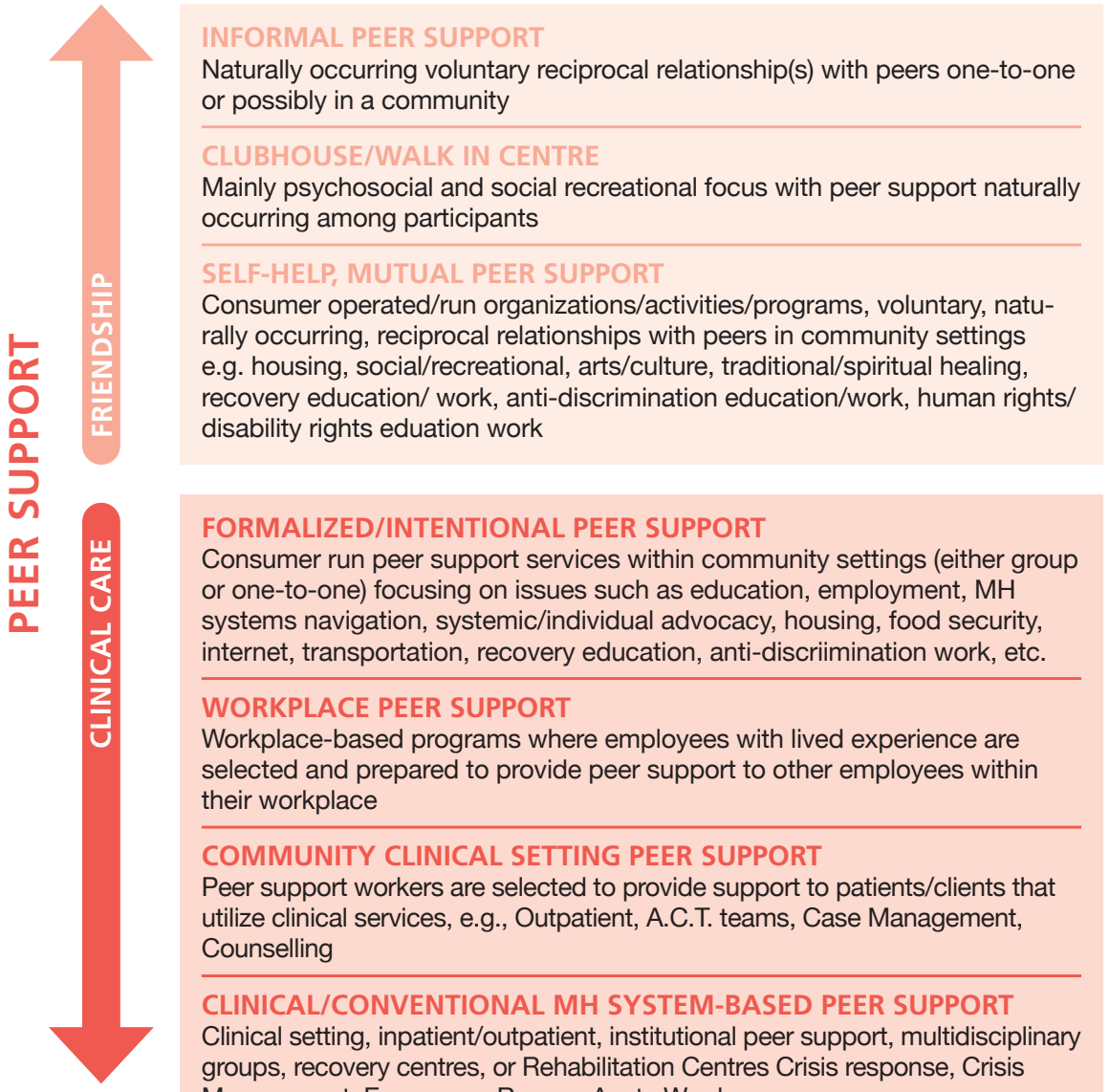
APPENDIX 3

Spectrum of types of peer support

Figure 1: Spectrum of Types of Peer Support



Guidelines for the Practice and Trainiing of Peer Support | 16

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APPENDIX 4

Psychopharmacological resources

The **Canadian Mental Health and Addiction Network** at **Porticonetwork.ca** is a network of addiction and mental health sites from across Canada that offers clinical tools, evidence-based materials for health care providers, social workers and others; along with teaching handouts and information on medications such as:

Links to printable documents on medications and pharmacological treatments:

- Acamprosate
- Baclofen
- Disulfiram
- Naltrexone
- Topiramate
- Medications for the treatment of alcohol dependence

The **Centre for Addiction and Mental Health (CAMH)** has teaching handouts or fact sheets for medications used to treat addictions. Their **Understanding Psychiatric Medications** series provides one-page documents about:

- Antidepressants
- Antipsychotics
- Benzodiazepines
- Mood Stabilizers

Information about these and other topics can be found at:
http://www.camh.ca/en/education/about/camh_publications/Pages/default.aspx

The Here to Help website from British Columbia is a great resource for mental health and substance use information you can trust:
http://www.heretohelp.bc.ca/

APPENDIX 5

Psychopharmacologic treatment recommendations

The following chart outlines pharmacologic treatment recommendations for mood disorders comorbid with substance use disorders. These recommendations are from the Canadian Network on Mood and Anxiety Treatments (CANMAT). (Beaulieu et al., 2012, p. 45).

TABLE 3
Pharmacologic treatment recommendations for mood disorders comorbid with SUDs

Substance	MDD	Bipolar disorder
Alcohol	*First choice:* Mirtazapine Add-on naltrexone or alone Add-on naltrexone to sertraline[a]	*First choice:* Add-on naltrexone
	Second choice: Add-on disulfiram	*Second choice:* Add-on lamotrigine or alone Add-on valproic acid or alone Add-on disulfiram
	Third choice: Valproic acid Amitriptyline Desipramine Imipramine Escitalopram Memantine	*Third choice:* Add-on gabapentin Add-on topiramate Lithium
	Not recommended: Fluoxetine[b] Lithium Sertraline Nefazodone (withdrawn from the market)	*Not recommended:* Add-on quetiapine or alone
Cannabis	*First choice:* none	*First choice:* Add-on valproic acid to lithium
	Second choice: none	*Second choice:* Lithium Add-on valproic acid or alone
	Third choice: none	*Third choice:* none
	Not recommended: Fluoxetine[b]	*Not recommended:* none
Cocaine	*First choice:* none	*First choice:* Add-on valproic acid to lithium
	Second choice: none	*Second choice:* Add-on lamotrigine or alone Lithium Add-on valproic acid or alone Add-on quetiapine or alone Add-on risperidone or alone Add-on citicoline
	Third choice: Add-on risperidone or alone	*Third choice:* none
	Not recommended: Carbamazepine Desipramine Imipramine Nefazodone Fluoxetine Lithium	*Not recommended:* Carbamazepine
Heroin	*First choice:* none	*First choice:* none
	Second choice: none	*Second choice:* Methadone
Heroin (continued)	*Third choice:* Add-on buprenorphine or alone	*Third choice:* none
	Not recommended: none	*Not recommended:* none
Opiate	*First choice:* none	*First choice:* none
	Second choice: none	*Second choice:* none
	Third choice: Add-on imipramine to methadone	*Third choice:* none
	Not recommended:	*Not recommended:*
	Add-on fluoxetine to methadone Add-on sertraline to methadone maintenance for opiate-dependent patients	none
Amphetamine	*First choice:* none	*First choice:* none
	Second choice: none	*Second choice:* Add-on quetiapine or alone
	Third choice: none	*Third choice:* none
	Not recommended: none	*Not recommended:* none
Methamphetamine	*First choice:* none	*First choice:* none
	Second choice: none	*Second choice:* Add-on quetiapine or alone Add-on risperidone or alone
	Third choice: none	*Third choice:* none
	Not recommended: none	*Not recommended:* none
Polysubstance	*First choice:* none	*First choice:* none
	Second choice: none	*Second choice:* Switch from current antipsychotic(s) + add-on aripiprazole
	Third choice: none	*Third choice:* none
	Not recommended specifically for opiate plus cocaine polysubstance: Add-on desipramine to buprenorphine maintenance for opiate-dependent patients Add-on desipramine to methadone maintenance for opiate-dependent patients	*Not recommended:* none

[a]Not recommended for patients age >55.
[b]Can be a possible choice for adolescents and young adults.
First-choice recommendation: level 1 or level 2 evidence plus clinical support for efficacy and safety; second-choice recommendation: level 3 evidence or higher plus clinical support for efficacy and safety; third-choice recommendation: level 4 evidence or higher plus clinical support for efficacy and safety; not recommended: level 1 or level 2 evidence for lack of efficacy.
MDD: major depressive disorder; SUD: substance use disorder.

APPENDIX 6

Vignettes and examples for exercises

The following vignettes provided can be used in some of the exercises in the chapter, or for other illustrative purposes through the document when you need to provide an example.

Adult-focused Vignettes

Vignette 1: Paula is a 29 year old woman who uses crack cocaine and experiences persecutory voices and paranoid ideation. She has been arrested for panhandling and aggressive behavior. She has been referred to services two times in the past ten month however the assigned clinician has not been able to make contact with her as she changes her housing often or lives on the street. She has met with crisis workers in the community, then attend a community disturbance with police.

Vignette 2: Jim Bob is a 42 year old man diagnosed as having bipolar disorder. He was referred to Addiction Mental Health services four months ago due to a DUI (driving under the influence) and meets with his clinician every Tuesday,. He does not consider his alcohol use problematic but says his drinking has interfered with his goal of being a good father. Jim Bob usually drinks on weekends, and for the past three weekends he has participated in sober activities with his family. This has cut down his intake of alcohol, though he still tends to drink alcohol til he blacks out on Saturday nights.

Vignette 3: Wendy is a 49 year old woman diagnosed with schizoaffective disorder. She has a long history of using methamphetamine, and her two closest friends also use meth. She keeps in close contact with her clinician whom she considers an important support. She indicates that she wants to stop using meth because she wants to "have a better life" (which includes maintaining mental wellness, finding a job involving kids or animals, and being able to afford a piano someday). Wendy's friends are aware of her desire to stop using, and one friend is willing to engage in sober activities with her during the daytime. So far, Wendy has not used meth in 9 weeks, though she states she's often "bored" and tempted to use.

Vignette 4: John, a single young man who has been diagnosed with schizophrenia, occasionally shows up at the mental health clinic and requests to see someone. He has a clinician and saw him a month ago but cannot remember his name. His connection with the clinic are infrequent and he usually wants money, food or cigarettes. He uses cannabis on a daily basis but this has not been discussed with his clinician.

Vignette 5: Fred has been connected to the addiction mental health clinic for many years. He was an in-patient psychiatric rehab prior to this. He drinks alcohol daily, usually wine, and has stopped taking his anti-psychotic medication because of side effects. He meets weekly with his clinician and sometimes calls when in crisis. Fred states that using alcohol helps him forget his troubles; when asked about any downsides of drinking, he notes that his apartment manager says he is louder and seems angry when he drinks alot.

Vignette 6: Crystal is a grandmother who has used many different substances over the years. She maintains her mental wellness with injectable anti-psychotic depot medication she receives every two week from the mental health clinic nurse. She has binge episodes of crack cocaine and alcohol use, which she says has scared her daughter and granddaughter. She tries to stay abstinent from cocaine and has cut down her alcohol use.

Child and Youth Vignettes

Vignette 7: Jasmine is a 15 year old girl who came into Canada as a refugee. She experienced sexual abuse from a family member after moving to Canada. Physicians query whether she has FASD as she is impulsive, with high-risk behavior such as self-harm, stealing and polysubstance use. Her mother experiences with depression and is unable to provide supports.

Vignette 8: John is a 16 year old boy diagnosed with dysthymia. He uses cannabis several times a week which he says helps with anxiety, and has no interest in reducing his use. John has a history of suicidal ideation and was hospitalized recently, which has caused shame from his family. John and his family are in conflict regarding his request for medical marijuana, and his family thinks that his cannabis use is because he is addicted.

Vignette 9: Sally is a 10 year old girl whose parents experience chronic alcoholism. Sally has anxiety, enuresis, and poor relationships with peers. Her grades are low and school reports concerns about attendance, hygiene and nutritional intake.

Vignette 10: Mark is a 13 year old boy who has anxiety and ADHD (inattentive type). He has attendance issues, declining grades at school and is receiving school counselling. His mother is deceased and his father shows signs of depression. His older sibling Jacob is 24 years old, lives in the basement, and mood and substance use issues.

Vignette 11: Cassandra is a 17 year old female who experiences anxiety and depression and attends an addiction mental health clinic. She uses cannabis often but has reduced her use since meeting with a clinician regularly. She graduated from high school and then her mother reported that Cassandra has increased her use of cannabis again and has more disordered thoughts. She is now presenting with persecutory and grandiose delusions, auditory and visual hallucinations, weight loss and poor hygiene.

Vignette 12: Patrick is a 5 year old boy currently living with his maternal grandma. Patrick's mom uses many substances and engages in often unstable, sometimes violent relationships. While with his mom, 3 year old Patrick was found wandering alone on the highway and a guardianship order was put in place for kinship care with his grandmother. His mom visits sporadically. Patrick is terrified that people will leave him or that he will be removed from his grandmother's house. Patrick experiences night terrors and separation anxiety.

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