CORE ADDICTION PRACTICE:

Foundational Concepts and Practices for Substance Use Services and Supports

2018

PARTICIPANT'S RESOURCE GUIDE

ACKNOWLEDGEMENTS – PARTICIPANT'S RESOURCE GUIDE

Much appreciation is extended to the community of individuals who have worked in various ways over twenty-five years to support and develop what is now known as the Core Addiction Practice (CAP) program and its resources:

- Those who served as stewards for previous versions of the Addiction Counsellor Training (ACT) and Introduction to Addiction Services Clinical Practice (IASCP): Alcohol and Drug Programs' former Provincial Office and Regional Management Teams.
- Those long-time champions in our current health authorities who partnered to develop and implement the new CAP in three health authorities (Fraser Health, Vancouver Island Health Youth and Family Services, and Interior Health); and then ensured all health authorities in BC were given support for provincial implementation through the Provincial Planning Council for Mental Health and Substance Use Services.
- All of the personnel who daily demonstrate leadership and support for CAP under the auspices of the Addiction Knowledge Exchange project: Strengthening Substance Use Treatment Systems in BC.
- Our wonderful cadre of CAP facilitators, now in every region of BC, and working above and beyond the call of duty to educate health professionals and community partners to promote compassionate and effective responses for people seeking help for substance use problems.
- The current Provincial CAP Steering Committee, which is comprised of CAP champions from all health authorities and the Ministry of Health, and is the sponsor for this updated version of the Core Addiction Practice materials and resources. 2012 members are: Emily Arthur (chair), Denise Bradshaw, Michelle Dartnall, Mary Marlowe, Sherry Mumford, and Rae Samson.
- All of you who assisted in creating this 2013 version of CAP by providing new materials, updated wording, data and references. It could not have been done without you.

The Core Addiction Package was:
Compiled and edited by Monica Jobe-Armstrong - 2008
Updated by Carol Savage Todd – 2013

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INTRODUCTION TO CORE ADDICTION PRACTICE

Core Addiction Practice (CAP) is a five day practical and skill-based course designed to introduce information, theories and concepts about psychoactive substance use, and the strategies and skills needed for providing effective supports and services for those with substance use problems.

Objectives

The objectives of CAP are:

- To ensure that all those who provide specialized supports and services for people with substance use problems have foundational knowledge and skills to provide those services in ways that are evidence-informed, effective, professional and consistent.
- To develop capacity within partner and collateral service systems to respond effectively to people with substance use problems.

Background and Context

- The current version of CAP is the culmination of over twenty-five years of curriculum development and training. CAP is a fluid and changing course because knowledge in the field of substance use treatment is constantly evolving.
- CAP has had the expressed support of The BC Mental Health and Substance Use Planning Council, and since 2010 has been used in all five regional health authorities.

The National Framework for Action and the National Treatment Strategy

In 2005 the Canadian Centre on Substance Abuse, in partnership with key government and non-government leaders in the field from across Canada, established *The National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada.*[i]

A key focus was the development of a national treatment strategy - outlined in 2008 in *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy.*[ii] Commonly known simply as the "National Treatment Strategy", this document outlines Concepts, Principles and Strategic Areas for Action to guide ongoing improvement in the substance use field. Central to the recommendations is a tiered model of services and supports that recognizes that people with substance use problems receive assistance in many different ways – not just from services identified as "substance use treatment". Also key to the tiered model is the recognition that there is a significant range of services (from less to more specialized, intensive and/or costly) that people may access for help at different times or under differing circumstances. This conceptualization of a continuum of services recognizes there are important roles for many: substance use service professionals, allied professionals in health, human services, justice and education, peer support and self-help groups, and community members.

National Workforce Development Strategy

Workforce Development was also a key priority within the National Framework for Action. A key product of work done since in this area is the national competency profile found in *Competencies for Canada's Substance Abuse Workforce.*[iii]

Competencies comprise the knowledge, skills and perspectives required to effectively fulfill a given role. They are commonly acquired through a combination of life experiences, education, training and work.

Those identified in the CCSA profile include competencies for seven different types of roles within the substance use field:

- Administrative Support
- Health Promotion
- Supervisory
- Withdrawal Management
- Counselling
- Senior Management
- Support and outreach

The competencies outlined are of two types:

- Technical – What is done
- Behavioural – How it is done

Both sets of competencies are shown below. An asterisk (*) indicates those that are addressed, at a foundational level, by CAP

Canadian Centre on Substance Abuse (CCSA) Technical Competencies

- Case Management*
- Community Development
- Conflict Management
- Counselling*
- Crisis Intervention
- Diversity and Cultural Responsiveness
- Ethics and Professionalism*
- Family and Social Support*
- Group Facilitation
- Mental Health*
- Outreach
- Pharmacology*
- Prevention and Health Promotion
- Program Development, Implementation and Evaluation
- Screening and Assessment*
- Teamwork
- Treatment Planning*
- Understanding Use, Abuse and Dependency*

Canadian Centre on Substance Abuse (CCSA) Behavioural Competencies

- Adaptability and Flexibility*
- Analytical Thinking and Decision Making
- Client-Centred Change*
- Client Service Orientation*
- Collaboration and Network Building*
- Continuous Learning*
- Creativity and Innovation
- Developing Others
- Diversity and Cultural Responsiveness*
- Effective communication*
- Ethical Conduct and Professionalism*
- Interpersonal Rapport/Savvy*
- Leadership
- Planning and Organizing
- Self Care*
- Self Management
- Self Motivation and Drive
- Teamwork and Cooperation

CAP and Accreditation

As a consistent, provincially-supported learning program for practice in the substance use field, CAP is a resource for demonstrating compliance with accreditation standards.

For more information regarding the relevant accreditation standards for your organization:

Accreditation Canada (Qmentum Standards): **http://www.accreditation.ca/accreditation-programs/qmentum/standards/substance-abuse-and-problem-gambling-services/**

Council on the Accreditation of Rehabilitation Facilities (CARF): **http://www.carf.org/Programs/**

Council on Accreditation (COA): **http://www.coacanadastandards.org**

Continuing Your Learning

- One component of the National Workforce Development Strategy is the Canadian Network of Substance Abuse and Allied Professionals (CNSAAP). Primarily an online resource, this network can be found at: **http://www.cnsaap.ca.**
- Addiction Services and Allied Professionals of BC (ASAP BC) is an association of substance use service providers and organizations in BC that supports ongoing program and professional development through leadership, information sharing, advocacy and educational activities: **http://www.asap-bc.org.**
- Throughout BC there are a number of other Communities of Practice developing that focus on substance use treatment and supports. At the time of writing, you can contact the Addiction Knowledge Exchange Lead for your Health Authority (through your CAP Facilitator) to learn more about what is available in your area.
- The Centre for Addiction Research of BC (CARBC) at the University of Victoria provides valuable online resources related to population-based change efforts, including a wealth of materials in their sections titled "Helping Communities", "Helping Schools", and "Helping Campuses". All are available at **http://www.carbc.ca.**
- A number of BC's post-secondary institutions are offering courses or programs on Substance Use, Substance Abuse or Addiction. Check online calendars, professional schools or your regional Addiction Knowledge Exchange Lead for more information.

The Key References and Resources section of this manual also provides information on how to access many of the key resources that will be helpful for effective substance use practice in BC.

Key Related Topics and Learning Resources

While CAP is focussed on the foundational and general knowledge and skills specific to substance use treatment, it is intended to be used in conjunction with other key learning resources, including those that follow.

Gender considerations

There is ample evidence confirming the importance of applying a gender lens to the understanding of substance use problems and how service providers respond. Excellent resources abound, such as those found at **http://www.coalescing-vc.org/** and in *Highs and Lows: Canadian Perspectives on Women and Substance Use*.[iv]

Aboriginal cultural competence and safety

As culturally-competent and safe practice is essential for anyone working in the field of substance use treatment, it is strongly recommended that all CAP participants who work within BC's health authorities also participate in the Indigenous Cultural Competency program offered through the Provincial Health Services Authority. Enquire through your supervisor, manager, or by direct email to icc@phsa.ca.

Trauma-informed practice

The pervasiveness of trauma in the histories of adults presenting for substance use treatment is by now well known.[v]

BC's Trauma-informed Practice Guidelines are expected to be released in early 2013. Guidelines are expected to be accompanied by an Organizational Checklist to support self-audits of outpatient clinics and other practice settings. Resources readily available at time of writing include the Trauma-Informed Online Tool at **http://www.coalescing-vc.org/virtualLearning/section1**.

Valuing diversity and responding effectively to all the people we serve

Substance use problems affect everyone - which calls on us to be "culturally competent" for each person we work with. People who experience marginalization and stigma of many kinds may be at higher risk for substance use and mental health problems. It must be the goal of every substance use service provider that the people we serve experience us as welcoming, compassionate and skilled. Some key resources for welcoming diversity include:

Lesbian, Gay, Bisexual, Transgendered, Transsexual, Two-Spirited, Queer (LGBTTQ)

Asking the Right Questions 2: Talking With Clients about Sexual Orientation and Gender Identity in Mental Health, Counselling and Addiction Settings. Toronto ON: Centre for Addiction and Mental Health. Available for download at **https://knowledgex.camh.net/amhspecialists/Screening_Assessment/assessment/ARQ2/Pages/default.aspx**

Multicultural practice

Although there is not yet a wealth of material to guide substance use service providers, the following article underscores the importance of cultural differences and provides some direction for counsellors in the context of therapeutic alliance.

Cultural difference and the therapeutic alliance: An evidence-based analysis. Vasquez, Melba, in American Psychologist, Vol 62(8), Nov 2007, 878-885. doi: 10.1037/0003-066X.62.8.878

Anti-Stigma and Discrimination Materials

Through your C.A.P Facilitator, your regional Addiction Knowledge Exchange Lead or your Substance Use Services manager, you can determine how to access the most current knowledge resources and supports related to reduction of stigma and discrimination against people with substance use problems. While there is currently no province-wide learning program geared to stigma, mental health and substance use, there are many examples of such programs. For example:

- The Centre for Addiction and Mental Health in Ontario has developed a learning package for combatting stigma against people with concurrent mental health and substance use problems. Intended for use within our helping systems and in the community, it can be found at: **http://knowledgex.camh.net/ke_workspace/oih/mha_capla/chile2011/Shared%20Documents/Componente%20Presencial/Stigma%20-%20Estigma/CAMH%202005%20Beyond%20the%20Label%20Toolkit.pdf** or by searching for "CAMH Beyond the Label".
- While not specifically addressed at stigma and substance use problems, the Mental Health Commission of Canada has information about the Open Minds project at **http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Programs_province_011.pdf.**
- The Mental Health Commission of Canada has partnered with IWK Health Centre in Nova Scotia to produce an anti-stigma video that can be found at **http://www.youtube.com/watch?v=LTIZ_aizzyk&feature=plcp**

CAP Supplementary Modules

These resources, developed by Fraser Health (with VIHA Youth and Family Substance Use Services contributing the Youth Module) specifically as supplements for CAP and to be used selectively depending on the needs of participants, include modules focussing on:

- Youth
- Older Adults
- Aboriginal Peoples
- Mandated Clients

Ask your Facilitator how you can access these materials.

Setting the Context for Helping: Foundational Principles for Practice in Substance Use Services and Supports

Daunting as it may be to expect competency in serving a range of populations, being trauma-sensitive, culturally-competent and evidence-informed as to our choice of methods, some core concepts and principles have been identified[vi] that are common to all "best and promising practices". These can be relied on as the foundation for effective helping.

Responsiveness:

More than just answering or accepting, a responsive practitioner provides a favourable reaction. The practitioner creates a welcoming environment for the person they are serving, including and remaining open to diversity and complexity. S/he is encouraging of each person's unique story and is willing to "meet the person where they're at".

Responsive services operate with an "every door is the right door philosophy", welcoming those who seek assistance and demonstrating willingness and interest in each person's perspective and apparent needs. While no service can be expected to be" all things to all people", responsive services actively support transitions to more appropriate services once it is recognized that something different is needed.

Compassion:

Most commonly, compassion is understood to consist of a combination of empathy and caring. A client might say of a compassionate worker: "The difference is, she cares."

Compassion involves genuineness – the real response of one human being to another, albeit within the necessary boundaries of the professional helping relationship

In the Third Edition of Motivational Interviewing, Miller and Rollnick[vii] have added compassion as one of the four elements of the "spirit of MI" and define it as follows: "To be compassionate is to actively promote the other's welfare, to give priority to the other's needs."

Respect

Respect has many components: positive regard, consideration, interest. It is demonstrated when there is evidence that the worker sees the person they are assisting as doing the best they are able to do in their present circumstances. Respect involves acknowledging that while the person served may at the moment feel and appear quite helpless, they have many strengths and can be counted to bring those to help with their struggles with psychoactive substances. A respectful helper is always aware that the person they are serving is "driving the bus", while at the same time knowing they may be counted on for guidance and support to get the person to their destination.

Respect also acknowledges that in accessing services, the client is, at least momentarily, seeing themselves as needing more than their existing strengths and resources. The respectful helper begins with the assumption that the client has solid knowledge about what they need, and begins the working relationship by listening and seeking to understand those needs and existing strengths from the client's perspective.

Partnership

Partnership implies the activity of two or more people working side by side with an identified common purpose. While the roles of the client and helper are different, both have a shared understanding of what will be involved and are engaged in achieving the agreed-upon ends.

Again quoting Miller and Rollnick[viii]: "(Partnership) is an active collaboration between experts". They also liken the helping relationship to "…dancing rather than wrestling. One moves with rather than against the person." While specifically addressing Motivational Interviewing, this description fits equally well for skilled helping in general.

The "magic wand" that brings the core principles to life

And what is the one element that draws all of the above core practice principles together?

> Listening.

A Note on Stigma and Language

What is the "correct" language to use when referring to services we provide for people with substance use problems? Recent years have seen some significant changes in language, exemplified by some Health Authorities changing their program names from" Addiction Services" to "Substance Use Services." While some of our key organizations have already-established identities such as the "Centre for Addiction Research" or the "Canadian Centre on Substance Abuse", a consensus is emerging about the importance of language in this field. Just as the knowledge base is evolving, so is our way of describing the work we do.

Following is a quote from the First Annual Report on BC's Ten-Year Plan to Address Mental Health and Substance Use in British Columbia.[ix]

> *Public attitudes and beliefs often based on fear and misunderstanding, can stereotype people living with substance use problems or mental illness. The resulting prejudice and discrimination can isolate people within their own families and communities, making it hard for them to seek help.*
>
> *Healthy Minds, Healthy People recognizes that careful attention to the language we use can help reduce stigma and make things easier for people when they are ready to reach out for support. For example, the term "substance use" includes all psychoactive substances – legal and illegal – and can be qualified according to the different outcomes associated with their use (e.g. beneficial or problematic). By contrast, moral labels such as "drug abuse" may suggest that those experiencing problems with substances are "bad" people. The term "abuse" in other contexts is commonly associated with violent behaviour of people who harm children, elders, spouses, or animals. If someone is harming themselves through the use of substances, labelling them as an "abuser" will likely discourage them from seeking help. In addition, the phrase "drug abuse" is generally applied to the use of illegal or controlled substances for non-medical reasons. We do not generally think of alcohol or tobacco as "drugs". And yet tobacco or alcohol use – and their associated harms and costs – are much more widespread in our society than the use of illegal substances.*

There are many different terms used in the mental health and substance use field, with no consensus about preferred language. Nor will widespread adoption of neutral language by itself fully address the profound impact of stigma on individuals and families. However, greater attention to how we describe our own mental health and substance use problems, and those of others, is an important step in reducing stigma and discrimination, and promoting better health for individuals, families and communities.

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[i] Canadian Centre on Substance Abuse. (2005) *National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada.* Retrieved October 2012 from **http://www.ccsa.ca/Eng/Priorities/NationalFramework/Pages/default.aspx**

[ii] National Treatment Strategy Working Group. (2008). *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy.* CCSA. Retrieved October 2012 from **http://www.nationalframework-cadrenational.ca/uploads/files/TWS_Treatment/nts-report-eng.pdf**

[iii] Canadian Centre on Substance Abuse. (2010). *Competencies for Canada's Substance Abuse Workforce.* Ottawa, ON: CCSA

[iv] Greaves, L. & Poole, N. (Eds.) (2007). *Highs and lows: Canadian perspectives on women and substance use.* Toronto, ON: Centre for Addiction and Mental Health.

[v] Poole, Nancy and Diane Smylie. (2013) Trauma-informed practice guide for BC (in draft November 2012). Vancouver, BC: BC Centre for Excellence in Women's Health.

[vi] For example, in British Columbia Ministry of Health Services. (2004). *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction*; National Treatment Strategy Working Group. (2008). *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy; Miller, William R. and Stephen Rollnick. (2012) Motivational Interviewing: Helping People Change, Third Edition. (See reference list at end of manual).*

[vii] Miller, William R. and Stephen Rollnick. (2012) Motivational Interviewing: Helping People Change, Third Edition. Guilford Press, New York. (p.20)

[viii] As above. (p. 15)

[ix] British Columbia Ministry of Health and Ministry of Children and Family Development. (2011). *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia – First Annual Report.* Retrieved October 2012 from **http://www.health.gov.bc.ca/library/publications/year/2011/HMHP-progressreport-2011.pdf.** Used with permission.

MODULE I: UNDERSTANDING SUBSTANCE USE IN OUR SOCIETY AND OURSELVES

MODULE 1: UNDERSTANDING SUBSTANCE USE IN OUR SOCIETY AND OURSELVES

Psychoactive Substance Use and Our Society

HISTORY OF PSYCHOACTIVE[1] SUBSTANCE USE

The use of psychoactive substances is not new. Evidence exists that humans have been using alcohol and plant-derived drugs for both their presumed therapeutic effects, for religious purposes, and for social or recreational purposes since humans first appeared on the planet. For example, mead (made from honey) is thought to be the oldest alcoholic beverage, dating back to about 8000 B.C. Beer and berry wine have been found to be used about 6400 B.C.; and grape wine dates back from 300-400 B.C. Tobacco has been used for centuries in a ceremonial way by North American aboriginal societies, and was introduced in the 1500s in Europe as a herb useful for treating anything, including "persistent headaches", "colds" and "abscesses and sores on the head". Opium used in early Egyptian and Greek cultures around 1500 B.C. as a remedy "to prevent excessive crying of children", was viewed as a cure-all in Greek medicine, and used extensively recreationally, in the forms of opium cakes and candies sold on the street. The earliest reference to cannabis use is in a pharmacy book written in 2737 B.C. by a Chinese emperor who called cannabis the "Liberator of Sin" and also recommended it for " ... gout, rheumatism, malaria, beriberi, constipation and absent-mindedness".

The way that we view drugs has been influenced by major events in pharmacology, in medicine and through cultural change. For example, the use of vaccines in the 19th century helped convince people that medicine can produce drugs with beneficial effects that are very powerful. Psychoactive substances have been used extensively around the world as part of spiritual questing; and those involved in the "age of Aquarius" in the 1960s and 1970s condoned using drugs to "know yourself, be yourself, and experience yourself".[i]

CURRENT RESEARCH ON PREVALENCE OF USE

Remaining current on trends and research in psychoactive substance use is important to maintaining a high level of professionalism in practice. Practitioners should be able to critically read research and understand its benefits and limits. This module looks at several different areas of substance use research. As you work through the module, try to keep in mind how these findings could be applied to your clinical practice.

1 Psychoactive substances are drugs (including alcohol) that are used to change the mood or state of mind of the user.

Canadian Tobacco, Alcohol and Drugs Survey (CTADS) - (Health Canada with National and Provincial Partners)

Formerly separate surveys known as the Canadian Tobacco Use Monitoring Survey and the Canadian Alcohol and Drug Use Monitoring Survey, the two have now been combined into CTADS.

Health Canada monitors the use of psychoactive substances by Canadians aged 15 years and older on an ongoing basis. The Canadian Tobacco, Alcohol and Drug Use Survey gathers and provides information on substance use behaviour, outcomes and trends – both nationally and by province.

In 2011 more than 10,000 Canadians provided information in telephone interviews. This sample size is believed to allow the findings to be generalized to all people in Canada who are 15 and older. The summary report, (found at **http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2011/summary-sommaire-eng.php)** provides the highlights of findings as well as comparisons to previous years.

Some highlights of the 2011 survey:

Alcohol

- 89.7% of Canadians 15 and over have used alcohol in their lifetime.
- 78% have used alcohol within the past 12 months. This rate has remained generally the same over past years' surveys.
- The average age of initiation to alcohol use for respondents 15 to 24 years was 16.0 years.

In 2011, Canada's Low-Risk Drinking Guidelines were introduced.[ii] In 2011:

- 14.4% of Canadians aged 15 and older drank more than the amount recommended to prevent risk of chronic health problems such as cardiovascular disease and cancer
- 10% drank more than the amount recommended to prevent acute risk.

Cannabis

- 39.4% of Canadians have used cannabis in their lifetime.
- 9.1% have used cannabis within the past 12 months. This is a decrease from the previous year's 10.7%
- The prevalence of past-year cannabis use decreased since 2004's Canadian Addiction Survey for males (18.2% to 12.2%), females (10.2% to 6.2%) and youth aged 15-24 (37% to 21.6%).
- The average age of initiation to cannabis was 15.6 years.

Other illicit drug use in the past year

- Cocaine/"crack" .9%
- "Speed" .5%
- Hallucinogens .9%
- Methamphetamine (Estimate not given due to "high sampling variability)

Psychoactive pharmaceuticals

- The rate of past-year use of psychoactive pharmaceuticals (i.e. "prescription drugs") decreased from26.0% to 22.9%. Of those, 3.2% said they had used the drug(s) for a purpose other than what it was prescribed for.

Drug-related harms in past year

- Any related harm to self – among users of any drug 17.6%
- Any related harm to self – total population 1.8%

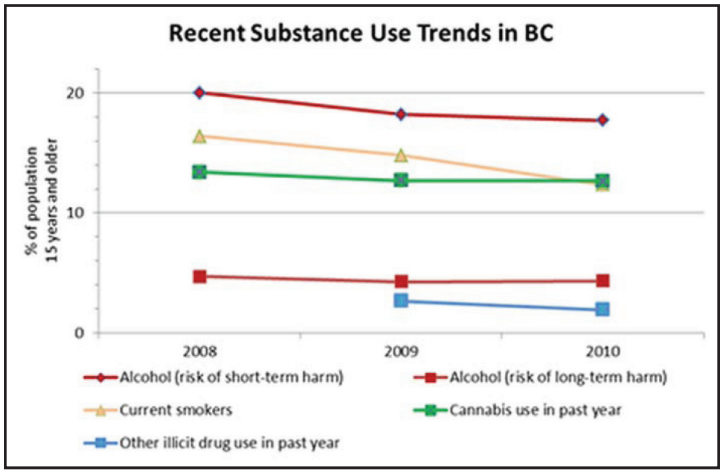
Youth data (15-24 years of age)

- 70.7% reported using alcohol in the past 12 months. This rate has remained generally the same over past years' surveys. Among youth who reported drinking the past year, just over 21% exceeded low-risk drinking guidelines.
- Past-year use of at least one of five illicit drugs (cocaine/crack, speed, hallucinogens excluding salvia, ecstasy, and heroin) decreased from 11.3% to 4.8%.
- Rates of use for some drugs are much higher than they are for adults. Three times higher for cannabis and 5 times higher for any of the five drugs listed in the above bullet.
- Youth were approximately 5 times more likely than adult to report they had experienced harm due to drug use

The Alcohol and Other Drug Monitoring Project (Centre for Addictions Research of BC with National and Provincial Partners)

The AOD Monitoring Project utilizes data from a variety of sources to put together a picture of substance use prevalence and patterns in British Columbia. AOD Monitoring Project provides key indicators and data for ongoing education and research, as well as informing policy development at the national, provincial and regional levels. More information and key findings can be found at **http://carbc.ca/FactsStats.aspx**

Sample illustrations follow.


Recent Substance Use Trends in BC
% of population 15 years and older
20
10
0
2008
2009
2010
Alcohol (risk of short-term harm)
Alcohol (risk of long-term harm)
Current smokers
Cannabis use in past year
Other illicit drug use in past year

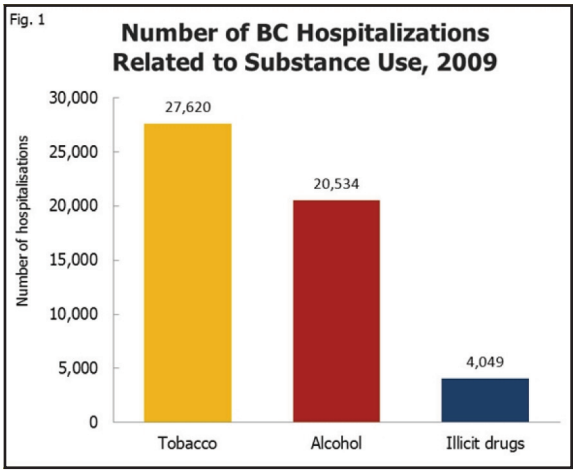


Fig. 1
Number of BC Hospitalizations Related to Substance Use, 2009
Number of hospitalisations
30,000
25,000
20,000
15,000
10,000
5,000
0
27,620
20,534
4,049
Tobacco
Alcohol
Illicit drugs

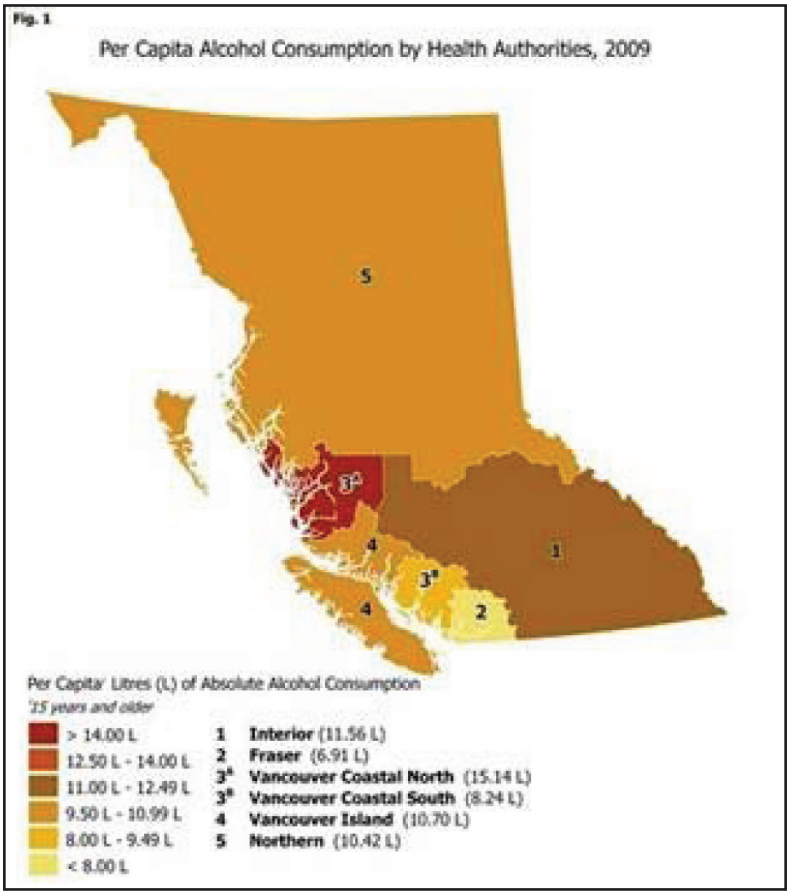


Fig. 1
Per Capita Alcohol Consumption by Health Authorities, 2009
5
3N
4
1
3S
4
2
Per Capita Litres (L) of Absolute Alcohol Consumption
15 years and older
> 14.00 L
12.50 L - 14.00 L
11.00 L - 12.49 L
9.50 L - 10.99 L
8.00 L - 9.49 L
< 8.00 L
1 Interior (11.56 L)
2 Fraser (6.91 L)
3N Vancouver Coastal North (15.14 L)
3S Vancouver Coastal South (8.24 L)
4 Vancouver Island (10.70 L)
5 Northern (10.42 L)

BC's Adolescent Health Survey (McCreary Centre Society)

Undertaken every five years, the most recent Adolescent Health Survey of BC public school students grades 7 to 12 was carried out in 2008. Findings of this and previous surveys can be found at **http://www.mcs.bc.ca**.

Data of interest include:

- Among those who reported using alcohol or cannabis the previous Saturday, about 60% of 18 year olds and 95% of those aged 12 or younger had either abstained completely or had not experienced any related consequences.
- Overall rates of ever using alcohol, tobacco and marijuana have continued to decrease over the past ten years.
- Alcohol continues to be the most commonly-used substance for the youth responding to this survey.
- By the age of 18:
  - 78% have used alcohol at least once.
  - 50% have used marijuana at least once.
  - 40% have used tobacco.
  - 15% have used ecstasy.
  - 10% have used cocaine.
  - Almost 3% have used methamphetamine.
  - 31% had experienced no problems as a result of their substance use.
  - 25% had passed out as a result of substance use; and 31% were not able to remember things they had said or done.[iii]
- Gender differences:
  - Females were more likely to have tried tobacco or taking prescription medications without a doctor's consent.
  - Males were more likely to have tried hallucinogens, heroin or steroids.

For more detailed information on patterns in substance use by girls and women over several years, and how that compares with men and boys, see the article by Nancy Poole and Colleen Dell available through the CCSA website.[iv]

Costs of Substance Use Problems in Canada

The overall costs to Canadian society of substance use problems have most recently been estimated using data from 2002.[v]

It was found at the time that the impact in terms of lost productivity, direct health care costs, direct law enforcement costs, and other, more indirect costs, was $39.8 billion per year, or $1,267 per capita.

Tobacco accounted for about $17 billion or 42.7% of that total estimate. Alcohol accounted for about $14.6 billion (36.6%) and illegal drugs for about $8.2 billion (20.7%).

Theoretical Models of Substance Use Problems and Addiction

The search for the underlying causes of problematic use of alcohol and other drugs has led to many theoretical and conceptual models being developed over time in the field. Each of these models has its own perspective on the nature and cause of the problem and how it should be treated. Therefore, the theoretical foundation on which a system or a practitioner bases their work will greatly influence how services are offered, and the way helpers approach their work.

THEORIES OVER TIME

Over time, many different theories of the causes of addiction have been articulated. Following are some of the major theories. You may note that aspects of these ways of thinking about substance dependence and addiction continue to influence our language, how some services and supports are structured, and the nature of the work we do today. As with most theories, there can be conceptual benefits to taking the given perspective, as well as risks.

Moral Theory

The moral theory denotes substance "misuse" as a vice or a sin. The theory implies that some individuals, through their own free will, make a conscious choice to become or remain substance "abusers" or "addicts" and that they are exhibiting their moral inferiority if unwilling or unable to change.

Spiritual Theory

The spiritual theory attributes substance use problems to the absence of a metaphysical focus within the affected individual. This theory suggests that some individuals are powerless over their substance misuse unless they acknowledge their inability to self-correct without a spiritual force to guide them.

Disease Theory

In the origins of this theory, substance dependence or addition is deemed to be a result of a unitary disease characterized by specific features including loss of control over drug consumption. People with substance dependence are considered to be different from non-problematic users; their illness is progressive, has an identifiable natural history, and will always be a part of the person's makeup.

Some implications that have been attributed to this theory are:

a) The goal of treatment is always abstinence.

b) Recovery without treatment is unlikely.

c) Once a person has stopped using the problem substance, the potential for relapse is always present regard less of the duration of the sobriety.

In recent years – with the greatly-increased knowledge of neuroscience, many professionals have updated their language regarding this theory and will now say "Addiction is a brain disease".

Symptomatic Theory

Within this context, substance use problems are a symptom of another mental disorder, such as anxiety, depression, neurosis, post-traumatic stress disorder. The major implication of this theory is that treatment of the underlying psychiatric disorder will lead to the remission of substance use problems. Therefore attention is focussed on diagnosing and treating coexisting psychiatric illness as "primary".

Learning Theory

This theory contends that addiction is a result of complex processes of behaviour acquisition and reinforcement. Initially, a person uses a psychoactive substance either as a means of coping with distress or increasing pleasure; and it works. Having been reinforced, the substance use is repeated as a means of achieving the same ends. Eventually, the ongoing substance use results in increased distress rather than the desired ends; and other means of reducing distress or increasing pleasure are interfered with due to the substance use. In reality several contingencies appear to reinforce or maintain use of alcohol or other drugs, including:

- The effects of the drug(s);
- The genetic and physiological make-up of the individual
- Social aspects of substance use
- The individual's ability to tolerate aversive environments or physical states; and the individual's level of need to reduce distress.

Dislocation Theory

In his book: The Globalization of Addiction[vi], Bruce Alexander posits that addiction results from people being "shorn of their cultures and individual identities by the globalization of a free market society in which the needs of people are subordinated to the imperatives of markets and the economy." In other words, dependence on psychoactive substances can be seen as an adaptive response to an intolerable situation of disconnection from community and self.

Alexander proposes a shift to a socio-economic paradigm for understanding and addressing the changes needed to reduce widespread problems related to addiction.

BIOPSYCHOSOCIALSPIRITUAL MODEL

The Biopsychosocialspiritual Model is an attempt to integrate the diverse orientations and perspectives found in the many models of psychoactive substance use. This is the model that the international community and the government of British Columbia have adopted as the guiding model for its substance use treatment programs. It has also been known as the "holistic model", and is closely related to the Medicine Wheel that is used by some aboriginal cultures for healing.

This theory postulates that problematic substance use is the net result of a complex interaction between a combination of biological, psychological, social and spiritual determinants.

The biopsychosocial spiritual model was described by Dr. George Engel in the 1970's, when his research findings indicated the significance of acknowledging "the importance of patients and of attention to clinical phenomena in the medical world of modern science". Engel began to appeal for a comprehensive biopsychosocial model as an alternative to what he labelled the "biomedical reductionism" that had become dominant in medicine. He called for the adoption of a broadly inclusive, systems-based, conceptual framework that legitimated, among other things, paying close attention to the patient's social needs and emotional realities and the training of a new generation of "biopsychosocial clinicians".[vii]

The four components of the model are as follows:

- BIO: physical factors, factors within the body, such as medical effects of substances, neurological effects, genetic risk factors
- PSYCHO: influencing factors related to emotions and experiences such as emotional state, self-esteem, cognition, mood.
- SOCIAL: factors related to the person's interactions with other people, including social support, cultural and family contexts.
- SPIRITUAL: presence or lack of meaning, purpose or connection in life; sense of connection and belonging; level of groundedness and spiritual self-care.

Problematic substance use is the net result of a complex interaction between a combination of biological, psychological, social and spiritual determinants. The question "what substance use syndromes at which stage of their development and in what kinds of patients respond under what conditions in what short and long term range ways to what measure by whom?" redirects questions toward the nature of substance use problems rather than the cause. The theory acknowledges that problematic substance use is complex, variable and multifactoral.

Implications for Clinical Practice

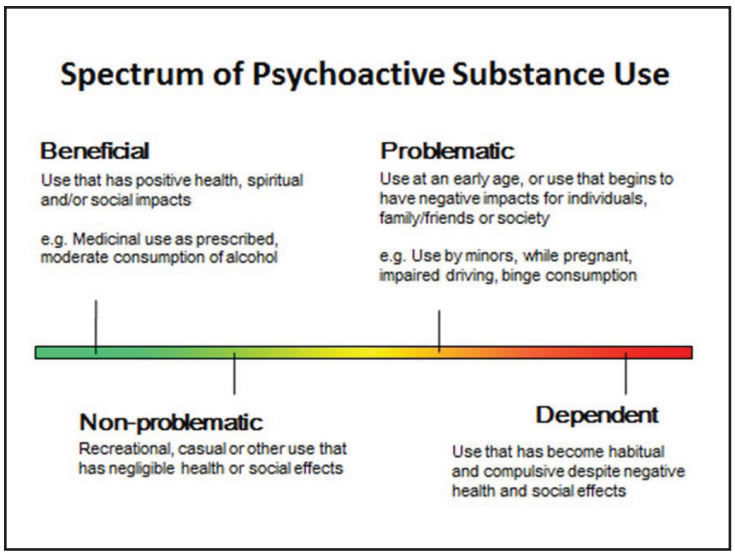
Subscribing to this model has implications for clinical practice:

- Problematic substance use embraces a variety of syndromes, including dependency syndrome and substance misuse-related disabilities.

- Problematic substance use exists across a continuum of severity.
- The development of problematic substance use follows a variable pattern over time, and may or may not progress to a fatal stage, depending on the type of syndrome and/or degree of severity.
- There is no one superior treatment for all problematic substance use.
- The population of people who experience serious problems related to their substance use is heterogeneous.
- Successful treatment depends on accurate and comprehensive assessment and matching of affected individuals to the most appropriate treatment.
- Recovery may or may not require abstinence, depending on the degree of severity and/or the type of syndrome.
- The client's commitment and involvement is required.

Spectrum of Substance Use

When looking at alcohol and other drug use, we can see a range of instances and patterns of use, from beneficial use to non-problematic use to problematic use to dependence. Individuals may move from one point of the continuum and remain stable there or may gradually or rapidly move to another point. It is also important to note that individuals may be at different points on the continuum with respect to their uses of different substances. There are a variety of ways of representing these concepts. The following is from *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia (2010).*



TYPE	SUBSTANCE USE	REASONS	CONSEQUENCES
Beneficial Use	Coffee/tea to increase alertness; prescribed medications; ceremonial use of tobacco	Health, spiritual, social or physical benefit. Can be used to manage symptoms of mental illness (when authorized by physician.)	Positive health, spiritual or social improvement
Non-problematic Use	Use that has no or negligible health or social impacts.	Personal choice; health-related concerns; family, religious or cultural traditions or beliefs	Minimal negative consequences.
Problematic Use	Use in higher-risk situations or amounts, or of illegal substances. May involve use of higher doses due to increased tolerance; trying stronger drugs, or adding drugs. A habit or pattern can develop and become the norm around which activities must revolve.	Use can become a lifestyle preference to avoid stress, uncomfortable feelings, responsibilities, conflicts; or to cope with negative withdrawal symptoms Can use to manage symptoms of mental illness (without physician involvement)	Family/work/school/community involvement impacted. May impact the safety and wellbeing of others. Legal and/or financial problems as well as worsened reputation may result. Personal values and/or health are compromised
Dependent Use	Drug use becomes a debilitating preoccupation and is the centre of social interactions. Person is unable to predict or control substance use. Periods of abstinence tend to be short-lived and can be extremely uncomfortable. Extreme intoxication is common. Previously unacceptable methods of using the substances can become possible.	To feel “normal” To feel able to function To forget or numb psychological trauma or pain To avoid both physical and psychological symptoms of withdrawal and experience intoxication	Serious negative consequences in many areas of life Physical problems may include loss of weight, blackouts, and injuries from falls and accidents Behaviour and feelings can become uncontrollable (anger, guilt, shame, self-hatred) Can be involved in illegal activities to afford substances Avoids social involvement; isolates

Key concepts

- Instances and patterns of psychoactive substance use occur along a spectrum. By definition non-use or abstinence does not fall on the spectrum.
- For some people, their use of one substance may be beneficial or non-problematic, while their use of other substances may be problematic; these patterns of use may shift over the lifespan.
- Some individuals are more vulnerable than others to developing problem or dependent use. This depends on a wide variety of factors, including stage of physical and/or mental development, gender, genetic makeup. It also depends on each person's strengths, supports, and other protective factors.
- There is often a loss of choice and control over using a particular substance for people who develop chronic dependent patterns of use, or addiction to that substance.
- It has been estimated by the World Health Organization that within the larger population:
- About 75% of people have either no, or low, risk of substance use problems.
- About 20% of people have some level of risk; and
- About 5% of people have a high risk of problems related to their psychoactive substance use.

Harm Reduction

Harm reduction is an important component of the overall response to problematic substance use, including for the Substance Use Services treatment system. Harm reduction involves "meeting the client where they're at" and supporting them to move in the direction of improved health. For some clients, abstinence or ceasing the use of their substance(s) of choice is a desired and realistic goal. For others, reducing their use, using in less risky ways, or stabilizing their lives in other ways—such as securing housing, employment, or reconnection with family—are more immediate goals. Harm reduction is also important for treatment providers because if a client relapses, which for many is a part of the recovery process, they are at higher risk for adverse consequences such as fatal overdose.

Some substance use treatment services (such as withdrawal management programs and intensive residential or day treatment programs) may have higher thresholds and expectations about abstinence of clients, although they can incorporate some harm reduction approaches appropriate for their setting. Harm reduction can save lives and reduce preventable illnesses and disease, so it is essential for treatment providers to understand its principles and how they fit within a health system response to problematic substance use.

DEFINITION OF HARM REDUCTION

The International Harm Reduction Association (2010) describes harm reduction as:

Policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and communities, without requiring decrease in drug use.[viii]

PRINCIPLES OF HARM REDUCTION

The BC Ministry of Health publication, *Harm Reduction: A British Columbia Community Guide*, outlines six principles of harm reduction. These are excerpted below.[ix]

Pragmatism

Harm reduction accepts that the non-medical use of psychoactive or mood altering substances is a near-universal human cultural phenomenon. It acknowledges that, while carrying risks, psychoactive substance use also provides the user and society with benefits that must be taken into account. Harm reduction recognizes that drug use is a complex and multifaceted phenomenon that encompasses a continuum of behaviours from abstinence to chronic dependence, and produces varying degrees of personal and social harm.

Human Rights

Harm reduction respects the basic human dignity and rights of people who use psychoactive substances. It accepts the user's decision to use drugs as fact and no judgment is made either to condemn or support the use of psychoactive substances. Harm reduction acknowledges the individual drug user's right to self-determination and supports informed decision making in the context of active psychoactive substance use. Emphasis is placed on personal choice, responsibility and self-management.

Focus on Harms

The fact or extent of an individual's psychoactive substance use is secondary to the harms from drug use. The priority is to decrease the negative consequences of drug use to the user and others, rather than decrease drug use itself. While harm reduction emphasizes a change to safer practices and patterns of psychoactive substance use, it does not rule out the longer-term goal of abstinence. In this way, harm reduction is complementary to the abstinence model of substance use treatment.

Maximize Intervention Options

Harm reduction recognizes that people with substance use problems benefit from a variety of different approaches. There is no one prevention or treatment approach that works reliably for everyone. It is choice and prompt access to a broad range of interventions that helps keep people alive and safe. Individuals and communities affected by psychoactive substance use need to be involved in the co-creation of effective harm reduction strategies.

Priority of Immediate Goals

Harm reduction establishes a hierarchy of achievable steps that taken one at a time can lead to a fuller, healthier life for substance users and a safer, healthier community. It starts with "where the person is" in their drug use, with the immediate focus on the most pressing needs. Harm reduction is based on the importance of incremental gains that can be built on over time.

Involvement of People Who Use Drugs

The active participation of psychoactive substance users is at the heart of harm reduction. People who use drugs are seen as the best source of information about their own substance use, and are empowered to join with service providers to determine the best interventions to reduce harm from substance use. Harm reduction recognizes the competency of people who use drugs to make choices and change their lives.

CONCERNS ABOUT HARM REDUCTION APPROACHES

People who use drugs, and especially those with substance dependence problems, are often stigmatized and marginalized because of their use. Providing compassionate care for people is an important way of engaging them in health services, as further stigma and discrimination can exacerbate issues that may be contributing to their problems. However, attitude change is one of the most difficult strategies to implement in the harm reduction field. Harm reduction as an appropriate goal for treatment may be controversial for some people, including practitioners. Practitioners need to address their own concerns about harm reduction as well as be able to respond to the public's concerns about harm reduction approaches they may face in their day-to-day work. Some common concerns about harm reduction are described below in an excerpt from *Harm Reduction: A British Columbia Community Guide*.

Concern: Harm reduction enables drug use and entrenches addictive behavior - This is rooted in the belief that substance users have to hit "rock bottom" before they are able to escape from a pattern of substance use and that harm reduction protects them from this experience. For those who do not want to quit, cannot quit, or relapse into substance use, harm reduction can effectively prevent HIV, hepatitis C, fatal overdose, and other drug-related harms. Harm reduction is often the first or only link that marginalized substance users have to the health and social service system and, as such, can be a gateway to substance use treatment. Harm reduction services increase the possibility that psychoactive substance users will re-engage in broader society, lead productive lives and quit using psychoactive substances, instead of contracting and transmitting infectious diseases and/or succumbing to drug overdose death.

Concern: Harm reduction encourages psychoactive substance use among non-drug users - This is based on the notion that harm reduction "sends out the wrong signal" and undermines primary prevention efforts. Some feel that helping psychoactive substance users stay alive, reduce their exposure to risk and become healthier may encourage non-users to regard psychoactive substance use as safe and to want to start using psychoactive substances. This view underestimates the complexity of factors that shape people's decisions whether to use psychoactive substances. It also ignores numerous scientific studies that have found no evidence that the introduction of needle distribution, supervised injection sites, or other harm reduction programs increases psychoactive substance use.

Concern: Harm reduction drains resources from treatment services - Harm reduction interventions are relatively inexpensive and cost effective. They increase social and financial efficiency by interrupting the transmission of infectious disease at a lower cost, rather than waiting to treat complications of advanced illness at a much higher cost.

Concern: Harm reduction is a Trojan horse for decriminalization & legalization - Harm reduction attempts to deal with the harms from psychoactive substance use as it occurs within the current global regulatory regime. Some advocates of harm reduction want to see changes in the way governments have been attempting to control the trade and use of currently illegal drugs; others do not. Harm reduction itself is neutral regarding the question of legalization. The philosophy of harm reduction applies equally to alcohol and tobacco use, which is legal in most countries.

Concern: Harm reduction increases disorder & threatens public safety & health - Often referred to as the "honey pot effect", this concern assumes that harm reduction programs will attract drug dealers and compromise the safety and well-being of the surrounding community. Evidence has conclusively demonstrated that harm reduction programs do the opposite. They have a positive impact on public health by reducing the prevalence of blood borne viruses such as HIV and hepatitis C. Needle exchange programs often recover more needles than they distribute, which means fewer used needles discarded publicly in the community. Supervised injection services reduce the number of public injections by providing a safe, indoor alternative to open substance use. Protocols between police and harm reduction service providers ensure drug trafficking laws are enforced – open drug dealing is discouraged, while drug users are encouraged to access needed services.

EVIDENCE-BASED HARM REDUCTION APPROACHES

There are many harm reduction approaches that now have a solid base of supportive evidence. Among these are the following approaches that may be offered in partnership with, or as part of substance use treatment services.

Education and Outreach

Drug education materials with a harm reduction focus are a cost effective way to target psychoactive substance users. These materials do not promote psychoactive substance use, but rather tell users how to reduce the risks associated with drug use, especially the transmission of HIV and hepatitis C. Harm reduction education materials can teach safer injecting techniques, overdose prevention and proper condom use. The materials frequently attain high levels of cultural acceptability and approval among target populations, with impacts on knowledge, attitudes and self-reported or planned behaviour.

Outreach programs seek face-to-face contact with people who use drugs. They deliver information, resources and services to hard to reach populations of psychoactive substance users and establish links between isolated drug users and critical health services. Outreach programs provide literature about HIV and hepatitis C risk reduction, promote teaching and modelling of risk reduction by leaders of drug user networks, distribute condoms and bleach kits, make referrals to services, provide counselling and support community development. The involvement of people who use drugs is an important component of effective outreach as peers help change group norms by demonstrating changes in their own behavior.

Low Threshold Support Services

A key attribute of harm reduction practice is the concept of low threshold service delivery. Low threshold services have minimum requirements for participation and normally address basic health and social needs of the substance user. For many people it is impossible to address psychoactive substance dependence or deal with the multitude of related health problems without first having a safe, stable place to live and nutritious food to eat. Low threshold substance use services do not require abstinence. Instead, they work towards engaging participants who actively use psychoactive substances while reducing drug-related harm. These services help to stabilize participants and direct them to treatment services when they are ready. Ongoing contact with service providers allows for the development of trust while the minimal requirements provide opportunity for building a history of successes rather than reinforcing the experience of failure.

Opiate Replacement Therapy (O.R.T.)

Methadone maintenance therapy (MMT) is the current gold standard for treating opiate dependence. It may be thought of as a long term treatment for some dependent opioid users, just as insulin is a long term treatment for diabetes.

Methadone is a legal opioid medication prescribed by physicians and dispensed by community pharmacists. Each dose is consumed orally, in most cases in the presence of a pharmacist. Methadone works by binding with receptors in the brain that also bind with heroin, resulting in reduced cravings for heroin. There is no "high" or changes in behaviour associated with taking methadone. It is relatively safe and has few side effects. MMT reduces the use of other opioids, injection related health risks, mortality and drug-related criminal activity. It improves physical and mental health, social functioning, quality of life, pregnancy outcomes and client connections to other critical medical and social services. MMT is also highly cost effective.

MMT is an established international best practice. In B.C., MMT is administered by the College of Physicians and Surgeons of B.C. The B.C. Methadone program has expanded significantly in the past decade to improve its reach among opiate-dependent British Columbians and has been found to be successful in retaining clients, reducing criminal activity, reducing use of other opiates, and increasing attachment to stable housing.

Buprenorphine (Suboxone) is another opioid replacement medication. Buprenorphine (Suboxone), unlike methadone, has both opioid agonistic and antagonistic effects. This means it binds more strongly to receptors in the brain than do other opioids, making it more difficult for opioids (or opiates) to react when buprenorphine is in the system.

People on maintenance with Suboxone do not have a risk of overdose from buprenorphine alone, no matter what dosage is taken or route of administration it is taken by, due to the "ceiling effect" on respiratory depression.

Like full-agonist opiates, buprenorphine can cause drowsiness, vomiting and respiratory depression. Taking buprenorphine in conjunction with central nervous system (CNS) depressants in people who are not tolerant to either agent can cause fatal respiratory depression. Sedatives, hypnotics, and tranquilizers can be dangerous if ingested with buprenorphine by a person who is tolerant to neither opioids nor benzodiazepines. Co-intoxication with ethanol carries the greatest risk for lethal overdose.

When initiating onto Suboxone , people switching from other opiates should wait until mild to moderate withdrawal symptoms are encountered. Failure to do so can lead to the rapid onset of intense withdrawal symptoms, known as "precipitated withdrawal". For short-acting opioids such as codeine, hydrocodone, oxycodone, hydromorphone, pethidine, heroin, and morphine, 8-16 hours from the last dose is generally sufficient. For longer-acting opioids such as methadone at least 48 hours from the last dose is needed to prevent precipitated withdrawal.

[i] 2008 version of CAP attributed much of this section to Ray, O. and Ksir, C. (1999). *Drugs, Society and Human Behaviour.* No publisher identified. Web search indicates McGraw-Hill Ryerson was most recent Canadian publisher.

[ii] http://www.ccsa.ca/Eng/Priorities/Alcohol/Canada-Low-Risk-Alcohol-Drinking-Guidelines and http://www.carbc.ca/HelpingCommunities/ToolsResources/LowRiskDrinkingGuidelines.aspx

[iii] http://www.carbc.ca/Portals/0/PropertyAgent/558/Files/5/CARBC_Bulletin5.pdf

[iv] http://www.ccsa.ca/2005%20CCSA%20Documents/ccsa-011142-2005.pdf

[v] Rehm et al. (2006). *The Costs of Substance Abuse in Canada 2002*. Canadian Centre on Substance Abuse. Retrieved October 2012 from http://www.ccsa.ca/2006%20CCSA%20Documents/ccsa-011332-2006.pdf

[vi] Alexander, B. K. (2008). *The globalisation of addiction: A study in the poverty of spirit.* Oxford: Oxford University Press.

[vii] Brown, Theodore M. (2000). The Growth of George Engel's Biopsychosocial Model. (*Corner Society Presentation*) University of Rochester. Copy retrieved October 2012 at http://www.human-nature.com/free-associations/engel1.html

[viii] A position statement from Harm Reduction International. (2010 version). Accessed October 2012 at http://www.ihra.net/what_is_harm_reduction

[ix] *Harm Reduction: A British Columbia Community Guide (2005).* BC Ministry of Health. Can be accessed at http://www.health.gov.bc/library/publications/year/2005/hrcommunityguide.pdf

MODULE II: PSYCHOACTIVE DRUGS AND HOW THEY AFFECT US

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Basic Pharmacological Concepts

Psychoactive substances alter brain functions, primarily by producing desired changes in mood. Other processes that may be altered are perception, attention, learning, memory, concentration and abstract thought.

WHAT IS A DRUG?

For the purposes of Core Addiction Practice, a drug is any psychoactive substance that is used to change the mood or state of mind of the user.

WHY PEOPLE USE DRUGS

Aside from those who have developed a dependency on a psychoactive substance, there are many reasons people use drugs:

- Relief from pain
- Reduction of uncomfortable or unwanted levels of activity or feelings
- Increase in level of activity and feelings of energy and power
- Altered consciousness
- Feelings of intoxication

DRUG CATEGORIES

Practitioners working in Substance Use Services need information about the different psychoactive substances their clients use for several reasons (for assessment of withdrawal, potential harm assessment, and for goal setting and treatment planning purposes). There are many ways to group and categorize the different psychoactive substances and one of the most common is ways is based on the pharmacological effects they have on the central nervous system. This version is adapted[i] from Health Canada's most recent edition of *Straight Facts About Drugs and Drug Abuse*. For other sources and ways of classifying psychoactive substances, see Web Resources for Ongoing Learning at the end of this manual.

Stimulants	Depressants	Opiates	Hallucinogens	Cannabis
Drugs that excite or speed up central nervous system. Generally used for their ability to increase alertness and endurance, to keep people awake for a long period of time, to decrease appetite and to produce feelings of well-being and euphoria. Can increase aggressiveness.	Cause a slowing down of the central nervous system. In general, at low doses, produce a feeling of calm, drowsiness and well-being. . (Initially, in some people alcohol can cause a feeling of excitement and increase in energy. At higher doses, can produce severe intoxication, unconsciousness and death.	Opiates are e ffective painkillers, decrease anxiety, relax muscles, and can also make users feel intense pleasure	Dramatically affect perception, emotions and mental processes Distort the senses and can cause hallucinations – sensory images similar to dreams or nightmares.	Causes euphoria, sedation, relaxation, decreased anxiety and increased appetite. Cognitive impairment occurs, including reaction time, motor skills, short-term memory, attention span, judgement and coordination. Distortions of time, space, vision and hearing can occur. High doses of marijuana can result in acute mild to severe anxiety and mild to severe paranoia. Very high doses in naïve users can (rarely) produce a hallucinogen–like psychotic state. Chronic use can lead to and negatively alter the course of severe mental health disorders, e.g. schizophrenia; and can lead to chronic cognitive impairment with continued use.

Examples of Stimulants:	*Examples of Depressants:*	*Examples of Opiates:*	*Examples of Hallucinogens:*	*Examples of cannabis:*
Caffeine Cocaine, e.g. crack cocaine Amphetamines e.g. - Dexedrine - Methamphetamine, e.g. Crystal Meth - Diet Pills Drugs to treat ADHD e.g. Ritalin Decongestants	Alcohol GHB (Gamma hydroxybutyrate) Solvents/inhalants Benzodiazepines: - Valium (Diazepam) - Ativan (Lorazepam) - Xanax (Alprazolam) - Rivotril (Clonazepam) - Serax (Oxazepam) Rohypnol Barbiturates - Seconal - Tuinal General Anaesthetics Antihistamines	Analgesics(pain killers): - Heroin - Morphine - Methadone - OxyContin (Oxycodone) - Percodan (Oxycodone and ASA) - Percocet (Oxycodone and Acetaminophen) - Codeine - Demerol (Meperidine, Pethidine) - Fentanyl and Dilaudid (Hydromorphone) - Buprenorphine (Suboxone)	Magic Mushrooms MDA/MDE Ecstasy (MDMA) Acid/ LSD Mescaline/Peyote PCP (Phencyclidine) Ketamine Nitrous Oxide	Marijuana Hashish Hashish oil Marinol Sativex

Psychosis -inducing Drugs

It is known that some drugs such as amphetamines and cocaine can cause drug induced psychosis. This psychosis can last from a few days up to a week, (although most psychosis clears spontaneously without requiring medication within 3-5 days after cessation of the drug); and is often characterized by hallucinations, delusions, memory loss and confusion. This usually results from prolonged or heavy street-drug use; and responds well to treatment. The sleep deprivation often caused by heavy continuous use of these drugs contributes to some of the symptoms of psychosis.

Methamphetamine (also known as "crystal meth")

It is estimated that 10-20% of methamphetamine abusers develop psychosis. Typical symptoms include paranoia and auditory hallucinations, which cannot be distinguished from other psychotic disorders such as schizophrenia.

The onset of psychosis often occurs gradually with continued use but can sometimes occur suddenly even with very little use. Using methamphetamine can trigger the psychosis, but that doesn't necessarily mean that the psychosis will end when the psychoactive substance use stops. This psychosis may continue on even after quitting. If the psychosis does stop, using methamphetamine again, or sometimes stress alone without the methamphetamine, can trigger the recurrence of the psychosis.

Psychoactive drugs and psychotropic (Mental Health) medications

Except for benzodiazepines, it has been found that alcohol and other psychoactive drugs do not interact with psychotropic medications and that it is important to stay on those medications (e.g. antidepressants) even when drinking or using other drugs. However psychoactive substances often do have a negative impact on the disease prognosis itself so it is better not to use them while on psychotropic medications.

FACTORS INFLUENCING THE EFFECTS OF PSYCHOACTIVE SUBSTANCES

The effects of alcohol and other drugs depend on many factors.

Psychological factors can play a critical role in the effect of a drug. The person's expectation than an effect will occur (placebo effect) is very powerful. The "think-drink" effect[ii] is an example. Subjects expecting alcohol can become intoxicated drinking grapefruit juice. A person's previous drug experience and mood can also have an influence. Physiological factors like body size, gender, health status, nutrition, and age as well as sociocultural factors like the physical and social environment (hospital vs. party) in which the drug is consumed are also factors that can influence drug effects.

Other key factors follow.

Concentration

The intensity of a drug effect depends largely on its concentration, which, in turn, depends on the dose administered; the way in which the substance is absorbed, distributed, metabolized and eliminated by the body; drug interactions; and other factors.

Dose

Dose refers to the amount consumed. Depending on the substance being consumed, the ability to estimate the dose varies. For medication (prescription or non-prescription), the dosage is normally written on the label.

For illicit drugs, dose is hard to estimate. For psychoactive substances derived from plants (e.g., marijuana), different strains of plants or cultivation techniques will alter the potency of the drug. For synthetic drugs (e.g., ecstasy) potency will vary depending on many factors including chemical techniques of the manufacturer, purity, age, storage conditions.

For alcohol, a dose can be estimated using the concept of the "standard" drink:

	=		=		=	
341 ml (12 oz.) beer/coolers (5% alcohol)	=	43 ml (1.5 oz.) liquor (40% alcohol)	=	142 ml (5 oz.) wine (12 % alcohol)	=	85 ml (3 oz.) fortified wine (16-18% alcohol)

In 2011, Canada's new Low-Risk Alcohol Drinking Guidelines were released. There are a wide variety of ways in which these guidelines can be used: as part of public education activities, or with clients who may be interested in assessing their own use in relation to the guidelines.

The Guidelines are available through the Canadian Centre of Substance Abuse at **http://www.ccsa.ca/Eng/Priorities/Alcohol/Canada-Low-Risk-Alcohol-Drinking-Guidelines**. They are also available through the Centre for Addictions Research of BC, along with additional support materials such as fact sheets on alcohol screening, alcohol and women, alcohol and youth, and the like. **http://www.carbc.ca/HelpingCommunities/ToolsResources/Low-RiskDrinkingGuidelines.aspx**

Overdose prevention

It is essential for anyone working with individuals who have substance use problems, including but not exclusive to dependent use, to be aware of the constant risk of overdose, and to be able to discuss it with the people we serve. Overdose can have very serious consequences, including death.

It is often assumed by those who use psychoactive substances that they are fully in control of their use, and are able to avoid high-risk situations. However there are a number of factors that can be at play that increase vulnerability to overdose – examples of which are listed below:

- Inexperience with the substance
- Enhanced physical or mental vulnerability, due to age, illness including but not limited to mental illness, use of prescribed medication or similar factors
- Unknown quality or purity of the substances used
- Use preceded by a significant period of abstinence
- Use of a familiar substance in an unfamiliar combination with others

Absorption

The bloodstream (and to a lesser extent the lymphatic system) delivers drugs to their sites of action. Drugs must be fat-soluble to enter the brain. Fat-soluble drugs also cross the placenta of pregnant women to affect the fetus and can pass into the milk of breastfeeding mothers. The speed at which the drug enters the bloodstream is determined by the route or mode of administration.

Route	Method	Rate of Absorption	Factors affecting rate
Ingestion	Oral administration (swallowing)	Tends to be slow since substances must pass from the stomach into the small intestine before entering the bloodstream	-presence of food in the stomach -stomach contents that dilute the drug -stomach contents that are highly acidic
Inhalation	Absorption into lungs	Occurs very quickly, effects can be felt within 6-10 seconds	how deeply user inhales -how long user holds their breath
Absorption across mucous membranes	Mucous membranes (lining of mouth, nose, eye sockets, throat, vagina, rectum etc.) are more permeable than surface skin	Fast and effective e.g., psychoactive substances that are snorted (cocaine) can be felt within 2-3 minutes	
· Injection	Subcutaneous injection (skin popping) – injection under the skin Intramuscular injection – injection directly into muscle tissue Intravenous injection (mainlining)- injection directly into the bloodstream	Because injection bypasses normal biological barriers, effects of the drug are felt very quickly, within 15 seconds	

Distribution

The bloodstream (and to a lesser extent the lymphatic system) delivers psychoactive substances to their sites of action. Drugs must be fat-soluble, relatively small molecule size, and not attached to blood particles to enter the brain. Fat-soluble drugs also cross the placenta of pregnant women to affect the fetus and can pass into the milk of breast-feeding mothers.

Metabolism and Elimination

As a drug is absorbed into the body, bloodstream concentration begins to fall, reflecting the movement into the tissues (distribution) and later, the drug's metabolism and excretion from the body. Age, genetic determination and disease may affect the rate at which this process occurs. Although some psychoactive substances are excreted from

the body unchanged, most drugs go through a metabolic process (complex chemical transformation) that diminish their potency and promote their elimination. The body process transforms fat-soluble substances into water-soluble substances (metabolites). This process occurs mainly in the liver, but can also occur in the stomach, intestines, brain and kidneys. Sometimes metabolites also have an effect on the brain, and are then further metabolized. The concept of "half-life" is often used to describe the rate of excretion of a drug from the body. This is the time required for the drug concentration in the blood to fall by one-half.

Half-life can be used, in part, to determine how frequently a drug should be administered to maintain an expected effect as well as the problem potential of a drug. A psychoactive substance with a long half-life, such as marijuana, is far less likely to cause withdrawal symptoms as opposed to a drug such as cocaine, with a short half-life which will cause severe withdrawal symptoms, increasing the odds that a youth will use the drug again to get rid of the symptoms.

The two main routes of elimination are the feces (from the liver through the bile ducts into the intestine) and through the urine (from the kidneys to the bladder). Certain psychoactive substances are excreted through the lungs in direct proportion to their bloodstream concentration (e.g., alcohol and how a Breathalyzer can detect alcohol). Minor routes whereby small amounts of a drug may be excreted include milk, saliva, and other body fluids (tears, sweat, semen, etc.)

Drug Interactions

A drug interaction occurs when one drug alters the effects or actions of another drug present in the body. Some reactions may be trivial; others may be life-threatening.

Psychoactive substances taken together can have a variety of effects:

- They can act independently of each other.
- The can enhance each other's effects because of the similarity of their action on the brain or because one drug increases the concentration of the other in the body by interfering with its distribution, metabolism or excretion.
- They can have an antagonistic effect where one drug "blocks" or prevents another drug from producing its effect, the two drugs have opposite effects on the brain or if one drug alters the absorption or distribution of another.

With illicit drugs, drug interactions can be difficult to predict due to the number of uncontrollable variables involved, such as drug dose, potency and purity.

KEY CONCEPTS FOR UNDERSTANDING THE EFFECTS OF ALCOHOL AND OTHER DRUGS

Tolerance

Tolerance is defined as: "… a decreased pharmacological effect after repeated or prolonged exposure to the drug so that higher doses are need to achieve the same clinical effect."[iii]

Facts about tolerance

- Its onset varies from drug to drug.
- Cross tolerance: In some cases, when tolerance develops to one psychoactive substance, it can lead to the development of cross-tolerance to another psychoactive substance with similar pharmacological effects; e.g. methadone for heroin.
- The higher the dose taken, the more quickly tolerance develops.
- It develops more quickly if a drug is taken in a regular pattern than in a binge pattern.
- It develops more quickly if the user has a previous history of tolerance to that drug.
- It does not develop equally for all effects of a drug (e.g. the lethal dose may remain constant while the dosage necessary to get high may rise).
- It may develop more quickly with respect to effects like the loss of dexterity and alertness, which interfere with performance.

Tolerance can be a gradual process developing over a course of days, weeks or months or it can occur after just a few routine administrations. It is not just a physical neurological process, but a behavioural conditioning one as well.

Dependence, Withdrawal and Addiction

Dependence is a term often used interchangeably with addiction. They are actually separate concepts although Addiction can include Dependence.

Dependence

Dependence is a physiological (physical) state of changes in the brain produced by repeated administration of a drug, necessitating continued administration of the drug to prevent withdrawal (or abstinence) syndrome.

Facts about Dependence:

- Dependence may not be apparent as long as the drug is being taken.
- The magnitude of dependence and the severity of withdrawal vary with the amount, frequency and duration of drug use, as well as the drug's half-life and the person's physiological (including genetic) make up.
- Dependence in itself does not mean a substance has abuse potential. Many medical drugs can "cause" dependence (e.g. insulin for diabetes, inhalers for asthma, antidepressants for depression), yet these are not substances of abuse.
- Tolerance and dependence are separate phenomena and may develop independently of each other; however, they often occur together.
- Drugs that are injected (e.g. heroin) or inhaled (e.g. nicotine) are more likely to produce dependence than those that are swallowed.

Addiction

Addiction was previously thought of as "psychological dependence". It shows itself in a behavioural pattern of drug use that leads to changes in the nerve cells of the brain, producing compulsive drug use, inability to cut down or control drug use, overwhelming craving for the drug, and continued use despite negative consequences.

Some facts about Addiction:

- Addiction does not occur in everyone who uses psychoactive substances, even if the use exceeds risk levels.
- Although withdrawal symptoms are common when a person who is addicted to a drug discontinues its use, not everyone who is addicted has acute withdrawal symptoms. A person can be addicted to a substance without having acute withdrawal symptoms when it is discontinued, especially with addictive binge use of the substance.
- Addiction also includes a strong tendency to relapse after discontinuation of the substance. This is different from dependence (e.g. on an antidepressant) where the effects of discontinuation of the substance make the person less likely to want to take it again.

Withdrawal (abstinence) syndrome

This syndrome is the appearance of mental and physical (body and brain) reactions to cessation (or sometimes even decrease) of a dependence-producing substance. Re-administration of the substance alleviates the discomfort. The degree of dependence is indicated by the severity of the withdrawal symptoms.

Facts about Withdrawal

- Withdrawal symptoms manifested tend to be the opposite of the primary drug effect. That is, the withdrawal symptoms are often the reverse of the acute effects of the drug. For example, withdrawal from depressants is characterized by hyperactivity of the central nervous system (e.g. irritability, seizures); while withdrawal from stimulants produces hypoactivity – slowing of central nervous system activity – and mood depression.
- The severity of symptoms varies with the type of drug, the frequency of use, dosage, duration of use, abruptness of discontinuation and other pharmacological factors.
- Withdrawal from some drugs, such as alcohol, barbiturates and benzodiazepines, can be life threatening because of the risk of seizures (and in the case of alcohol, other possible severe symptoms); and may need to take place under medical supervision. Severe GHB withdrawal can also be life threatening. Withdrawal from opioids can be very unpleasant but is rarely life-threatening.
- In some instances, one psychoactive drug may be used to suppress withdrawal in an individual physically dependent on another drug with similar pharmacological effects. For example, benzodiazepines can be used (short term) to prevent or decrease symptoms of alcohol withdrawal.

Post-Acute Withdrawal Syndrome (PAWS)

The withdrawal process can be thought of in two stages with the first stage being the acute, intense and immediate physical and mental effects that occur right after a person stops using alcohol or other drugs. The second stage is the

long-term effects that occur after the initial acute withdrawal stage as the brain begins to adjust to working without the artificial stimulation and disruption to normal brain functioning that occurs during alcohol and/or other substance misuse and the psychosocial stress of coping with life without drugs. This condition is referred to as Post-Acute Withdrawal Syndrome (PAWS) and can last anywhere from six months to two years after the last use, though symptoms tend to peak in intensity over the first three to six months of abstinence. A person can experience the symptoms of PAWS without having experienced acute withdrawal symptoms.

The severity of post-acute withdrawal symptoms appears to be primarily impacted by two factors:

- The amount and degree of brain dysfunction or disruption that has been caused by the length of use, the type of substances used, and any injuries that occurred associated with the use.
- Stress factors experienced early in the recovery process and the severity of the psychological and social stressors that may occur.

Symptoms of post-acute withdrawal vary according to the substance or substances the person has stopped using or cut down, as well as the individual characteristics of the person and their history of use.

Withdrawal from alcohol [iv]

For example, during the *acute* phase of withdrawal from alcohol (up to 7-10 days after the person's last drink), a person can experience:

- Physical symptoms:
  - Fast heart beat
  - Sweating, facial flushing
  - Muscle trembling, muscle spasms, hand and body tremors
  - Insomnia, restlessness
  - Numbness, tingling or burning sensations in arms or legs
  - Nausea, vomiting
  - Ringing in the ears
  - Dry mouth
  - Itching
  - Seizures
  - Stomach pain
  - Chest infections
  - Poor balance when walking

The latter four types of symptoms can be considered severe and require the attention of a physician.

- Psychological symptoms:
  - Anxiety
  - Paranoia
  - Hallucinations
  - Severe confusion.

The latter two can be considered severe and require the attention of a physician.

Post-acute withdrawal from alcohol (lasting up to six months) can include:

- Physical symptoms:
  - Insomnia, restlessness
  - Headache
  - Tiredness, weakness
  - Muscle trembling
  - Sexual problems, e.g. Impotence
- Psychological symptoms of post-acute withdrawal can be expected to gradually decrease over 3-12 months, and include:
  - Anxiety
  - Depression, mood swings
  - Irritability
  - Poor concentration
  - Poor memory
  - Impulsiveness
  - Difficulty in thinking clearly, making plans or decisions

Educating your clients about post-acute withdrawal syndrome

It is important to continue to reassure and support clients through their post-acute withdrawal symptoms. Having completed the acute phase of withdrawal from any substance, clients can tend to forget about or ignore PAWS. This can happen because they want to feel well, do feel better, don't want to think about the true length of time to achieve

full recovery, and/or want to get on with their lives. Some ignore PAWS symptoms that serve as triggers to use, as part of their process leading to relapse. The risks appear when clients mistake PAWS symptoms as resulting from their relationships, circumstances, or their own failings to "just get on with it", leading to increased stress, discouragement, or reduced self-efficacy.

The purpose of ensuring we review PAWS symptoms over weeks and months with the people we serve is to assist to prevent relapse. It can also promote hopefulness – when the person realizes improvement over time, and that there will be an end to these feelings.

Some ways your client can manage PAWS symptoms:

- Having a support person to talk with honestly about how they are feeling, without minimizing, feeling ashamed or incompetent.
- Keeping PAWS in perspective by developing an understanding of the process of addiction.
- Adopting strategies of self-care and self-protection: Good nutrition, adequate sleep and exercize, avoiding trigger foods, people and situations.
- Developing a personal spiritual practice.

In the Appendix to this Module you will find handouts for counsellors to use when discussing PAWS with their clients. There are also handouts for clients, which can be accessed through the link noted at the end of the Appendix.[v]

SOME ADDITIONAL BASIC PHARMACOLOGICAL CONCEPTS

Homeostasis	A state of physiological balance. When a psychoactive substance is taken, the body attempts to regain homeostasis by exerting a pull in the opposite direction of the drug being taken.
Rebound Effect	The body's attempt to achieve homeostasis by pulling in the opposite direction of the drug. For example, a sedative drug can cause sedation initially, but a simultaneous rebound reaction of stimulation and agitation will occur. The rebound will be lower in amplitude but longer in duration than the initial drug effect
Blackouts	A blackout is an amnesia-like period associated with drinking. Someone who is drinking may appear normal; later they may have no recollection of events. While blackouts appear to occur when blood alcohol levels are rising, they do not seem to be linked to a previous history and can occur at any time in the course of someone's alcohol misuse. Blackouts are not the same phenomenon as unconsciousness due to alcohol or other drug poisoning.
Feed Forward	Brain research has shown that a person can begin experiencing the effects of using a certain drug if exposed to learned antecedents to use of that drug. For example, a cocaine-dependent person's brain begins acting as if he has inhaled cocaine at the time that person passes the place where they previously went to purchase the drug.

Expectancy	Refers to a psychoactive effect, which occurs due to the user's expectation than an effect will occur as a result of using a certain substance. For example, subjects expecting alcohol have been shown to behave as if they were intoxicated after drinking grapefruit juice.

Neurobiology of Drug Use

Neuroscience is in the process of greatly expanding our understanding of the processes of psychoactive substance use within the brain, and some of the reasons that people continue to use these substances in the face of undeniable reasons not to do so.

While learning about these processes and brain activities, it is important to keep in mind, and to remind the people we serve, that there is also very strong evidence of the brain's ability to heal.

Dr. Michael Merzenich, Emeritus Professor at the University of California at San Francisco, began researching on what is now called "neuroplasticity" as a result of his interest in how, after cochlear implants, individuals who were born deaf were able to learn to interpret what they were hearing. The original research has expanded to explore many other areas, to the point where Dr. Merzenich asserts that whatever changes the brain undergoes, it has an inherent ability to recover.[vi]

THE BRAIN

The brain regulates the functions of itself and the rest of the body. Different regions of the brain regulate specific functions. The reward system is the part of the brain that makes us feel good.

NEURONS

Neurons, as well as other kinds of cells, make up the brain's complex network of billions of nerve cells. Neurons communicate with each other and also send information from the brain to the rest of the body. To communicate with the rest of the body, the brain sends messages from one neuron to the next and ultimately to the muscles and organs of the body. That is one of the reasons mental health medications have physical side effects in the whole body, not just mental side effects.

Neurons can also store information as memories.

The neuron contains three important parts:

- A central cell body – directs all activities of the neuron
- Dendrites – short fibers that receive messages from other neurons and relay those messages to the cell body
- Axon – long single fiber that transmits messages from the cell body to dendrites of other neurons

NEUROTRANSMISSION: HOW THE BRAIN COMMUNICATES

In a neuron, a message is an electrical impulse. The electrical message travels along the axon until it reaches the end. To send a message, a neuron releases a chemical messenger, or neurotransmitter, into the tiny gap, or synapse, to other neurons. The neurotransmitter crosses the synapse and attaches to key sites called receptors located within the cell membranes of the dendrites of the adjacent nerve cell. Receptors have special shapes so they can only collect one kind of neurotransmitter. In the branches of the receiving end of the neuron, the dendrites, the neurotransmitter stimulates or inhibits an electrical response. The neurotransmitter is then broken down or is reabsorbed into the sending neuron.

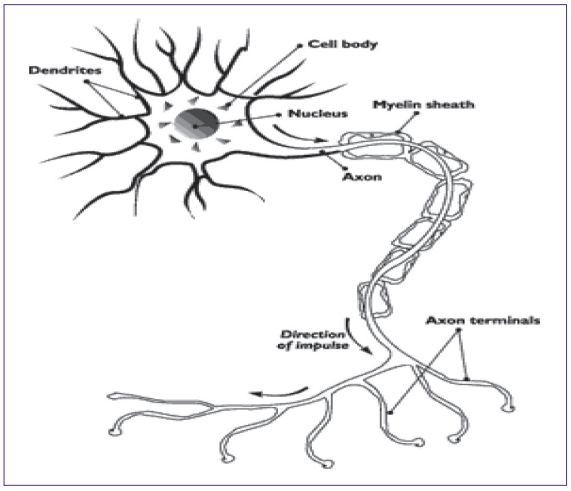

Figure 1: Drawing of a Neuron.[vii]

Once the message is received by the dendrites, it is relayed to the cell body and then to the axon. The axons then transmit messages, in the form of electrical impulses, to other neurons or body tissues. The axons of many neurons are covered in a fatty substance known as myelin. Myelin increases the rate at which nerve impulses travel along the axon. This communication between neurons is extremely complex and scientists are still trying to fully understand how it works.

NEUROTRANSMITTERS

There are many different types of neurotransmitters, each of which has a precise role to play in the functioning of the brain. Generally, each neurotransmitter can only bind to a very specific matching receptor. Therefore, when a neurotransmitter couples to a receptor, it is like fitting a key into a lock. The six main neurotransmitters that are important to work in the Substance Use Services field include:

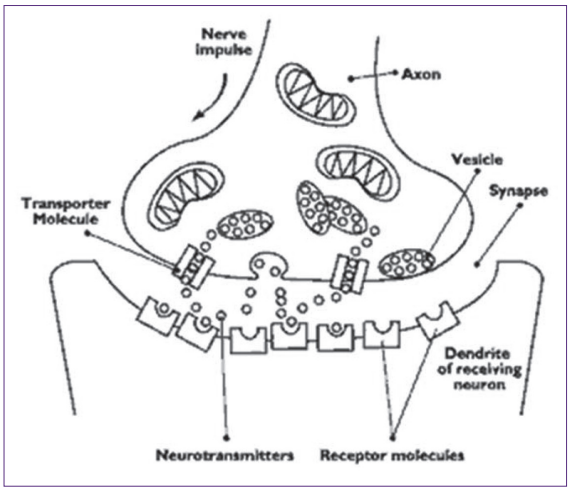

Figure 2: Drawing of a Synapse.

Dopamine

Dopamine is a neurotransmitter that has many pathways and many functions. The pathway related to addiction is the reward system pathway of the brain. When dopamine is released, a person feels pleasure. Dopamine is most often released in response to events in the brain, the body or the environment. The pleasure "reward" reinforces the behaviours that led to the occurrence of that reward.

Dopamine is the "natural high" in the brain. All substances that can cause dependence, from alcohol to marijuana to methamphetamine to nicotine, release dopamine directly or indirectly. If a substance does not release dopamine in a certain way, a person cannot become dependent on it. Antidepressants are an example of this.

Dopamine is also involved in "survival rewards", i.e. the reinforcement and reward from eating, drinking liquids and from sexual activity.

With addiction to a psychoactive substance, there is often reduced pleasure from stimuli other than the substance, including survival rewards (e.g. food, water) and others such as music and nature. Hence the often-heard term the "highjacked brain".

Dopamine has other pathways in the brain (i.e. other than the reward pathways) that are involved in learning behaviours, motivation, control of behaviors, sleep/arousal, and mood, in particular depression.

Acetylcholine

This neurotransmitter is distributed widely in the brain. It is involved in the cognitive functions of the brain – knowing, thinking, learning and judgment and memory. It is also involved in behavioural arousal, attention, energy conservation, mood, and in Rapid Eye Movement (REM) activity during sleep. The effect on REM sleep is why some nicotine users can have abnormal REM sleep, leading to a poor night's sleep.

Norepinephrine

This neurotransmitter may be important for regulating waking, influencing level of arousal and attentiveness. Strattera (Atomoxetine), a selective norepinephrine reuptake inhibitor, is used to treat the inattention, hyperactivity and impulsivity of Attention Hyperactivity Disorder (ADHD)). Norepinephrine is also involved in pain perception, sleep/arousal, depression and anxiety, appetite and initiating food intake.

Serotonin

This neurotransmitter plays a role in control of mood, in particular in depression and anxiety, as well as other mood states. It is also involved in pain perception (why people who are depressed often have a stronger perception of pain) and sleep/arousal regulation, libido, regulation of body temperature and regulation of body weight. (Some of these contribute to the side effects of antidepressants that affect serotonin). Modulation of impulsiveness and aggressiveness is also one of the functions of serotonin.

Gamma Amino Butyric Acid (GABA)

GABA is the inhibitory neurotransmitter found in most regions of the brain and exerts generalized inhibitory functions. In other words, it is the" calmer downer" in the brain. Too little leads to anxiety and too much causes a person to fall asleep. Anaesthetics activate GABA to produce sleep for surgery. Alcohol and benzodiazepines in particular affect how GABA functions, although other substances can affect it indirectly.

Endorphins

These neurotransmitters play a major role in pain perception. They also produce a feeling of pleasure, decreased anxiety, and muscle relaxation.

Endocannabinoids

Endocannabinoids are a family of lipid neurotransmitters in the brain and body. Research strongly suggests they help the body, including the brain, stay healthy (maintain homeostasis) and ward off disease. Unlike the other neurotransmitters, they are not stored in vesicles but made and released as needed to restore homeostasis.

This system is always active. It is like a car in idle: speeding up or slowing down as necessary to keep the brain and body activity normal. Examples of brain functions endocannabinoids affect: appetite, short term memory, perception of pain, stress, focussing of attention. Examples of body functions they affect include digestion and the reproductive system.

DRUG EFFECTS ON NEUROTRANSMISSION

A psychoactive substance is carried to the brain by the blood supply and, unless kept out by the blood-brain barrier, can diffuse out of the blood into the brain tissue. In most cases, the drug has its effects because the molecular structure of the drug is similar to the molecular structure of one on the neurotransmitter chemicals.

Psychoactive substances can affect neurotransmission in many ways, including:

- Destruction of neurons – e.g. chemical warfare agent
- Alteration of neuron membranes – inhibit or stimulate ion exchange
- Effect on enzymes – enzymes synthesize neurotransmitters, drug can impact production
- Release of neurotransmitters – drug can effect release of neurotransmitters from vesicles
- Destruction of neurotransmitters – drug may facilitate or retard neurotransmitter breakdown
- Inhibition of uptake – drug can facilitate or inhibit reabsorption of neurotransmitter
- Mimicking neurotransmitters - go to the same receptors as the neurotransmitter itself; usually acts like the neurotransmitter and has the same effects; can sometimes interfere with the normal functioning of the neurotransmitter; marijuana effect on endocannabinoids.
- Blocking a receptor – drug blocks receptor site, therefore blocking the neurotransmission
- Change receptor sensitivity – attaching to postsynaptic receptor, alters receptivity and may enhance or retard action of neurotransmitter

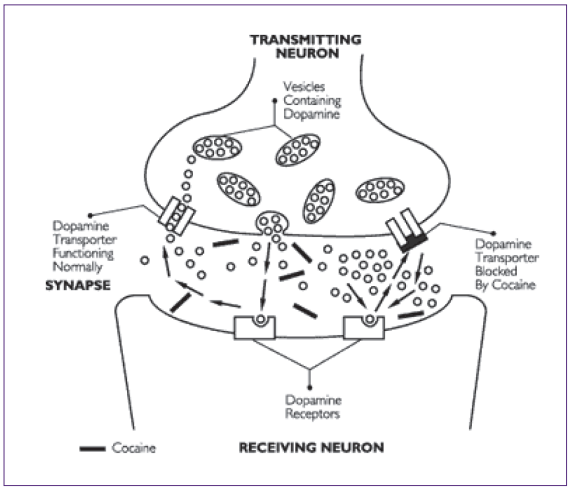

Figure3#: Drawing of Cocaine entering synapse.

When cocaine enters the brain, it blocks the dopamine transporter from pumping dopamine back into the transmitting neuron, flooding the synapse with dopamine. This intensifies and prolongs the stimulation of receiving neurons in the brain's pleasure circuits, causing cocaine "high."

Alcohol and Other Drug-Related Perinatal and Birth Effects

STIGMA AND JUDGMENTAL ATTITUDES TOWARDS PREGNANT WOMEN WHO USE ALCOHOL

The use of alcohol by women who are pregnant is an area fraught with misconceptions, myths and judgmental attitudes. Even for those working in the Substance Use Services field, providing services to these women in a caring and welcoming manner which respects their capacity to make decisions about their care can be challenging. The difficulty of accessing substance use services that were free of judgmental attitudes was demonstrated in a study by Poole and Isaac[viii] who found that the top barriers to substance uses treatment for pregnant women were:

- Shame (66% of participants)
- Fear of losing their children if they identified a need for treatment (62%)
- Fear of prejudicial treatment on the basis of their motherhood/ pregnancy status (60%)
- Feelings of depression and low self-esteem (60%)

It is important to recognize that becoming pregnant is a strong motivator for reducing or stopping drinking. Women who continue to drink during pregnancy do so for a reason, the most common of which are:

- *Don't know they are pregnant* – since almost half of Canadian pregnancies are unplanned, women may consume alcohol before they know they are pregnant.
- *Mental Illness* – women may be self-medicating for an undiagnosed mental disorder.
- *Coping with difficult life situations* – such as poverty, unemployment, homelessness, family violence, physical, psychological, or sexual abuse; and/or the related lack of resources to cope with stress in alternative ways.
- *Role of alcohol in society* - Social pressures to drink alcohol and/or poor role models. The attractiveness of alcohol use portrayed in advertising.
- *Lack of knowledge about the impact of alcohol* – Many people don't know that even small amounts of alcohol consumed during pregnancy can affect the developing fetus.
- *Can't stop* – alcohol use has developed to the point of addiction or dependency.

EFFECTS OF ALCOHOL ON THE FETUS

A number of risks to the baby exist if the mother drinks alcohol when pregnant. Alcohol causes a range of serious physical and mental defects in the developing baby including brain damage (resulting in lifelong learning disabilities and problems in memory, reasoning and judgment), vision and hearing problems, slow growth and birth defects.

It is not known how much alcohol it takes to cause the damage though it is known that a baby's brain is very sensitive to alcohol when it is developing. Alcohol stays in the fetus much longer than in the mother's body. Therefore, there is no safe amount of alcohol to drink during pregnancy. Because the baby's brain and nervous system are developing throughout the pregnancy, there is also no safe time to drink alcohol during pregnancy. Depending on when the alcohol is consumed, different regions of the developing brain and body are affected. The table below illustrates the vulnerability of the fetus to defects during different periods of development.

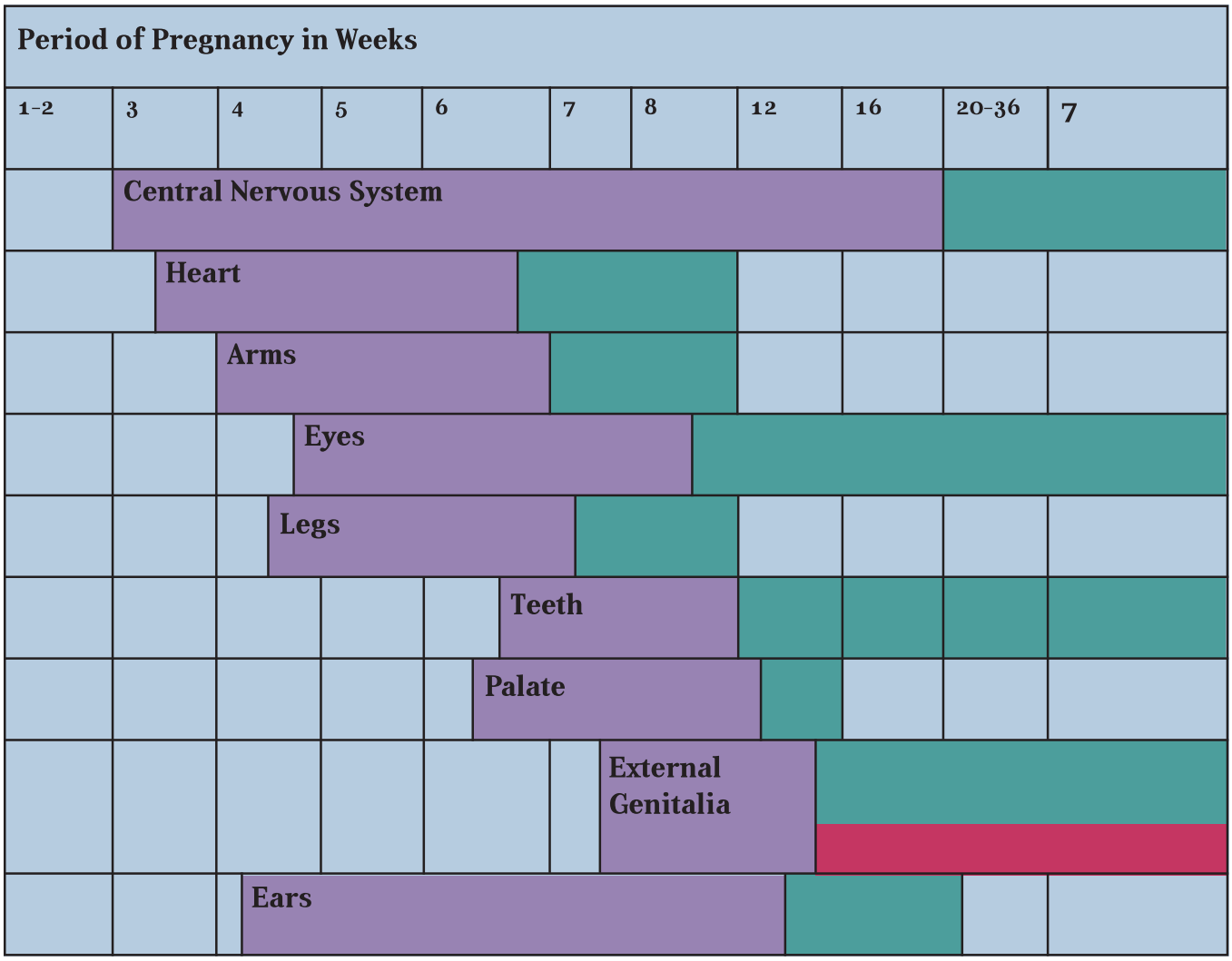

Table 5: Vulnerabilities of fetus to alcohol at stages of pregnancy[ix] *Dark portions of the bar show the most sensitive periods of development, during which the teratogenic effects on the sites listed would result in major structural abnormalities of the child. The lighter portions of the bars shows periods of development during which physiological defects and minor structural abnormalities would occur.*

The impact of alcohol varies depending on the amount, timing and frequency of alcohol consumed and depends on other factors such as genetics of the fetus and mother, mother's nutrition during pregnancy, mother's metabolism, overall state of health of the mother and social, economic, environmental and physical factors. Drinking during pregnancy may also result in problems during the pregnancy (e.g. miscarriage, stillborn or premature baby, increased risk of placenta abnormalities). Different types of drinking affect the fetus in different ways. Binge drinking (drinking large amounts of alcohol in short periods of time) is especially damaging because the mother's blood alcohol content is much higher. If a woman cannot stop drinking, cutting down or stopping drinking is still better for the baby.

A father's drinking cannot cause FASD but it is a risk factor. Research has shown that women with partners who drink are more likely to drink themselves during pregnancy.

FETAL ALCOHOL SPECTRUM DISORDER

Since the first description of malformations associated with fetal exposure to alcohol was documented in France in 1968 and subsequently defined in 1973 in the United States, many terms have been used to describe the abnormalities associated with prenatal exposure to alcohol.[x]

Fetal Alcohol Spectrum Disorder (FASD) is the non-diagnostic umbrella term used to describe a range of disabilities (and diagnoses) that may occur in a person whose mother drank alcohol during pregnancy. Diagnosing individuals with FASD is a relatively new area in Canada, with Canadian diagnostic guidelines for FASD first being released in 2005. Diagnoses under FASD include:

Fetal Alcohol Syndrome (FAS) – In order to diagnose FAS, three criteria must be met:

1. Characteristic facial features, which include: flattened midface; thin upper lip; indistinct or absent groove between upper lip and nose (philtrum); and short eye slits

2. Slower growth, prenatal and/or postnatal including: low birth weight, disproportional weight not due to nutrition, height and/or weight below the 5th percentile

3. Central Nervous System neurodevelopmental disabilities, such as: impaired fine motor skills, learning disabilities, behaviour disorders or a mental handicap (found in approximately 50% of those with FAS)

Partial Fetal Alcohol Syndrome (pFAS) – term used to refer to those with some characteristic facial abnormalities associated with FAS, and evidence of one other component (growth deficiency or central nervous system impairment)

Alcohol-related Neurodevelopmental Disorder (ARND) – refers to the variable range of central nervous system dysfunctions that are associated with alcohol consumption during pregnancy, without the characteristic facial or growth abnormalities

Alcohol-related Birth Defects (ARBD) – term used to describe children of women who drank heavily in pregnancy and have congenital birth defects such as skeletal abnormalities, heart defects, cleft palate and other internal organ problems and vision and hearing problems

There is no cure for FASD – it is life-long disability that is permanent and cannot be outgrown.

Prevalence of FASD

It is hard to estimate the number of people in British Columbia or Canada with FAS and other conditions within the spectrum because they are not reportable disabilities, which must be recorded by the Vital Statistics Registry in each province (such as muscular dystrophy, Down syndrome, spina bifida). Health Canada estimates that in Canada, 9 babies in every 1,000 births have FASD and that FASD is the leading cause of developmental disabilities among Canadian children.[xi]

However, FASD is often missed completely at birth or diagnosed much later in life.

See Module V for information on working with people living with FASD.

OTHER DRUG RELATED PERINATAL AND BIRTH PROBLEMS

The impact of the use of other drugs on the fetus has been difficult to study because of the involvement other factors that also have an impact on the pregnancy including:

- poor nutritional habits
- alcohol consumption
- other drug consumption
- use of more than one psychoactive substance
- lack of sleep
- a mother's general health prior to pregnancy
- genetics
- how much alcohol, tobacco or other drugs are consumed during pregnancy
- at what stage in the pregnancy the substance is consumed
- the length of time the substance is consumed

What is known is that women who use illicit substances while pregnant often experience problems during pregnancy and childbirth including:

- Increased risk of spontaneous abortion, miscarriage, stillbirth and early infant death.
- Increased risk of contracting HIV, hepatitis and other diseases if using unclean needles – these diseases can be passed onto the fetus.
- Increased risks of placenta abnormalities such as placenta previa (low-lying placenta) or maternal abruption (the premature separation of the placenta from the wall of the uterus).
- Increased risk of premature labour and delivery.

Many specific effects of alcohol, tobacco and other substances are still unknown, which is why it is safest to avoid their use when pregnant.

Effects of Drugs other than Alcohol on the Fetus

One of the most common possible effects of many psychoactive substances (e.g., tobacco, marijuana, stimulants, hallucinogens) on the fetus is preventing healthy fetal growth, resulting in a low birth weight baby. Low birth weight infants are more likely to suffer health and developmental complications throughout life, including visual and hearing difficulties, delayed speech, cerebral palsy, learning disabilities and respiratory problems.

Babies born to mothers who have used substances during pregnancy, including heroin, cocaine, methamphetamine, nicotine and marijuana, can have withdrawal symptoms. This is known as Neonatal Abstinence Syndrome and can include symptoms such as muscle spasms, irritability, high pitched crying, diarrhea, disturbed sleep, vomiting, and feeding and breathing problems. With heroin withdrawal, the baby's symptoms or irritability may persist for more than three or four months. With heroin withdrawal, there can also be a late infant withdrawal occurring at 3 – 6 months, which can be misinterpreted as colic.

Many psychoactive substances also increase the risk of Sudden Infant Death Syndrome (SIDS).

After the withdrawal period, unlike with alcohol, children whose mothers used heroin during pregnancy may do well in the long term, if they were not exposed to other risks and they are raised in a positive environment. There is also concern that babies of mothers who use inhalants in pregnancy may be at risk for the long lasting mental health and behaviour problems similar to Fetal Alcohol Spectrum Disorder.

However, some fetal exposure to psychoactive substances can have long term effects. Infants exposed to cocaine in utero can be born with kidney abnormalities. Recent review of studies show that other abnormalities in the newborn, previously thought to be due to cocaine, are probably due to polysubstance use and environmental factors. Current studies show only subtle changes in brain function.

With prenatal exposure to psychoactive substances like tobacco and marijuana, research has shown that these children have an increased risk for developmental, emotional and behavioural problems such as increased activity, inattention and impulsivity, and some cognitive problems. Marijuana may interfere with the endocannabinoids' role in normal brain development in the child and adolescent.

METHADONE MAINTENANCE DURING PREGNANCY

According to current research, it is preferable to continue opioid use during pregnancy rather than attempting to quit, because alternating between intoxication and withdrawal puts the fetus at higher risk of spontaneous abortion, miscarriage, premature labour, placental abruption or stillbirth. Methadone maintenance is a healthier alternative to continuing opioid use because the dosages are monitored and controlled. If methadone maintenance is not an option, continued safe use of opioids may be advised. Research has shown that women who are on a methadone program are healthier in general and have fewer complications during pregnancy and childbirth than those who continue to use heroin. This research finding is probably due to more than just the use of one psychoactive substance over another; women on a methadone maintenance program are in closer contact with support services, increasing their accessibility to medical and prenatal care. In addition, women on a methadone maintenance program do not have the constant stress of not being certain where they are going to get the money for psychoactive substances or their supply. Babies born to mothers on methadone will have some methadone in their system at birth and may not show some symptoms of withdrawal until 1-2 weeks after birth, but under medical supervision can be safely weaned off methadone with no harmful long term effects.

[i] With the generous assistance of Dr. Bayla Schecter, Regional Medical Advisor, Vancouver Island Health Authority, Mental Health and Addiction Programs. Appreciation is extended to Dr. Schecter for her many contributions in reviewing and commenting on this Module as a whole.

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[iv] Schecter, B. (not dated). For ADS Counsellors and Other Professionals: Withdrawal from Alcohol. One of a set of resource handouts on withdrawal from various substances; produced for Adult Mental Health and Substance Use Services, Vancouver Island Health Authority.

[v] Handouts created by Dr. Bayla Schecter, Regional Medical Advisor, Vancouver Island Health Authority, Mental Health and Addiction Programs.

[vi] For an easily understood summary from Dr. Merzenich of his work, see http://www.podcast.com/Science_and_Medicine/Medicine/I-64983.htm

[vii] Figures 1-3 from National Institute on Drug Abuse. (2005). Mind Over Matter: The Brain's Response to Drugs: Teachers Guide. National Institutes of Health, U.S. Department of Health and Human Services. Retrieved October 2012 from http://teens.drugabuse.gov/mom/teachguide/MOMTeacherGuide.pdf.

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APPENDIX TO MODULE II – POST-ACUTE WITHDRAWAL HANDOUTS FOR COUNSELLORS TO DISCUSS WITH CLIENTS

The following handouts for counsellors reflect the symptoms clients go through in acute and/or post-acute withdrawal. They were designed to aid counsellors to help their clients understand what the symptoms are, that they are not likely to be from some new physical or mental health problem (each handout has a caveat about contacting a health care provider if the symptoms persist) and that they will improve. They are available in a version to hand out directly to clients during acute and/or post-acute withdrawal. The client handouts can be obtained at mhas.prt@viha.ca.

Alcohol

Cocaine

Methamphetamine

Marijuana

Nicotine

Opiates

FOR ADS COUNSELLORS AND OTHER PROFESSIONALS

Withdrawal from Alcohol

The symptoms of withdrawal are temporary, and the person in withdrawal may not experience all of them. The person in withdrawal may experience some of them more intensely than others. If the symptoms persist or worsen, the person in withdrawal should be advised to consult his/her doctor in case the symptoms are related to another problem.

There is an explanation of some of these symptoms in more detail following the list of symptoms.

ACUTE WITHDRAWAL (FIRST STAGE): MILD TO MODERATE

The symptoms can start within 12 to 36 hours after the last drink and most of them will last for a few hours up to a few days. The symptoms are listed by frequency, with the first ones occurring more often.

PHYSICAL SYMPTOMS

- fast heart beat
- sweating, facial flushing
- muscle trembling, muscle spasms, hand and body tremors
- insomnia, restlessness
- numbness, tingling or burning sensations in the person's arms or legs
- nausea, vomiting
- ringing in the ears
- dry mouth
- itching

PSYCHOLOGICAL SYMPTOMS

- anxiety
- paranoia

ACUTE WITHDRAWAL (FIRST STAGE): SEVERE

The symptoms start within 5 to 10 hours after the person's last drink, get worse over the next 2 to 3 days, and last up to 7 to10 days.
If the new severe symptoms occur or the ones that were mild to moderate become severe the person should call/see his/her doctor as the person may need hospitalization.

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ACUTE WITHDRAWAL (FIRST STAGE): SEVERE (continued)

PHYSICAL SYMPTOMS

- seizures (convulsions)
- severe pain in stomach
- chest infections
- poor balance when walking
- fast heart beat
- sweating, facial flushing
- muscle trembling, muscle spasms
- insomnia, restlessness
- nausea, vomiting

PSYCHOLOGICAL SYMPTOMS

- hallucinations
- paranoia worsening
- very confused

POST ACUTE WITHDRAWAL (SECOND STAGE)

PHYSICAL SYMPTOMS

The physical symptoms can last up to six months. They gradually decrease during the 6 months.

- insomnia, restlessness
- headache
- tiredness, weakness
- muscle trembling
- sexual problems, e.g. impotence

PSYCHOLOGICAL SYMPTOMS

Some of the psychological symptoms are ongoing symptoms related to the person's use of alcohol. They will gradually decrease over 3 to 12 months.

- anxiety
- depression, mood swings
- irritability
- poor concentration
- poor memory
- impulsiveness
- difficulty in thinking clearly, making plans or decisions

DESCRIPTION OF SYMPTOMS

(in alphabetical order)

Anxiety: feeling that an unreal or imagined danger is about to happen, feelings of powerlessness accompanied by increased heart rate, increased breathing, sweating, trembling, weakness. Both excess caffeine and excess sugar can increase anxiety and insomnia.

Hallucinations: seeing, hearing, smelling or feeling things that are not real.

Insomnia: any form of disturbed sleep, especially early morning wakening. It may include nightmares. Dreams about drinking (the person or others drinking) are common in both first and second stages of sleep.

Itching: can be anywhere on the body. It happens without a rash.

Mood Swings: feeling very happy and then very sad. The swings are often related to low and high blood sugar and sugar cravings. This cause of the swings can be avoided by eating a regular balanced diet with minimal sugar.

Numbness, Tingling and Burning Sensations: the sensation that occurs when the person's hand or foot falls asleep or the person wakes up with the hand asleep. These sensations can occur anywhere on the body.

DESCRIPTION OF SYMPTOMS (continued)

Paranoia: the person who is paranoid has thoughts or feelings of being disliked (or if intense, hated) by other people; that they are thinking or saying bad things about the person; that the person is about to be harmed by other people. When the paranoia worsens, the person fully believes in the threat of harm and acts as if he/she is about to be harmed.

Seizures: Alcohol withdrawal seizures can happen up to 96 hours (usually in the first 48 hours) after your last drink. They can happen without the other symptoms of severe withdrawal. If they happen with the other symptoms of severe withdrawal, they usually happen before the other symptoms of severe withdrawal.

Tiredness, Weakness: may be related partly to low blood sugar. The low blood sugar causes a craving for sugar and sweet foods. The tiredness tends to cause a craving for caffeine.

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FOR ADS COUNSELLORS AND OTHER PROFESSIONALS

Withdrawal from Cocaine

The symptoms of withdrawal are temporary, and the person in withdrawal may not experience all of them. The person in withdrawal may experience some of them more intensely than others. If the symptoms persist or worsen the person in withdrawal should be advised to consult his/her doctor in case the symptoms are related to another problem.

There is an explanation of some of these symptoms in more detail following the list of symptoms.

ACUTE WITHDRAWAL (FIRST STAGE)

The symptoms appear within 12 hours after the person's last use of cocaine and last four to seven days.

PHYSICAL SYMPTOMS

- excessive sleepiness
- excessive appetite
- tiredness, low energy
- abdominal pain
- chills, tremors
- restlessness
- aching muscles

PSYCHOLOGICAL SYMPTOMS

- severe depression
- irritability
- mood swings
- vivid or unpleasant dreams
- drug hunger

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POST ACUTE WITHDRAWAL (SECOND STAGE)

The symptoms gradually decrease after six weeks. They can last for several months.

SYMPTOMS

- depression
- difficulty experiencing pleasure (anhedonia)
- sleep difficulty (too much or too little)
- vivid or unpleasant dreams
- drug hunger
- anxiety
- low energy

DESCRIPTION OF SYMPTOMS

(in alphabetical order)

Anhedonia: difficulty experiencing pleasure with the continued use of cocaine. After the person stops using the cocaine, the brain gradually recovers so that the person can experience pleasure normally. The ability to experience pleasure returns gradually, taking longer when there has been heavy use for a long time (can take up to one to two years to fully experience pleasure in very heavy users).

Anxiety: feeling that an unreal or imagined danger is about to happen, feelings of powerlessness accompanied by increased heart rate, increased breathing, sweating, trembling, weakness. Both excess caffeine and excess sugar can increase anxiety.

Drug hunger: an involuntary craving for cocaine that can be accompanied by images such as seeing imaginary persons and objects or feeling imaginary sensations as if they are real. The drug hunger is often accompanied by strong images or dreams of using cocaine. It can be triggered by many things such as: something in the person's surroundings that reminds the person of using; mood swings; or a sudden increase in body temperature. The drug hunger occurs intermittently (more often at first) for a few years.

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FOR ADS COUNSELLORS AND OTHER PROFESSIONALS

Withdrawal from Methamphetamine

The symptoms of withdrawal are temporary, and the person in withdrawal may not experience all of them. The person in withdrawal may experience some of them more intensely than others. If the symptoms persist or worsen the person in withdrawal should be advised to consult his/her doctor in case the symptoms are related to another problem.

There is an explanation of some of these symptoms in more detail following the list of symptoms.

Withdrawal from intermittent ("binge") high dose use is compounded by the effects of prolonged lack of sleep and food.

FIRST STAGE:

The symptoms last hours to a few days.

PHYSICAL SYMPTOMS

- Excess need for sleep
- Excess appetite, especially for carbohydrates
- Severe agitation, uncontrollable jerking movements
- Chills, tremors
- Aching muscles

PSYCHOLOGICAL SYMPTOMS

- Severe irritability, easily provoked aggression
- Intense and rapid mood swings
- Panic attacks
- Scattered thinking, poor concentration

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SECOND STAGE (post acute withdrawal)

The symptoms appear after the first stage and gradually decrease over two weeks. Some symptoms can last for several months.

SYMPTOMS

- Excess need for sleep
- Fatigue
- Low physical and mental energy
- Anxiety, mild to severe
- Severe depression
- Anhedonia
- Craving

ONGOING SYMPTOMS FROM METHAMPHETAMINE USE

Because methamphetamine can have long acting effects on the brain that persist in abstinence, it is important to remember that the symptoms from these effects on the brain can continue to occur for a varying length of time (can last several months) following discontinuation of methamphetamine. These symptoms may continue during withdrawal and may persist after withdrawal ends.

- Cognitive impairment, including poor memory, poor concentration, poor abstract thinking
- Hyper-vigilance, suspiciousness, paranoia
- Hallucinations
- Severe anxiety
- Obsessive compulsive thoughts and behaviours

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DESCRIPTION OF SYMPTOMS

(in alphabetical order)

Anhedonia: difficulty experiencing pleasure with the continued use of methamphetamine. After the person stops using the methamphetamine, the brain gradually recovers so that the person can experience pleasure normally.

Anxiety: feeling that an unreal or imagined danger is about to happen, feelings of powerlessness accompanied by increased heart rate, increased breathing, sweating, trembling, weakness. Both excess caffeine and excess sugar can increase anxiety.

Craving: Can occur especially in situations that require extra energy, e.g. moving, travelling long distances

Excess sleepiness: The excess need for sleep occurs especially with "binge" use.

Fatigue: This can be partly related to decreased iron and Vitamin B12 from poor eating habits while using the methamphetamine. The person may need to have a blood test for iron and Vitamin B12 as he /she may need to take one or both.

Hallucinations: seeing, hearing, smelling or feeling things that are not real, e.g. hearing voices.

Hyper-vigilance: constantly watchful to prepare for a negative event.

Mood Swings: feeling very happy and then very sad. The sadness can be a very severe depressed feeling.

Obsessive compulsive behaviour: e.g. repetitive drawing, cleaning, organizing

Paranoia: The person who is paranoid has thoughts or feelings of being disliked (or if intense, hated) by other people; that they are thinking or saying bad things about the person; that the person is about to be harmed by other people. When the paranoia worsens, the person fully believes in the threat of harm and acts as if he/she is about to be harmed.

FOR ADS COUNSELLORS AND OTHER PROFESSIONALS

Withdrawal from Marijuana

The symptoms of withdrawal are temporary, and the person in withdrawal may not experience all of them. The person in withdrawal may experience some of them more intensely than others. If the symptoms persist or worsen the person in withdrawal should be advised to consult his/her doctor in case the symptoms are related to another problem.

There is an explanation of some of these symptoms in more detail following the list of symptoms.

In **severe withdrawal**, the symptoms start 24 to 48 hours after the last use of marijuana, increase over the next 7 to 10 days and gradually decrease in severity over 2 to 3 weeks. They may continue to occur some of the time (off and on) for several months

In **mild withdrawal**, because the active ingredients of marijuana are stored in the fat cells in the person's body, the symptoms will only occur some of the time (off and on), but may be present for several months.

The symptoms are listed by frequency, with the first ones occurring more often.

PHYSICAL SYMPTOMS

- sleep difficulty
- loss of appetite, nausea, diarrhea
- restlessness, muscle tremors, shakiness
- excess sweating, night sweats, flushing
- headache, stomach pains, dizziness
- cough worsening with brown phlegm for a few weeks to two months

PSYCHOLOGICAL SYMPTOMS

- irritability
- anger, aggression
- drug craving
- anxiety, nervousness
- poor concentration

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ONGOING SYMPTOMS RELATED TO MARIJUANA USE

These symptoms may continue during withdrawal. These effects related to marijuana use may be present for several months.

- depression
- paranoia
- poor short term memory
- decreased motivation
- tiredness, lack of energy

DESCRIPTION OF SYMPTOMS

(in alphabetical order)

Anger, Aggression: These symptoms may not start until 4 to 6 days after the last use of marijuana and may last up for approximately 2 weeks.

Anxiety: feeling that an unreal or imagined danger is about to happen, feelings of powerlessness accompanied by increased heart rate, increased breathing, sweating, trembling, weakness. Both excess caffeine and excess sugar can increase anxiety and insomnia.

Cough with Brown Phlegm: this is due to the lungs getting rid of the tars if the marijuana was smoked. This symptom will not occur if the person continues to smoke cigarettes because the smoke will prevent the lungs from clearing the tars until the person stops smoking cigarettes.

Drug Hunger: The craving for marijuana will increase as the fat cell storage decreases. It may be most intense when there is no more fat cell storage, several months after the marijuana was stopped. It will be most intense in chronic heavy users.

Paranoia: the person who is paranoid has thoughts or feelings of being disliked (or if intense, hated) by other people; that they are thinking or saying bad things about the person; that the person is about to be harmed by other people. When the paranoia worsens, the person fully believes in the threat of harm and acts as if he/she is about to be harmed.

Sleep Difficulty: can be any form of disturbed sleep, including strange dreams.

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FOR ADS COUNSELLORS AND OTHER PROFESSIONALS

Withdrawal from Nicotine/Tobacco

The symptoms of withdrawal are temporary, and the person in withdrawal may not experience all of them. The person in withdrawal may experience some of them more intensely than others. If the symptoms persist or worsen the person in withdrawal should be advised to consult his/her doctor in case the symptoms are related to another problem.

The following symptoms occur when the person stops using cigarettes. They may also occur when other forms of tobacco are stopped, depending on how much and how long the person has been using the tobacco, e.g. cigars, chewing tobacco.

There is an explanation of some of these symptoms in more detail following the list of symptoms. These symptoms may start within 24 hours to 3 days after the last cigarette and will be the most severe on the first to third day after the last cigarette, depending on how much and how often the person smoked. They gradually decrease over a few weeks. Some symptoms may last a few months.

PHYSICAL SYMPTOMS

- restlessness
- increased appetite
- increased muscle tension
- daytime drowsiness
- excess sweating
- mouth ulcers
- constipation
- cough worsening with brown phlegm for a few weeks to two months

PSYCHOLOGICAL SYMPTOMS

- craving
- irritability, frustration or anger, impatience
- poor concentration
- depression mild to severe
- sleep difficulty
- anxiety

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DESCRIPTION OF SYMPTOMS

(in alphabetical order)

Anxiety: feeling that an unreal or imagined danger is about to happen, feelings of powerlessness accompanied by increased heart rate, increased breathing, sweating, trembling, weakness. Both excess caffeine and excess sugar can increase anxiety and insomnia.

Cough with Brown Phlegm: this is due to the lungs getting rid of the tars if the person smoked the nicotine.

Depression: is a common withdrawal symptom that can last up to 5 weeks if the person has a history of severe depression in the past. If the person has had a severe depression in the past, there is a risk of another episode of severe depression up to 6-12 months after stopping. If the person is on an antidepressant and the person and their doctor were discussing stopping it, the antidepressant should not be stopped around the time the person stops smoking cigarettes. As well, a person with a severe depression history, or a current depression, will have increased severity of all the withdrawal symptoms except for increased appetite.

Increased Appetite: Increased appetite as a withdrawal symptom lasts up to 10 weeks. Increased appetite that persists beyond 10 weeks may be because nicotine acts to decrease a person's normal appetite, which in some people is stronger than others.

Length of Time Some Other Symptoms May Last: (in alphabetical order): constipation up to 4 weeks, poor concentration up to 4 weeks, mild depression or decreased ability to experience pleasure up to a few months, irritability up to 4 weeks, mouth ulcers up to 6 weeks, and restlessness up to 3 weeks.

Sleep Difficulty: can be any form of disturbed sleep.

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FOR ADS COUNSELLORS AND OTHER PROFESSIONALS

Withdrawal from Opioids

The opioids include Heroin, Morphine, Methadone, OxyContin (Oxycodone), Percodan (Oxycodone and ASA), Percocet (Oxycodone and Acetaminophen), Codeine, Demerol (Meperidine, Pethidine), and Dilaudid (Hydromorphone).

The symptoms of withdrawal are temporary, and the person in withdrawal may not experience all of them. The person in withdrawal may experience some of them more intensely than others. If the symptoms persist or worsen the person in withdrawal should be advised to consult his/her doctor in case the symptoms are related to another problem.

There is an explanation of some of these symptoms in more detail following the list of symptoms.

ACUTE WITHDRAWAL (FIRST STAGE)

Heroin and Morphine: The symptoms appear 8 to 12 hours after the last dose, increase over the next 3 days and gradually disappear over 7 to 10 days.
Oxycodone and Dilaudid: The withdrawal is similar to morphine but slightly less intense.
Methadone: The symptoms appear 24 to 48 hours after the last dose, increase over the next 3 to 6 days, and gradually disappear over 3 to 6 weeks.
Demerol: The symptoms appear 3 hours after the last dose, increase over the next 8 to 12 hours and gradually disappear over 4 to 5 days.
Codeine: The withdrawal is similar to morphine, but much less intense.

The symptoms are listed by frequency, with the first ones occurring more often.

PHYSICAL SYMPTOMS

- muscle, bone and joint pain, especially in the legs and lower back
- sweating, alternating with chills and waves of goose bumps
- loss of appetite, nausea, vomiting, stomach cramps, diarrhoea
- restlessness, nervousness, weakness
- muscle spasms and kicking movements
- insomnia
- fever, headache, flu-like feeling
- rapid heart rate
- runny eyes, runny nose, sneezing, yawning

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ACUTE WITHDRAWAL (FIRST STAGE): (continued)

PSYCHOLOGICAL SYMPTOMS

- anxiety
- obsession with getting the drug
- irritability

POST ACUTE WITHDRAWAL (SECOND STAGE)

The symptoms can last for 2 to 6 months. They gradually decrease during the 2 to 6 months.

PHYSICAL SYMPTOMS

- insomnia
- weakness, tiredness
- poor appetite
- muscle aches

PSYCHOLOGICAL SYMPTOMS

- unable to tolerate stress
- overly concerned about physical discomfort

DESCRIPTION OF SYMPTOMS

(in alphabetical order)

Anxiety: feeling that an unreal or imagined danger is about to happen, feelings of powerlessness accompanied by increased heart rate, increased breathing, sweating, trembling, weakness. Both excess caffeine and excess sugar can increase anxiety and insomnia.

Insomnia: can be any form of disturbed sleep, including nightmares.

Muscle spasms: uncontrolled movements of the muscles such as sudden movements of the large muscles of the arms or legs or small local muscle contractions such as eyelid muscle twitching; involuntary trembling or shaking.

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MODULE III: PERSON-CENTRED PRACTICE – ENGAGING WITH THE PEOPLE WE SERVE

MODULE III: PERSON-CENTRED PRACTICE – ENGAGING WITH THE PEOPLE WE SERVE

Effectiveness of Treatment: What Works?

The evidence is clear and strong: treatment for substance use problems is effective; and a wide range of therapeutic interventions have evidence of effectiveness. To date, it appears that no one evidence-based approach has better outcomes than others. Attempts to determine whether any one approach is more effective with a given population (such as Project MATCH in the US) have so far been inconclusive, or have not supported the "matching" approach that had currency in the late 1980s and 1990s.[i]

> *It is important to recognize that any attempt to identify the "most effective" approaches has serious limitations, because the evidence base is only comprised of information on approaches that have been the subject of controlled clinical trials. As well, the evidence tells us unmistakably that the process by which the help or therapy is provided has a greater effect on treatment outcome than does the approach itself.*

Approaches for alcohol problems which have solid research support – based on systematic reviews of clinical trials – are shown on the table below:[ii]

Approach	*Description*
Motivational approaches (MI or MET)	In the US, a number of approaches have utilized the techniques of Motivational Interviewing and become known as Motivational Enhancement Therapy. It is important to note that Miller et al[iii] alert practitioners that all MET is not MI. The key is to work with the Spirit and Processes of MI as currently defined. MI is often used in conjunction with other approaches.
Brief Intervention	Single-session or short-term interventions that may include screening, assessment, advice, MI, or BCST strategies
Community Reinforcement Approach (CRA)	A multi-layered behavioural approach that combines functional analysis, skill training, relapse prevention, job search, and social-recreational counselling.
Behavioural Self-Control Training (BCST)	Combines the use of self-monitoring of alcohol use and behavioural strategies to reduce alcohol consumption.
Social Skills Training (SST)	Involves activities to enhance social skills, refuse alcohol, or cope with stressful situations.
Cognitive Behavioural Therapy (CBT)	Interventions that involve the client changing behaviour by changing the way they perceive their situation and challenges.
Couples and/or Family Therapy	Conjoint therapies that address the alcohol use directly or indirectly via a focus on couple or family relationships

Some reviews include Twelve Step Facilitation (TSF) as a proven approach. Other research says it is not effective. Twelve Step Facilitation uses as treatment tools the concepts and methods inherent in 12 Step programs. (It is not the equivalent of participation in a 12 Step program, which operates through mutual support rather than professional intervention.) In 1998, Project MATCH[iv] found no significant difference in the outcomes for clients participating in Twelve Step Facilitation programs than for those participating in in Cognitive Behavioural Therapy or Motivational Enhancement Therapy, as they were practiced in the early to mid-1990. Similar results were obtained in a 1997 study by the US Department of Veterans' Affairs[v] that compared Twelve Step Facilitation to Cognitive Behavioural Therapy. Other reviews have shown less convincing results.[vi] This is not to say there is not value in clients participating in 12-Step and similar mutual aid groups in the community, as millions will attest.

Evidence is more limited concerning methods for treating problems with drugs other than alcohol, as studies have so far been primarily focussed on motivational approaches and Cognitive Behavioural Therapy – with generally supportive results.

The Key to Successful Helping: the Therapeutic Alliance

Given that treatment has been found to result in better outcomes for people than no treatment, and that many approaches seem to be successful, what are the common factors that differentiate between the helpers who consistently have better outcomes with their clients and those who do not? The differences can be found in understanding the "hows" of helping.

Figure 1 illustrates the therapeutic factors that research has shown account for the outcomes of treatment.[vii]

When comparing the outcomes for people who have received treatment to those who have not, certain types of factors become apparent as contributing to the changes clients make in therapy. These are of two types:

- Client, or Extratherapeutic Factors
- Treatment Effects

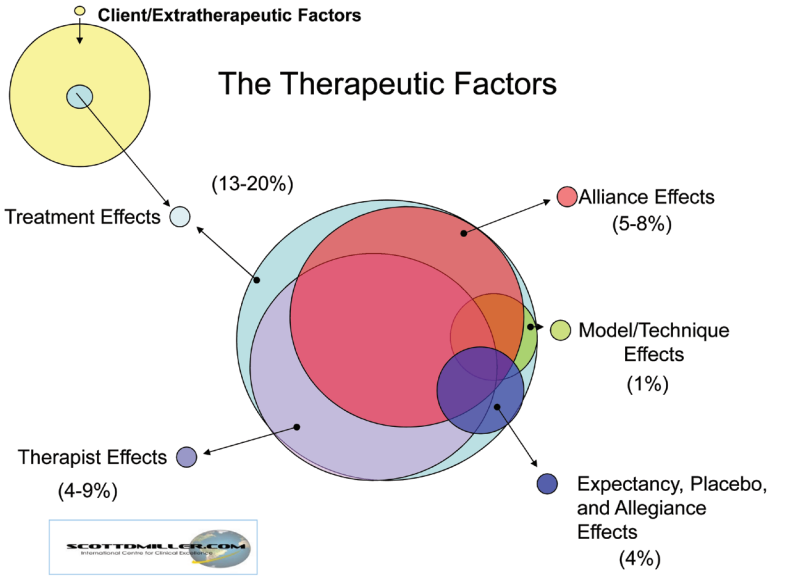


Figure 1

CLIENT/EXTRATHERAPEUTIC FACTORS (80-87% of what contributes to outcomes for clients)

These factors are independent of treatment and include clients' readiness for change, strengths, resources, level of functioning before treatment, social support systems, socioeconomic status, personal motivations, and life events.[viii] Client extratherapeutic factors have been estimated to account for 80-87% of the variability in scores between treated and untreated clients. Much of the variability appears to be due to the " … unexplained or unrecognized influences that clients bring to therapy, their circumstances and events that take place in their lives while they happen to be in therapy that either aid or hinder improvement."[ix]

TREATMENT FACTORS (13-20%)

Treatment effects are estimated to account for 13-20% of overall outcome. They include the following.

Practitioner Effects (4-9%)

Numerous studies have shown that some clinicians are more effective than others. Baldwin, Wampold and Imel[x] found that 97% of the difference in outcome between practitioners is accounted for by differences in forming therapeutic relationships. More effective practitioners form better therapeutic relationships with a broader range of clients. Interestingly, other practitioner qualities that have little or no impact on outcome include: age, gender, years of experience, professional discipline, degree, training, licensure, theoretical orientation, amount of supervision or personal therapy, or the use of evidence-based methods.

Alliance Effects (5-8%)

The amount of change attributable to the quality of the relationship between practitioner and client is due to alliance effects. The alliance serves as a mechanism for engaging the client in the treatment process; and the client's level of engagement is the most potent predictor of change in therapy.

Next to the level of consumer functioning at intake, the consumer's rating of the alliance is the best predictor of treatment outcome and is more highly correlated with outcome than clinician ratings.

In Module IV, in the Treatment Planning section, you will find more information on the nature of the alliance (the "three-legged stool" and the importance of feedback.

Expectancy, Placebo, and Allegiance Effects (4%)

These factors relate to both the client and the practitioner's expectations about therapy and it potential effects. For the client, these effects relate to the installation of hope, and expectations about the healing properties of the therapy. More specifically, they related to the client's belief in the practitioner and the treatment being provided.

For the practitioner, these factors include positive expectations, faith in therapy as a practice, and allegiance to the approach and methods they use.

Model/Technique Effects (1%)

As noted earlier, there are a number of proven approaches, as well as many more that are as yet unproven in research. No matter the approach, the effects depend on the degree to which these methods fit with the client's preferences and expectations, and activate other factors such as placebo and hope.

Models and techniques work best when they engage and inspire participants, and provide structure to the process of change.

> For many in the helping field, the names Scott Miller and Barry Duncan have become synonymous with Client-Directed, Outcome-Informed Therapy (CDOI), and the tools that have supported that: the Session Rating Scales and the Outcome Rating Scales.
>
> Scott Miller and associates have recently begun redefining some of the work that was previously done in partnership with Barry Duncan. In *What Works in Therapy: a Primer*[xi], Bertolino, Bargman and Miller translate the earlier work into what is now known as Feedback-Informed Therapy (FIT). In doing so, Miller et al make it clear that their major focus is on the results of therapy, rather than on the way(s) it is done. Results are measured based on feedback from the person(s) served. FIT also shines a light on practitioners who consistently achieve positive outcomes, and what they do to accomplish those. For more information about FIT, go to **http://scottdmiller.com/**
>
> For more information about CDOI, which continues under the leadership of Barry Duncan, go to **http://heartandsoulofchange.com/**

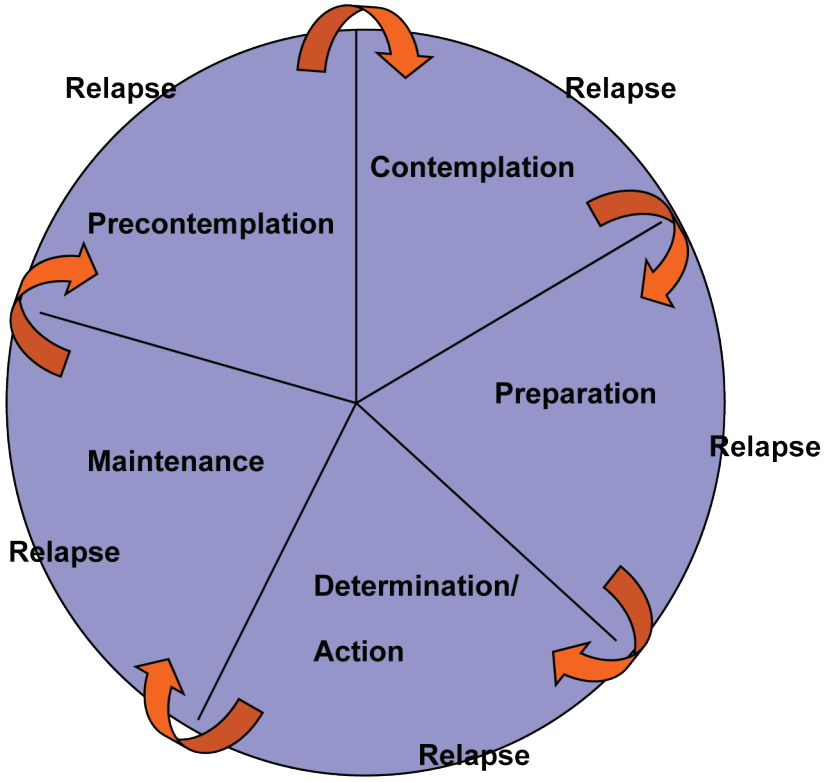
The Transtheoretical Model of Change

In the late 1980's and early 1990's, James Prochaska and Carlo DiClemente developed the Transtheoretical Model of Change[xii] based on their research involving observing and listening to thousands of people who made major changes, such as quitting smoking or quitting drinking.

The Transtheoretical Model radically shifted the way helpers assist others to achieve behavioural change, and has greatly influenced the substance uses field. The Transtheoretical Model is closely related to several proven approaches to working with alcohol and other drug issues, including motivational interviewing and solution focused therapy. It offers an integrative framework for understanding the process of behaviour change - whether that change involves the initiation, modification or cessation of a particular behaviour.

Prochaska and DiClemente's Transtheoretical Model shifted the view of change being a static event to that of a process over time, involving progress through six distinct stages: The Stages of Change. The Stages of Change represent a series of stages through which people pass as they change a behaviour. Each stage corresponds to the person's readiness to change, which shifts over time, resulting in people moving forward – and sometimes back again – through different stages until change can be maintained.

Relapse is viewed not as a failure, but as a common part of the change process and is seen as an opportunity to learn how to sustain change more effectively in the future. Change is not a linear, one-way process, but more like a circle with movement in both directions. Individuals can be at different stages of change with different life problems, with different substances (e.g. alcohol and marijuana), and with different health challenges (e.g. substance use and mental health problems). Each stage is associated with distinctive cognitive, emotional and behavioural characteristics.



STAGES OF READINESS FOR CHANGE

Precontemplation

The individual in the precontemplative stage is not thinking about changing his or her behaviour, as he or she does not see it as problematic. Therefore, it may be others who are perceiving a problem and encouraging or coercing someone into seeking help for a substance use problem. A person in the precontemplative stage may feel demoralized and quite hopeless about their situation, as they may have made several unsuccessful attempts to change in the past, and therefore have no belief that change is possible. A person may be seen as resisting change, when from their perspective the status quo is more rewarding than change as they see it. Being unaware of the need for change or being actively resistant is a normal reaction to the possibility of change. It is not pathological nor is it indicative of what many people refer to as "denial".

Contemplation

The contemplation stage is the entryway into the process of change. Clients in this stage are willing to consider that their substance use may be a problem and will contemplate the possibility of change. The stage can be characterized by a high degree of ambivalence as the client begins to assess the negative consequences of continuing substance use versus the positive effects. It is important to acknowledge the function of the substance in the client's life and to accept that ambivalence is a realistic response to a major lifestyle change. In the initial phase of contemplation, a

person can have a decreased sense of self-esteem as a result of admitting that s/he is experiencing a problem. It is important to remember that being willing to contemplate a problem is not making a commitment to change and that more support and motivation may be needed.

Preparation

The preparation stage indicates the individual's willingness to make a commitment to action, and suggests that a serious attempt at change may be made in the near future. The success of long term change depends on what is done during the preparation stage. People may not yet have resolved their ambivalence and will continue to re-evaluate themselves and their problem, but will become increasingly confident about their decision to change. Focus has shifted to solutions rather than the problem. The preparation stage requires a realistic assessment of what will be involved in achieving the change, and what resources or supports will be needed so that the client can proceed with a plan for change. There is a common danger of moving to the action stage prematurely, before the individual is fully ready. An individual should not move to the action stage until they have a degree of confidence that will be able to make the change and that it is important to them that they make it.

Action

In the action stage, the client will have made a plan and begun to implement it. An individual will begin to eliminate some behaviours, modify others and/or introduce new ones. In addition, the individual will have made a public commitment to action and be utilizing support, seeking external monitors and seeking feedback with respect to their plans. The client will experience an increasing sense of self-efficacy and may become very passionate about the change process in which she is involved.

Maintenance

Maintaining change is a challenging process that is characterized by achievement of a change goal that becomes a permanent part of the person's life. At this time, a client will be establishing and adhering to new patterns of behaviour. These changes may affect other life areas (e.g. employment, relationships, recreational activities, residence). People in the maintenance stage have concerns about high-risk situations or environmental temptations. Former behaviours will continue to hold some attraction for long periods of time, or during stressful occasions. External supports continue to be important for maintaining the change.

Termination

In this stage, the former problem no longer holds any temptation or threat. The person has confidence that the problem behaviour(s) will not return; and trusts their ability to cope without relapsing.

As with all stages, the person can re-enter the process of change from this point and into any of the previous stages.

Relapse

Relapse is a process rather than a stage. On average, relapse occurs four to seven times and is a common part of the change process, in fact, relapse is more common than not. Relapse occurs when, having made progress to later stages of change, the individual resumes old thought patterns and behaviours associated with their problem. When people are consciously aware that they have relapsed, they often experience guilt and disappointment. The vast majority

of people who relapse do not give up on themselves and their ability to change. Most return to contemplation or preparation stages, relatively close to making commitments to renewed action. If viewed as a learning experience, a relapse may be a case of taking one step backwards in order to take two steps forward. For more information on Relapse, see Module IV.

APPLYING THE STAGES OF CHANGE MODEL

With an understanding about an individual's stage of change, their sense of its importance, and their confidence about changing behaviour, a counsellor can tailor activities to make them relevant and useful to that person at that particular stage at that particular time. The more relevant the activity is to the person, the more likely they are engage with it. The following chart outlines different tasks the conunsellor can do depending on their client's stage of change.

CLIENT STAGE	KEY PRACTITIONER TASKS
PRECONTEMPLATION	Raise doubt – increase the client's perception of risks & problems with current behaviour. Reassure client they will not be pressured into changing. Engage them to identify the harms associated with their behaviour.
CONTEMPLATION	Acknowledge client's desire to quit the behaviour and their desire to continue the behaviour. Encourage the client to realistically assess the risks associated with continuing the behaviour.
PREPARATION	Support the client develop a change plan that is acceptable, accessible, and effective Assess the strength of the client's commitment to change. Help the client think creatively about how to develop the most effective plan.
ACTION	Support and reassure the client as they face unknown situations with new, untried skills. Careful listening and affirming clients that they are doing the right thing Check with the client to see if he or she has discovered any pars of the change plan that needs revision.
MAINTENANCE	Help clients to identify and use strategies to prevent relapse Assist client to use the new skills they have learned to handle on-going temptations (build self-efficacy).
RELAPSE	Resume the change efforts by attending to the tasks that go with the stage of change the individual has relapsed to, and not simply pick up where they left off before. Support the client to renew the processes of precontemplation, contemplation, preparation and action without becoming stuck and demoralized due to relapse.

IMPORTANT THINGS TO REMEMBER:

- Change is a process, not an event. It rarely follows lock-step from one stage to another, but can be messy and repetitive of several stages over time.
- It is essential to understand what stage the client is in at any given time in relation to each of their problems or problem substances in order to provide the appropriate supports and interventions.
- Despite the fact that they may present as seeking help to resolve their problem, many clients are in the precontemplative stage when they are first seen for assessment or counselling, and are not yet prepared to change.
- Clients who are in the pre-contemplative stage may be good candidates for brief intervention.
- Clients who are in the preparation stage of change (or later stages if this has not been done) can benefit from doing a functional analysis of their psychoactive substance use, thereby identifying triggers and consequences.

Motivational Interviewing

Motivation is a state of readiness or eagerness to change, which may fluctuate from one time or situation to another. Motivation is what provides the impetus for the focus, effort and energy needed to move through the entire process of change. To assist individuals to accomplish the various tasks required to move through the stages of change, Motivational Interviewing (MI), as developed by William Miller and Stephen Rollnick has been found to be a very useful approach. As one of what have been described as "collaborative therapies", MI is a good fit with the Transtheoretical Model of Change, Client-Directed Outcome-Informed Therapy and Feedback Informed Therapy.

> *** Learning the skills involved in Motivational Interviewing is not possible within the limits of CAP or this module. The section that follows is intended to provide an overview of some of the key concepts of MI as it is understood in 2012. It is strongly recommended that those participants in Core Addiction Practice who work in substance use services and supports take separate training (one or more courses) in Motivational Interviewing.

THE "NEW M.I."

Those familiar with Motivational Interviewing will note some key developments in the way it is described in the Third Edition.

- The Spirit of MI has moved even more front and centre, reminding learners that MI is more about the energy with which we engage people than it is about technique; and the elements of the Spirit of MI have been redefined.
- Rather than thinking of MI as having two phases, there are now four Processes outlined - reducing any sense of linearity in the work.
- The language of "resistance" has been altered to that of "discord" – reinforcing that when there is a difference between the client's perspective, values or direction, it is a product of the interaction between the counsellor and client rather than something within the client alone.

DEFINITION OF MOTIVATIONAL INTERVIEWING

In the Third Edition of *Motivational interviewing: Helping People Change*, Miller and Rollnick provide three layered definitions of MI.

1. *Motivational Interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change.*[xiii] (Lay person's definition)

2. *Motivational Interviewing is a person-centred counselling style for addressing the common problem of ambivalence about change.*[xiv] (Practitioner's definition)

Motivational Interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.[xv] (Technical definition)

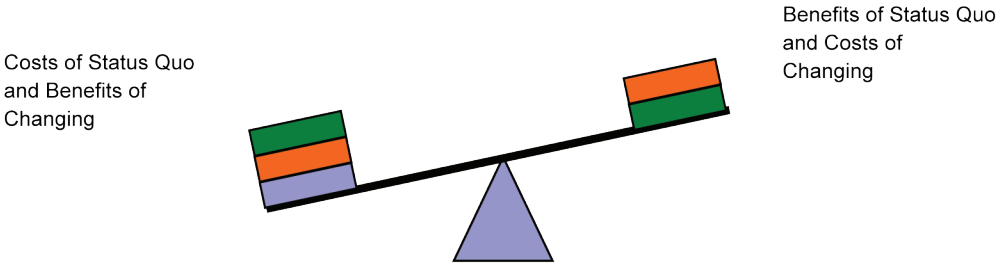
AMBIVALENCE

Miller and Rollnick say: *Ambivalence is both wanting and not wanting something at the same time.*" They also say: "*If you're ambivalent, you're one step closer to changing.*"[xvi]

We are all ambivalent about making any change. There is an appeal to the "known" of the status quo, and fear about whether change is possible. At the same time, the possibility of change draws us, and we see benefits in the changed state. In MI, ambivalence is viewed as a normal aspect of human nature, and working with ambivalence as an important part of creating change. Ambivalence is a key issue that must be addressed for change to occur; and it is when people get stuck in ambivalence that problems persist.

The client who comes to us for help has two sets of messages in their head about changing: the "pros" and the "cons". The natural response of anyone who is challenged about a behaviour about which they are ambivalent is to argue the other side. When working with an ambivalent client, advice-giving and other strategies that focus on actual behaviour change will be of limited value and will result in a common occurrence in the substance use treatment field: the counsellor arguing for change and the client responding with resistance. The most obvious form of this discord between what the counsellor is focussing on and what is forefront for the client is a client who drops out or doesn't show up for appointments.

The metaphor of a seesaw can be helpful in illustrating the concept of ambivalence. There are benefits and costs associated with behaviours and therefore two kinds of weights on each side of the balance, resulting in the person experiencing competing motivations.



In the 2012 version of Motivational Interviewing, ambivalence is named as a key element to address throughout all of MI's processes.

SPIRIT OF MOTIVATIONAL INTERVIEWING

The Spirit of MI is what is called the "mind-set and heart-set" that prevents it from becoming just a group of techniques used to guide people in a given direction.

There are now four key, interrelated elements of the Spirit of MI – all of which are not only to be experienced by the practitioner, but also demonstrated to the client.

Really, what Miller and Rollnick have discovered is that before we get into the work of focussing and planning on how to help clients pursue change, we need to get back to basics. We need to ***PACE*** *ourselves. The helpful message comes from the notion that "slow and steady wins the race." If we start out of the gate in "change at full blast" speed, we'll never maintain the momentum. First, we need to give attention to the PACE*[xvii]*:*

Establishing ***Partnership***

Demonstrating ***Acceptance***

Working from ***Compassion***

Calling forth motivation through ***Evocation***

Partnership

MI involves collaboration between the person served and the person serving, in which the work is done for the person, and with them, rather than done to them, or on them.

The metaphor used by Miller and Rollnick is dancing rather than wrestling, where there is definitely someone guiding the steps, but the dancers are partners.

> *MI is not a way of tricking people into changing. It is a way of activating their own motivation and resources to change.*[xviii]

Acceptance

Acceptance involves four elements:

- Absolute Worth – the "unconditional positive regard" cited by Carl Rogers[xix]
- Accurate empathy – an active interest in and effort to understand the other's perspective; a willingness to "walk a mile in their shoes"
- Autonomy Support – honouring each person's right and abilities to direct their own choices and actions.
- Affirmation – seeking and acknowledging the person's efforts and strengths

Together, these contribute to a working relationship where the client can experience acceptance and safety – elements which are essential not only for MI, but also for trauma-informed work and cultural competence.

Compassion

Compassion has been added as a new element of the Spirit of MI, based on observations that, given equal training and skill levels in MI, some counsellors consistently achieved better results with their clients. Compassion was found to be what made the difference.

Much more than simply "feeling what the client is feeling", compassion involves actively promoting the wellbeing of the person served, and giving priority to their needs (as they see them).

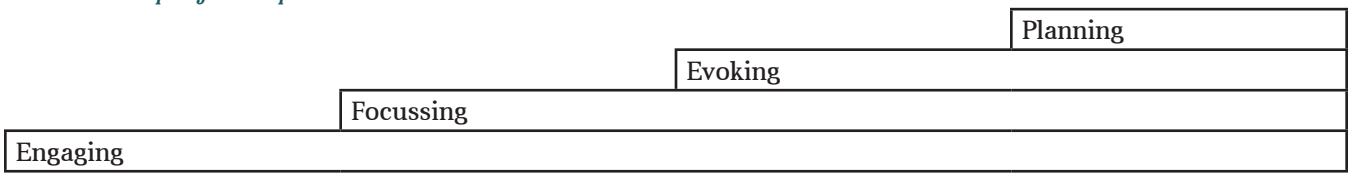
Evocation

MI is based on a strengths approach, in which it is believed that the person seeking help already has many of the resources it will take for them to make the change. The work of the helper is to bring forth those inherent strengths and resources, including wisdom and a desire for health, to achieve the desired change. These inherent qualities are recognized in 12 Step programs when people talk about bringing forward their "experience, strengths and hope."

FOUR PROCESSES OF MOTIVATIONAL INTERVIEWING

These four overlapping processes create the "flow" of MI. While each in some ways is dependent on the achievement of the one that it follows in the list below, one does not end when the other begins. Miller and Rollnick illustrate them as stair steps[xx].

The "stair steps" for MI practice



For learners participating in Core Addiction Practice (CAP), we place an emphasis on the processes that allow counsellor and client to get to the point of being able to create a plan for change.

Engaging

As noted in the beginning of this Module, the development of a working alliance is essential for success in supporting a person to change.

Engagement is far more than developing a friendly, pleasant relationship. It is defined as: "the process of establishing a mutually trusting and respectful helping relationship."[xxi]

In organizations where completion of an initial assessment is required as an entrée to helping sets a potential trap for the helper attempting to engage the client. In instances such as this, it is proposed that the helper establish the situation as one where information is being exchanged by both the helper and helpee. The helper can be guided by "E->P->E->": Elicit->Provide->Elicit when it comes to information. In providing or asking for information, the helper must:

- Obtain the permission of the client for both eliciting and providing information.
- Focus on what the person most wants or needs.
- Present information clearly and in manageable doses.
- Use autonomy-support language.
- Don't prescribe the client's response.

Other traps to avoid include:

- The Expert Trap – indicating "I'm in control here, and I have the answers."
- The Premature Focus Trap - trying to solve the problem before establishing the alliance, including listening to what the client is telling you about their perception of their problem(s). Considering the Stages of Change, pre mature focus also occurs when the helper assumes the client is further along in the stages than they actually are.
- The Labelling Trap – when the helper alone defines what the problem is and expects the client to accept it (i.e. a medical diagnosis, or "addict").
- The Blaming Trap – implying that it is important to identify whose fault it is that the problem exists.
- The Chat Trap – where the communication between client and counsellor consists primarily of undirected conversation, not focussed on the client's concerns and goals.

O.A.R.S. – Core Interviewing Skills for Engagement

It can be useful for helpers in the engagement process to keep in mind the acronym OARS.

- O=Asking Open questions; that is, questions that invite exploration and deeper understanding.
- A=Affirming the client's ability to create the desired change, as well as reinforcing and encouraging actions that can take them in the direction of that change. Affirmation must be used skillfully so as not to imply judgement about "good" or "bad" directions. At the same time, affirmation indicates respect, and is only given to what is truly known or appreciated.
- R=Reflective Listening – the skills of not only deeply hearing what the other person is telling you, but being able to communicate to them you have heard it and value it.
- S=Summarizing. When the helper communicates back to the client the core of what they understand of the client's perspective, the client is able to consider what has been fed back to them, confirm or deepen its truth and feel encouraged to continue.

Focussing

Whatever the role of assessment may be, the focus of MI is formed through a purposeful conversation that has change at its heart."[xxii]

In the Focussing process, the helper joins with the client to set a direction for their work together. Not a one-time event, focussing is: " … an ongoing process of seeking and maintaining direction."

Direction can come from:

- The client – what they have come for help to achieve, or what they decide they want to achieve as the work progresses
- The setting – the overall purposes of the helper's agency or organization
- The expertise of the helper – including what they bring to the helping relationship in terms of knowledge and experience.

SOME ETHICAL GUIDELINES FOR THE PRACTICE OF MOTIVATIONAL INTERVIEWING

1. *The use of MI component processes is inappropriate when available scientific evidence indicates that doing so would be ineffective or harmful for the client.*
2. *When you sense ethical discomfort or notice discord in your working relationship, clarify the person's aspirations or your own.*
3. *When your opinion as to what is in the person's best interests differs from what the person wants, reconsider and negotiate your agenda, making clear your own concerns and aspirations for the person.*
4. *The greater your personal investment in a particular client outcome, the more inappropriate I it is to practice strategic evoking. It is clearly inappropriate when your personal investment may be dissonant with the client's best interests.*
5. *When coercive power is combined with a personal investment in the person's behaviour and outcomes, the use of strategic evoking is inappropriate.*

Evoking

Evoking has similarities to "strengthening motivation to change" – the second phase of the old model of MI.

Change Talk

In the evoking process, the helper is attuned to "change talk" on the part of the client, and actively supporting and encouraging such talk, being sensitive to the client's natural ambivalence.

There are several types of change talk to be aware of.

Preparatory Change Talk is concerned with the "pro change" side of the client's ambivalence. Typically, they may express:

- Desire – "I want to…."
- Ability – "I can …."
- Reasons – "This is important to me because …."
- Need – "I can't keep doing this."

Mobilizing Change Talk indicates the client is working on resolving their ambivalence, and moving toward a commitment to change. The helper will hear:

- (Most obviously), Commitment – "I will …."
- Activation – "I am ready to …."
- Taking steps – "I have been doing …."

Some find it helpful to remind themselves to tune in for DARN CAT for both Change Talk and Sustain Talk.

Sustain Talk

Sustain talk is the mirror image of change talk in that it expresses all or any of the above in support of not making change.

The MI practitioner will not only stay attuned for both Change and Sustain Talk, but will remain conscious of the balance of the two – hoping for a situation where the former dominates.

Planning

Planning is possible when client and counsellor have achieved engagement, been able to bring focus to what needs to be worked on, brought the client to a place of feeling "ready, willing and able" to change, then planning for change can begin. "The essence of the Planning process in MI (is) to move from discussing (the) importance (of change) to developing a specific change plan that the person is willing to implement."[xxiii]

Skills for the Planning Process of MI are further detailed in the later chapters of the 2012 book.

As participants in Core Addiction Practice move to Module IV, which is focussed on common clinical processes in substance use treatment, it is important to consider those from the perspective of Person-Centred Practice, as outline in Module III.

[i] Martin, Garth W. and Jurgen Rehm. (2012). The Effectiveness of Psychosocial Modalities in the Treatment of Alcohol Problems in Adults: A Review of the Evidence. The Canadian Journal of Psychiatry (57-6), 350-358.

[ii] Adapted from Martin, Garth W. and Jurgen Rehm. (2012). The Effectiveness of Psychosocial Modalities in the Treatment of Alcohol Problems in Adults: A Review of the Evidence. The Canadian Journal of Psychiatry (57-6), 350-358.

[iii] Miller, William R. and Stephen Rollnick. (2012) Motivational Interviewing: Helping People Change, Third Edition. Guilford Press, New York.

[iv] Project MATCH Research Group. (1998). Matching Alcohol Treatments to Client Heterogeneity: Project MATCH three-year Drinking Outcomes. Alcohol Clinical Experience Research (22), 1300-1311.

[v] Ouimette, P.C., J.W. Finney, R.H. Moos. (1997). Twelve-Step and Cognitive-Behavioural Treatment for Substance Abuse: A Comparison of Treatment Effectiveness. Journal of Consulting Clinical Psychology; (65), 230-240.

[vi] Ferri, M., L. Amato, M. Davioli. (2006). Alcoholics Anonymous and Other 12-Step Programs for Alcohol Dependence. Cochrane Database Systemic Review (3), CD005032.

[vii] With the permission of Scott Miller, the illustration and definitions have been taken almost directly from Bertolino, Bob, Susanne Bargmann, Scott D. Miller. (2012). Manual 1: What Works in Therapy: A Primer. International Center for Clinical Excellence. Can be accessed from www.centerforclinicalexcellence.com

[viii] Hubble, M.A., B.L. Duncan, S.D. Miller, and B.E. Wampold. (2010). The Heart and Soul of Change: Delivering What Works in Therapy – 2nd Edition. Washington, DC: American Psychological Association. (p. 23-46).

[ix] Bertolino et al. (p.6)

[x] As cited in Bertolino et all (p. 7)

[xi] As above.

[xii] Prochaska, J.O., DiClemente, C.C. & Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviors. American Psychologist, 47(9), 1102-1114.

[xiii] Miller, William R. and Stephen Rollnick. (2012) Motivational Interviewing: Helping People Change, Third Edition. Guilford Press, New York.(p. 12)

[xiv] As above. (p. 21)

[xv] As above. (. 29)

[xvi] As above. (p.6)

[xvii] Burke, Paul. (2012). Thoughts on Improved Practice. (Electronic newsletter re new approaches to Motivational Interviewing). Access through http://www.paulburketraining.com/

[xviii] Miller and Rollnick. (2012). (p. 15-16)

[xix] Rogers, C.R. (1980) as cited in the above. (p.17)

[xx] Miller and Rollnick. (2012). (p. 26)

[xxi] As above (p. 40)

[xxii] As above (p. 94)

[xxiii] As above (p.255)

MODULE IV: BEGINNING CLINICAL SKILLS AND TOOLS

MODULE IV: FOUNDATIONAL CLINICAL SKILLS AND TOOLS

Introduction

WHAT IS "TREATMENT" IN THE SUBSTANCE USE FIELD?

Before the components of the clinical process are explored, it is useful to understand the "big picture" within which the work is being done.

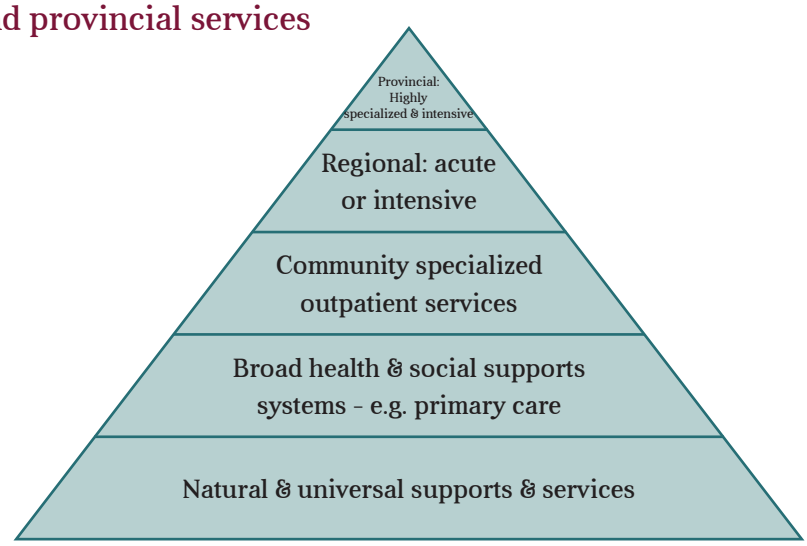
Substance use treatment has evolved significantly from the days when people seeking help for serious substance use problems understood that getting help required a stay (usually 4-6 weeks) in a residential facility. We now know that the majority of people can benefit from community-based services – some following a short stay (7 days or less) in a withdrawal management program (formerly known as "detox".)

In line with the National Treatment Strategy noted in the Introduction to CAP, Substance Use professionals are increasingly replacing the language of "treatment" and "therapy" to reflect the necessary partnerships with clients reflected in Module III. "Treatment" is being replaced with "a system of services and supports", which more accurately reflects the full range of options available to people on a journey of recovery.

The National Treatment Strategy describes the system in Canada as one that is comprised of roughly five "tiers" of services and supports. What is important about the tiers is that they describe functions of the system (rather than client groups), and are not linear or discrete; (i.e. people move on many different paths through and across the tiers). One way of representing the "tiered system" is shown below.

The pyramid shape is used here to indicate that the numbers of people who require each level of supports becomes smaller as the tiers build from the base. In health services in general and substance use services specifically, the cost per person served increases significantly as the tiers rise.

Local, regional and provincial services



The foundational tier shows the diversity of supports available within the person's community. Examples would be family, friends and neighbors, self-help and mutual support groups, churches and other spiritual communities, cultural groups and the like. Many individuals require only these supports to prevent substance use problems or recover from problems if they occur. This level of supports is essential for all, including those who access help from time to time in the "higher" tiers.

The next tier up ("Tier 2") represents those services that are also available to all, regardless of the nature of their health or social problem. For people with substance use problems, key functions in "tier 2" include general practitioners in the medical field, community counselling services, educational programs, income assistance, food and shelter programs for those who need assistance with those. Included here as well are so-called "low barrier" health and outreach services that welcome people with substance use and mental health problems when they require assistance for problems related to their mental illness or substance use problems, but are not seeking help for the substance use or mental illness themselves. Again, this tier is essential for people who may use tier 3, 4, or 5 services for periods of time.

"Tier 3" represents the functions provided by community-based substance use specialists, such as Health Authority- or Health Canada-funded Substance Use Services (often integrated structurally with Mental Health Services.) It also represents specialized medical services such as methadone clinics, and supported housing, education or employment programs that are directly mandated to serve individuals in recovery from substance use problems. Ideally, people with serious substance use problems are connected with community substance use services before they are referred to a more intensive regional or provincial program. Whether or not this occurs, it is essential that when they complete those more intensive programs, they are bridged back into their community Substance Use Service for ongoing support and treatment.

The fourth tier of services are usually (but not always) created to serve a regional population. Examples would be regional withdrawal management programs that provide medical oversight.

Finally, "tier 5" represents those services that are highly specialized, and often have a provincial catchment area. Intensive residential treatment programs such as Heartwood or Burnaby Centre would be included in this category.

Given the breadth of options, and what we know about the importance of developing a treatment/recovery plan in collaboration with clients that responds to their unique needs and resources, as well as their beliefs and expectations, it becomes essential that we develop a good understanding of all of those, and that we familiarize ourselves with the programs and services that are accessible to clients in our given geographic area of the province.

Hence the importance of skillfully-done screening, assessment, and treatment planning for each person served.

BEGINNING THE WORK: CREATING A CLIENT-DIRECTED ENVIRONMENT

As discussed previously, the client's perception of the relationship with the practitioner is second only to client factors in being responsible for gains made in therapy. This relationship building begins immediately upon contact with the client so it is important that a client's first contact with any service is a positive one. The probability of the client having a positive experience can be increased by providing:

A client directed environment - space, procedures, paperwork, language

Respect – doing the small everyday acts that convey the sense that the individual is valued, important, competent and worthy

Welcoming and friendly reception

It is also essential to be aware that on any day we may be attempting to assist someone for whom experiences of trauma are being triggered as a result of, or a precursor to, their coming for help. In Module V you will find guidance on how you can respond in the moment to help your client with immediate tools for grounding or containment.

INTAKE

Since intake is the doorway to help, Duncan and Sparks[i] suggest that intake be collaborative and do all the things that collaborative therapy does including:

- Invite client participation
- Offer choices
- Instill hope for a positive outcome
- Listen
- Respect client preferences
- Initiate a positive relationship

Duncan and Sparks go on to list several things an intake worker can do to invite clients into a collaborative relationship:

- Match the style and pace of the intake conversation with what the client seems to prefer.
- Give adequate information about how your site works and what might be expected.
- Give prospective clients choices (e.g. male/female practitioner, day/evening appointments, particular ethnic or language-fluent therapist) where available.
- Attempt to get some idea of what clients are hoping to achieve.
- Without "promising the moon," assure the client that what they are calling for is what your site does.
- Highlight the client's motivation to address the issues at hand when appropriate.
- Don't ask overly sensitive or large amounts of information – stick with most important information.
- Make sure they have a number to call if they have any questions before next appointment.

Intake screens individuals promptly and responsively to determine the urgency of need. The following things are determined:

- If the client is in the right place.
- If the client is in imminent danger.

- Potential lethality including harm to one's self or others.
- Client's emotional status and imminent psychosocial needs.
- Client's strengths and available coping mechanisms.
- Resources that can increase service participation and success; and
- The most appropriate and least restrictive service alternative for the client.

Urgent and/or immediate needs

It is important to be aware that a client may present with some needs which will require immediate and prompt action. Situations which may require crisis intervention include:

- The person seems to be currently withdrawing from a substance and in need of withdrawal management services.
- The person is unsafe and/or in need of child protection or police services.
- The person is a danger to him/herself or others and in need of assessment by a mental health specialist, or contact with police.

Right place for right service

When discussing which services can be offered and what the client is looking for, it may appear that the services offered are not what the client wants or needs. If this is the case, other options in the community should be suggested and the client should be assisted to find what they need in the most appropriate and accessible place possible.

Referral to a physician

In order to determine whether an individual needs to be referred to a physician, screening tools should include the Medical Triggers Screening Tool (MTST) or its equivalent. A copy of the MTST is included in the Appendix to Module IV. **NOTE: A youth version of the MTST should be used for clients under the age of 19. This version is discussed in the CAP Supplementary Module on Youth.

A referral to a physician knowledgeable about addiction medicine, and familiar with current best practices in substance use treatment is recommended, if available in your local area.

Other Information to be gathered at Intake

Some basic demographic information should be gathered and recorded at intake, including:

- Identifying information, including name, date of birth and Personal Health Number (if available)
- Current residence
- Emergency health needs
- Emergency contacts

- Safety, imminent danger or risk of future harm, as applicable
- Legal status

SCREENING

Screening for alcohol and other substance use

Recognition is the first step towards treatment. It identifies whether the individual may have a substance use problem that requires further attention and perhaps a comprehensive assessment. Screening is a brief process that is used to help a counsellor determine the probability that a problem exists, substantiate that there is a need for concern, or ascertain that further evaluation is warranted. The screening process also helps determine eligibility and appropriateness for services provided by substance use services. If, based on the initial screening, it appears that the services offered are appropriate, a more comprehensive assessment is then completed in order to formulate a treatment plan.

Screening usually involves an informal interview and a brief standardized screening tool. The informal interview gives counsellors the opportunity to establish rapport with the individual, begin to build trust and engage a person in the treatment process. Using motivational interviewing will help a counsellor gather information in a non-judgmental way and understand the individual's view of their situation. Screening is an exploratory process, much like a road map which shows many destinations and many different routes to travel. It helps determine what's going on in an overall way with a client's use of substances and with other life issues, helps determine where their use fits on the Spectrum of Substance Use, and lays the groundwork to explore a number of possible goals and actions to pursue.

Determining "where the client is at"

In line with what the effectiveness of client-directed approaches, it is important that the practitioner initially explore what concerns are bringing the client for help, *from the client's perspective.* Depending on whether the client has been required to attend substance use treatment by a third party (e.g. family member, Child Protection worker, Probation Officer), it is also important to learn more about the concerns of the third party, as well as your client's perspective on those concerns. Clearly, a youth who has been "kicked out" of his family home, a parent referred to you because their child has been removed, or a young person facing breach of probation charges, will likely have more urgent concerns that need to be addressed directly before a more generalized comprehensive assessment and treatment plan can be considered.

Because client engagement is the single best predictor of outcome, exploring the client's theory of change is an excellent way to engage with a client. A client's theory of change is simply his or her ideas about what needs to happen to solve the situation that brought them to see you. The client is not a passive recipient of treatment – he or she must be an integral partner of the treatment.

During screening, and without placing primary emphasis on substance use, the counsellor makes a preliminary observation about the client's level of involvement with the various psychoactive substances being used and if any mental health problems are suspected. As was discussed in Module II, psychoactive substance involvement is reflected along a continuum from beneficial to dependent use. An individual may be at different places on the continuum with the different psychoactive substances he/she uses. It is important to remember that especially for those clients with concurrent disorders, use anywhere along the continuum can be harmful use.

Screening for co-occurring mental health problems

Given the significant incidence of mental illness concurrent with substance use, Health Canada recommends that all individuals seeking help from the Mental Health system be screened for co-occurring substance use problems. Likewise, Health Canada recommends that everyone seeking services from the Substance Use system be screened for co-occurring mental health problems. This is in order to ensure that all individuals are welcome wherever and whenever they enter the system, and receive timely and seamless access to services. Not screening for both mental health and substance use problems may result in misdiagnosis, over treatment with psychiatric medication and/or the neglect of appropriate interventions; and may interfere with a client's ability to carry through with the treatment plan. Identifying the co-occurring problems and intervening early increases the likelihood of positive treatment outcomes.

See Module V for more information on clinical practices related to concurrent mental health problems.

Screening for other issues

In talking with the client, try to learn about other issues they face, some of which may be more pressing than the psychoactive substance use. For example, a client who is injecting heroin and is living a street life may need assistance to reduce the potential harm associated with injection drug use and may also benefit from shelter assistance.

During any screening, it is essential to consider suicide risk and to conduct a more formal suicide risk assessment if there is any indication of the need for one. Protocols for suicide risk assessment vary from one employer to another in BC, however consistent practice using a supported protocol or tools is essential. If you are not familiar with the one utilized in your work, consult your supervisor or manager.

Substance use screening methods

For those working in substance use services, screening becomes second nature. A variety of strategies can be applied to gather information for a screening. Remember, the purpose of the screening is to identify whether the services offered may fit with what the client wants or needs.

Counsellor observations

Having an informal interview with an individual gives the counsellor the opportunity to observe their behaviour and non-verbal cues. Making observations and using your judgment (e.g., observe their behaviour and appearance and listen to the thoughts they express) are important tools for screening. Observations can be recorded using an informal checklist of behavioural, clinical and/or social indicators to provide signs of possible problems.

Information from others:

If you have direct contact with others involved with the individual, e.g. family members, probation officers, outreach workers, social workers, etc., you may have access to their observations and concerns (within the limits of consent and confidentiality). Whatever observations you or others make should be checked out with the client to ensure that they are not just assumptions.

Asking a few questions

Asking a client a few direct questions about substance use in a non-judgmental manner can reveal indications of possible problems. The following are possible questions that can be asked, with positive responses to any one question indicating the need for further investigation:

- Do you use alcohol or other psychoactive substances, and wish to have support or help concerning that?
- Do you think you have a problem with alcohol or other psychoactive substances?
- Have you ever had any problems at school, work, with your family, with your peers, with your health, or with the law related to your use of alcohol or other psychoactive substances?
- Has a relative, friend, doctor or other health worker been concerned about your drinking or other drug use or suggested cutting down?
- Have you ever said to another person "No, I don't have an (alcohol or other drug] problem, when around the same time, you questioned yourself and FELT, "Maybe I do have a problem?"
- Do you want to change your alcohol and other drug use behaviour or reduce your consumption?
- Do you desire help or support because of a family member's drinking or other drug use?

Formal Screening Tools

There are a number of formal screening tools that have been developed in the substance use field. Screening tools differ in many ways including what they screen for (only alcohol, alcohol and other drugs), the timeframe the questions refer to and their complexity. Some screening tools are simple and free and can be used by anyone whereas others must be purchased or require training and have restrictions on who can purchase, administer or interpret the results. Screening tools should only be used as one piece of the screening process and counsellors should only choose the tools they are qualified and trained to administer and that are appropriate for their client (e.g. developed for correct target group, culturally and developmentally appropriate).

Allied professionals are more likely to be involved in initial screenings than substance use services practitioners. Substance Use treatment practitioners should support allied professionals to be aware of the role they can play, familiarize them with screening tools and services to refer to in the community.

A few examples of screening tools, as well as web addresses for accessing others, can be found in the Appendix to this Module.

Things to remember:

While screening for substance use and mental health problems, keep in mind that an individual might:

- be in crisis, withdrawal or extremely agitated
- have a history of, or have recently experienced trauma

- have substance use and mental health problems that are interacting with each other (e.g., using cocaine or methamphetamine could trigger a manic episode in someone with bipolar disorder)
- have a mental health problem that is in remission
- use substances to self-medicate mental distress (e.g., smoking marijuana only when depressed or feeling sad)
- have had other symptoms in the past that differ from current symptoms
- not see his/ her substance use or mental health problem as a "problem"
- be motivated to get help for one problem but not others (e.g., wants to stop hearing voices, but unwilling to stop smoking marijuana)

Brief Intervention

In instances where a person being screened has not indicated they are seeking treatment at this time, or if they are being screened by someone who does not have the capacity to do substance use treatment, very brief intervention methods have been found to be helpful if used skillfully (i.e. in line with Motivational Interviewing and a sound understanding of the Stages of Change.) Brief interventions is typically defined as one to four short (15 to 20 minute) sessions for non-treatment-seeking individuals; and which incorporate advice, motivational interviewing and counselling (McQueen et al, 2011 as cited in Rush below).

Quoting Brian Rush[ii]:

> *There is a wealth of evidence pertaining to the effectiveness of (brief intervention) …. in primary care settings, medical wards and other hospital settings such as trauma clinics and emergency departments.*
>
> *More research is needed on who benefits most from brief interventions delivered outside substance use treatment settings by trained health care professionals, especially with longer term follow-up and drug abusing populations well represented…. The existing data suggests that (a) brief intervention should be formally considered as part of the community's continuum of care, and (b) it is not necessarily targetted only at people experiencing mild to moderate levels of risk and harm/ severity.*
>
> *Recent work extends the positive findings on (brief intervention) to drug use/abuse other than alcohol.*

In the past 2-3 years, brief intervention has included an option of referring the person to treatment if the initial processes lead to that point. These methods are known as SBIRT.

Both the BC College of Physicians and Surgeons and the College of Physicians and Surgeons of Canada have established guidelines for brief intervention with people with problems related to alcohol use. They can be found at:

BCMA Guideline: **http://www.bcguidelines.ca/pdf/problem_drinking.pdf**

Canadian College of Family Physicians Guideline: **http://www.sbir-diba.ca/**

Assessment

If, upon completion of the screening process, it is determined that an individual has developed or is at risk of developing a substance use problem, and that the services offered can be tailored to meet the wants and needs of the client, the next step is a comprehensive assessment. Assessments are used to fit services to the individual based on an ongoing assessment of that person's needs and level of functioning.

A comprehensive assessment may take place over a few weeks and involve assembling information from a variety of sources . (this is directly from the NHS – NTA – care planning practice guide. 2006

Its important to understand that the written process of assessment has many dimension – not just a structured interview. A written summary that is in most instances shared with the client is the product of assessment processes.

The assessment process is an opportunity for the individual to explore his/her concerns, their current level of functioning, and the ways in which they believe drinking or use of other drugs is impacting their life. Assessment serves several different purposes:

- To strengthen the working relationship.
- To determine the existence, nature and extent of the problem.
- To priorize the most urgent or potentially harmful problems.
- To determine what type of service, if any, is appropriate.
- To gather information for the purposes of treatment planning.
- To bring on additional supports or resources if indicated; or make referrals as needed.
- To gain a deeper understanding of the client and their situation.
- To evaluate progress regarding goal attainment and treatment outcome by establishing baseline information.

DIMENSIONS OF A COMPREHENSIVE ASSESSMENT

Assessment should be comprehensive, integrative, strength based and culturally responsive. It should be seen as an incremental and ongoing process conducted over a number of meetings, using multiple assessment methods, and be updated regularly.

Though assessment information is primarily obtained through the client's self reports, additional information from multiple sources of information (including individual, parents or other family members, significant others, previous treatment records, other agencies) and collaborating with other service providers may be gathered with the client's permission. Information gathered in the assessment should be limited to information that is pertinent to meeting the client directed goals.

Again, the importance of the practitioner's ability to establish a rapport and relationship with the client cannot be overemphasized since client engagement is the single best predictor of outcome. Remaining empathic, hopeful and connected with the client will strengthen the assessment process.

In addition, it is particularly important that the assessment process include the individual's motivation and readiness for change and his/her ability to follow treatment recommendations. Identifying a person's strengths, supports and resources are also crucial. Remember to honour the client's theory of change.

As indicated by the Biopsychosocialspiritual approach used in substance use treatment (Module I of CAP), and the approaches outlined in Module III, comprehensive assessment explores aspects of the client's life in relation to all those domains in order to gain a whole picture of the person. Assessment begins with the client "where they are at", and the concerns that are forefront for them.

The following is a summary of the dimensions of a comprehensive assessment.

1. **Presenting problem and precipitating events** are important to capture from the client's perspective. Why are they coming for help now? Is anyone pushing them to come? Are there any crisis issues?

2. **Strengths and supports** refer to resources that can be identified and mobilized to assist with client care. Learn what has helped the client live as successfully as they have been able to, given the problems they have experienced. What has worked for them in the past in confronting their substance use and related problems?

3. **Family relationships and other support systems** refers to identifying supportive family members or other supports for the client. Also, gather information on familial patterns of substance misuse or mental health problems, as well as identifying substance-affected members. Check out the client's family of origin and any current living arrangements. Are there safety concerns? Screen for family violence, abuse, neglect or exploitation. Are there vulnerable people (children or others) at risk due to your client's substance use? (If you are not familiar with what you are required to do if this is the case, speak with your supervisor or manager immediately.)

4. **Past or current use of services** refers to the use of this organization or other organization's services by the client, either currently or in the past, and what has been their experience in using those.

5. **Life areas** assesses both the impact of substance use on life areas (family, school, job, legal, etc.) and on problems which exist in these areas that may be unrelated to substance use, or that may be contributing to the substance use. What is the current work/school situation? Are there charges pending? What's the money situation? What leisure activities are there besides psychoactive substance use?

6. **Alcohol and other psychoactive substance use** includes information on amount of use, risk level, patterns of use, routes of administration, dependency syndrome, predictability of substance use, urgency and priority given to use, tolerance and reverse tolerance, presence of withdrawal symptoms (and the use of substances to deal with symptoms), compulsion and craving, and relapse history. It is also important to gather the age of first use and the length of problematic use, any periods of abstinence, preferred psychoactive substances and last use, previous treatment involvement.

7. **Mental health status and developmental assessment**, as applicable.

8. **Medical and dental history**

9. **Trauma assessment** (See Module V for more information on trauma-informed practice)

10. **Housing status, history and description of living conditions**

11. **Other information necessary to provide services** e.g. culture, religion or spirituality

12. **Client's theory of change** refers to the client's frame of reference with regard to the presenting problem, its causes and its potential remedies.

SPECIALIZED ASSESSMENT

Other areas where specialized assessments may need to take place involve mental health, neurological, medical, vocational, educational, or employment factors. Most commonly these are carried out by a third party. Ideal practice is to have the third party work in close conjunction with the substance use counsellor. At a minimum, the client must have a clear understanding of the purpose of the specialized assessment and its relationship to their goals, and be "bridged" to the specialist and back to the counsellor.

STANDARDIZED ASSESSMENT TOOLS

Standardized tools can assist in the assessment process and improve the practitioner's ability to identify patterns related to substance use. As with screening tools, assessment tools differ in what they assess and what training and qualifications a person should have in order to administer and interpret them. Standardized assessment tools should be used as one piece of the assessment process and practitioners should only choose the tools they are qualified and trained to administer or partner with other agencies to conduct this piece of the assessment.

A list of assessment tools used with adults, and where to access them, can be found at the end of this module.

Treatment Planning

Once the assessment is complete, the counsellor and the client will have a more complete picture of the client's psychoactive substance use and what their issues and strengths are in all areas of their life. According to Miller, Mee-Lee, Plum and Hubble[iii], three key procedures are involved in operationalizing client-directed, outcome-informed work:

13. a highly individualized service delivery plan for each client in care;

14. formal, ongoing feedback from clients regarding the plan, process and outcome of treatment;

15. the integration of the plan and feedback into an innovative and flexible continuum of care that is, because of points 1 and 2, maximally responsive to the individual client.

Underlying these procedures is ensuring that the client is an integral partner.

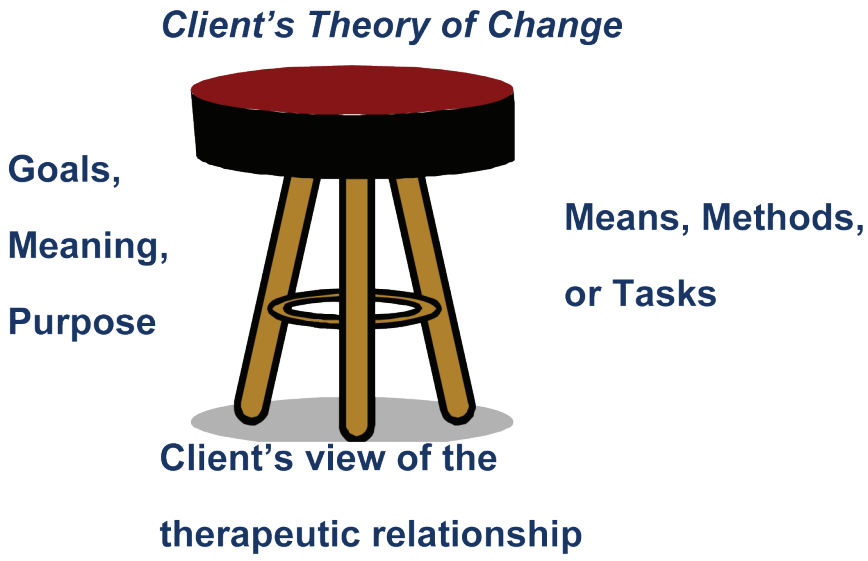
INDIVIDUALIZED SERVICE DELIVERY PLAN

An individualized service delivery plan is a written summary of a plan of action agreed upon by the client and counsellor at a given point in time. Miller, Mee-Lee, Plum and Hubble[iv] state that there are four essential ingredients for an effective alliance:

- Shared goals
- Consensus on means, methods or tasks of treatment
- An emotional bond
- The client's theory of change

Miller, Duncan and Hubble[v] explain how these four parts of the alliance can be thought of as a three-legged stool:

Each leg represents a core ingredient of the therapeutic alliance, and the client's theory of change is what holds everything together. Goals, methods, and a bond that are congruent with the client's theory of change are likely to keep people comfortably seated (i.e., engaged) in treatment. Similarly, any disagreement between various components works to destabilize the relationship, either making the stool uncomfortable or toppling it completely.



COLLABORATIVE GOAL SETTING

As discussed previously, shared goals are an essential ingredient to an effective alliance. Goal setting allows for the articulation of collaboratively-developed goals as well as providing some benchmarks by which both the client and the counsellor can measure progress.

According to Berg and Miller[vi], a well-formed goal has seven qualities:

1. The goal must be important to the client.

- Supports development of alliance.
- Respects the client.

2. Goals are kept small and achievable.
   - Helps client and counsellor recognize progress which is key to preventing drop out.
   - Easier to see what remains to be accomplished.
   - Accomplish a series of small goals which contribute to a bigger whole.

3. Goals are concrete, specific and behavioural.
   - Non-behavioural goals are difficult to achieve because success and progress are difficult to gauge.
   - Concrete goals can be counted, making determining success towards its accomplishment possible.

4. Goals express the presence of something or of a behaviour, rather than an absence.
   - Goals are stated in positive, proactive language about what client will do instead of what he/she will not do.

5. Goals are expressed as beginnings rather than endings.
   - Goals can be accomplished if we concentrate on starting them, then progress one step at a time.
   - Helps clients and counsellors find ways to be on "track" immediately.

6. Goals are realistic and achievable within the context of the client's life.
   - Avoid grandiose plans and concentrate on what's achievable.

7. Client sees the goal as involving "hard work".
   - Protect and promote the client's sense of self-worth and dignity.
   - Allows the client to internalize personal responsibility for achieving the goal.

Substance use goals

There is a wide range of goals that a client may consider related to their psychoactive substance use. Some clients express the desire to be rid of all the negative consequences related to their psychoactive substance use, while some may wish to cut down or stop certain substances. Some clients express the desire to quit all substances, but more often, there is ambivalence or resistance to doing so. Few clients will want to pursue total abstinence from all substances – and forever – at the onset of treatment. Most will want to look at shorter term, more realistic goals. Find out from the client what goals they are willing to consider related to their substance use. As their counsellor, gain some understanding of what their reasons for leaning towards a non-abstinent goal for their substance use. Reasons often include:

- One of the substances they use may not be causing many problems for them or is one they only use occasionally.
- Long-term abstinence is a concept that is often far removed from a client's present, "now" orientation. Quitting for a long time might mean two months for a client.
- Abstinence may seem unattractive or unattainable because their friends are heavily involved in substance uses.
- Substance use often provides a means of dealing with or escaping from problems and stresses. Abstinence would take away a very effective solution.

Non-abstinence goals:

- *Time-Limited Substance Use Goals:* Focus on getting the present substance use under control, whether it is abstinence for the day of the appointment, an evening, a weekend or whatever. If it is achieved, it can lead to more ambitious goals once smaller victories have been attained. The experience of being 'substance free', even if it is short-term, can provide some information and insight to both the client and the counsellor on what that's like and what the challenges in making more major changes might be.

- *Partial Abstinence Goals:* Some clients may be willing to be abstinent from a particular substance, but not others. If the client can gain control over one psychoactive substance, they may be willing to consider action on other substances. Watch for drug substitution, which sometimes occurs when the client cuts down on one substance, but the use of another substance begins to climb. Clear parameters on use of other substances need to be negotiated. If the client is not able to abstain from the designated substance, additional investigation on the relationship of this substance to other substances used may be needed, as one may be a trigger for the other.

- *Harm Reduction Goals:* It is often the case that the harm related to substance use comes as much from the negative consequences and risk behaviours associated with the substance use, as it may from the substance use itself. With clients who are involved in injectable substances, there are risks of HIV and hepatitis. This may well be more of a risk than the actual substance use itself. A more relevant goal for a client like this may be to look at ways to reduce the harm associated with the method of administering the substance, i.e. injection. Needle ex change programs are based on this principle. Perhaps switching IV cocaine use to inhalation methods may be in the client's best interests. In the short-term, harm reduction goals can work to minimize the immediate risk of harm to the client, and they are a beneficial stage in working with a client who may not be willing or able to consider abstinence or other non-abstinent substance use goals. Harm reduction goals are not the same as condoning substance use, but they may prove controversial to others involved in the client's life and become a point of discussion in the client's treatment plan, especially for younger clients.

- *Controlled Drinking/Substance Use Goals:* This may be an appropriate goal if the following factors are present: short histories of involvement; not physically dependent; no chronic health problems which would be made worse by continued involvement; no connection between use and dangerous or violent behaviour; no family history of substance use problems; no active substance problem in the home; suitable supports in the client's environment. Some people disagree with controlled drinking as a goal for adolescents, because alcohol use is illegal for youth. Use of some drugs is illegal for everyone, so controlled substance use may be similarly controversial. Pragmatically, any attempts to gain control of substance use by a client should be tried.

Goals in other life areas

The assessment completed with the client will point to numerous other areas in their life that may require attention. Some areas may require attention before the alcohol or other drug use problem e.g., immediate mental health issues, safety concerns, crisis issues, serious medical issues. Goal setting in these areas can follow a similar process described above; the goals need to be realistic, incremental and be in tune with the desires and capabilities of the individual client. It is important that whatever goals are chosen are the ones seen by the client as most important and ideally should be quickly and easily attainable in order to reinforce success.

UPDATING THE PLAN IN RESPONSE TO CLIENT FEEDBACK

Miller, Mee-Lee, Plum and Hubble (2005)[vii] advocate that the key to effective services is flexibility, that everything is a possibility to be explored and that "formal client feedback provide(s) a structure for collaborating with the client in the development, continuation, modification or termination of contact."

Instead of attempting to match clients to treatments, services should be tailored to the individual client. Clients are full partners in their care, identifying how change will happen and what they need. It is the role of the substance use practitioner to enhance the factors (i.e., alliance) that account for successful outcomes and use the client's theory of change to decide "… which approach, by whom, would be the most effective for this person, with that specific problem, under this particular set of circumstances." Valid reliable feedback regarding the client's experience of the process and outcome of treatment should be sought through a formal process so that a systematic and ongoing assessment of the fit and effect of the treatment is constantly occurring. In other words, assessment should not simply precede and dictate intervention, but rather weave in and out of therapeutic process as a pivotal component of treatment itself.

In order to engage the people we serve in providing the feedback that is invaluable to our practice, it is important that the practitioner and his/her colleagues have already established a workplace where there is a culture of feedback – in other words, where feedback is experienced in many ways (not only in client sessions, and the feedback is seen as respectful, valuable and of benefit to practitioners as well as clients.

Navigating the System of Care

In order to begin to develop a treatment plan and to match services to the needs of the client, practitioners need to be aware of the services available in their community - or available to them although located in other parts of the province (i.e. tier 4 and 5 services). The Substance Use Services (in many areas now called Substance Use Services System of Care includes:

Withdrawal Management

Withdrawal management (detoxification) services provide a range of medical and support services in safe environments for individuals withdrawing from the acute effects of alcohol and/or other drugs. Withdrawal management can be achieved through inpatient "detox", daytox or home detox programs or services.

Outreach Services

Outreach services identify and engage individuals known to have, or to be at risk of, having alcohol or other drug problems. These community-based services seek to facilitate improvements in health and reduction of substance-related risk or harm for individuals and groups that do not normally access fixed location services.

Community-based (Outpatient) Treatment Services

Outpatient services provide information, assessment, counselling and referral for persons attempting to change their own problem substance use and related problems on a non-residential basis. Service is also available for people who

are affected by someone else's problem. Treatment includes individual, family, couples and group work, as well as aftercare support. A harm reduction approach (which could include abstinence) is used, tailoring treatment to the needs and goals of each client.

Intensive Day/Evening/Weekend Programs

Intensive non-residential Day/Evening/Weekend (DEW) programs are for those whose problem substance use has been very harmful and who have stable living arrangements, family support, support of friends, and may have supportive employment. These four to five week programs offer intensive therapeutic group counselling in a non-residential setting.

Residential Treatment

Residential treatment programs include intensive individual and group treatment for those with serious problem substance use issues whose living arrangements do not provide the stability to support attending treatment in a non-residential setting and who lack the support of family and friends. These services provide a safe living environment, free of alcohol and other drugs for individuals who are pursuing their recovery.

Counsellors considering a referral to a residential treatment centre in BC should be familiar with the Service Model and Provincial Standards for Residential Substance Use Services in BC (Youth and Adult versions)[viii], and whether the selected treatment centre complies with those standards.

Support(ive) Recovery houses

These residence-based services offer pre-(intensive residential) treatment stabilization and post-(intensive residential) treatment reintegration into the community. Some programs provide Supported Housing while residents are involved in community-based day treatment. They provide safe, structured, substance-free living environments for clients currently in unstable or otherwise compromised housing. Some of these facilities may also offer low to moderate intensity psycho- education programs.

Stabilization and Transitional Living Residences (STLRs)

These residence-based services offer pre-(intensive residential) treatment stabilization and post-(intensive residential) treatment reintegration into the community, and are variations of Support Recovery models. They provide safe, structured, substance-free living environments for clients currently in unstable or otherwise compromised housing. Some of these facilities may also offer low to moderate intensity psycho- education programs.

Treatment services for youth, including residential services, are often structured differently than for adults. When considering a referral it is essential to ensure the needs, interests and vulnerabilities of youth are taken into account.

Case Management/Coordination of Care

In order to ensure that persons served by the Substance Use Services System of Care are able to access and use the type of services that they require to assist them to achieve their treatment goals, the primary counsellor for each client serves as their care coordinator, or case manager. Case management in this instance differs from case

management as it is generally practiced in Mental Health Services, as it does not generally involve outreach or out-of-offices services. Case managers work in partnership with clients to organize, coordinate and make use of various services, according to the client's individualized service plan.

In Substance Use Services, case management means:

- In partnership with the client, completion of a comprehensive assessment, to a level appropriate for the persons served, clarifying available options, and developing an individualized service delivery plan detailing the goals of the client and fitting services to the individual.
- Assisting the person served with implementing the individualized service plan; e.g. completing the necessary paperwork, and funding applications, consulting with other service providers (in the substance use treatments system and in other health and social services).
- Ensuring continuity of care and preventing or minimizing service gaps by assisting the persons served with movement from one service to another.
- Systematically gathering formal client feedback to regularly collaborate with the client in the continuation, modification or termination of the service based on the client's changing needs.
- Enhancing the factors (i.e., alliance) that account for successful outcome.
- Using the client's theory of change to guide choice of technique and integration of various therapy models.
- Following up to ensure that no further service is required and evaluating at what level the person served was able to achieve their desired outcomes.
- Maintaining a complete record of progress throughout their treatment plan, and documenting that progress and the outcomes.

Case management is critical to working successfully with clients and their families. The case manager plays a vital, ongoing role in seeing the whole picture from start to finish, and helping to motivate the client during the ups and downs that may accompany his/her treatment process. The case manager does follow up with the clients on missed appointments or when the client drops out of treatment, to attempt to re-engage and support them to try again. The case manager helps the client and family look at other options when the initial plans made don't work out.

When there are other professionals involved, the case manager coordinates the plan with them, ensuring that information is exchanged as needed (with the client's consent).

Referrals

It is generally preferable for the person who initially established a relationship with the client to see them through the entire treatment process. This may be possible if the client is at a lower level of problems with their substance abuse and requires outpatient counselling only. However, many clients require assessments and treatment services which are beyond the scope of the Substance Use Services worker e.g., medical screening, psychiatric assessments, learning issues. While the original worker may be able to act as the case manager and keep on top of the client's case, referrals may need to be done to provide the best service for the client.

When a counsellor refers a client elsewhere for treatment or assessment, ideally they should provide a summary of their assessment findings and a request for the services they want from the other service provider or agency. Release of this information is subject to the client's signed consent in both directions: information provided by the substance use counsellor and information sent back to them. The following information should be provided to the individual or agency the client is being referred to:

- Signed release of information
- Date of assessment, counsellor's name and agency
- Summary of client's current drinking/ other drug use, as well as the history of use of psychoactive substances
- Other identified problems and concerns
- Referral and/ or treatment recommendations

Medications and Admissions to Substance Use Treatment Services in BC

Historically, medications were discouraged in the field of substance use treatment because they were perceived as either impediments to treatment or as continued psychoactive substance use. It is now recognized that there is a role for pharmacotherapy in substance use treatment if medications are used in a controlled setting and as an adjunct to other forms of treatment. The treatment of substance use problems may require medication for treating overdoses in emergencies, withdrawal, substitution or maintenance therapy, and adjuncts to relapse prevention. In addition, a proportion of clients accessing Substance Use Services will require prescribed medications for a number of different co-morbid conditions. Physical conditions may include for example, diabetes, arthritis, hepatitis or HIV/AIDS. Psychiatric disorders may include schizophrenia, bipolar affective disorders, clinical depression, and other disorders with a biochemical or other physiological genesis.

There is now consensus that the ability to function and benefit from a treatment process is of primary significance and that for some clients, the appropriate use of medication serves to enhance their ability to access and participate in treatment.

When a comprehensive assessment of a client is completed, an assessment of the client's health status, and any use of medications related to their physical, psychiatric and substance use problems needs is included. It is important that the case manager diligently seek information from all available sources in order to gain a reasonable understanding of the nature and effect of the medications prescribed and the implications of their discontinuance. The assessing counsellor/case manager will consult with the Substance Use Services sessional physician (where available), the person's own physician, a pharmacist, or a physician who is knowledgeable about the medications in question regarding any outstanding concerns about the individual's medication(s). Clients will be assessed as to their ability to function and participate in the specific programs recommended in the treatment plan, irrespective of the matter of medications. Inability to function in a way that meets the requirements for participation is the sole criterion for denying admission to any Substance Use treatment program.

Case management will include regular liaison with the client's physician, mental health worker, psychiatrist, methadone prescriber, or other person responsible for delivery of the health service, including the medication, to ensure continuity and comprehensiveness of service. When referring the individual to any component of the system of care, the case manager will ensure that known information about the required medications is transmitted accurately to any receiving service.

Relapse Prevention and Management

As discussed in Module III, relapse is a common part of the change process of which both the counsellor and the client need to be aware. Relapse occurs when, having made progress to later stages of change, the individual resumes old thought patterns and behaviours associated with their problem. When people are aware that they have relapsed, they often experience guilt and disappointment. The vast majority of people who relapse do not give up on themselves and their ability to change. Most return to contemplation or preparation stages, relatively close to making commitments to renewed action. If viewed as a learning experience, a relapse may be a case of taking one step backwards in order to take two steps forward.

A relapse may either be a single use that indicates a loss of control over the substance use (often called a 'lapse' or a 'slip'), or it may be a general return to the previous pattern of substance use (commonly called a 'relapse').

Because relapse is such a common part of the change process, relapse prevention and management is an essential part of treatment work with clients. While in treatment, clients need to be prepared for the possibility of relapse so that when it occurs, it might not develop into a complete return to psychoactive substance use or other behaviour. It is a fine line to walk between talking about the high probability of relapse and feeling like permission to relapse is being given. It is important for the client to understand that by talking about relapse, the hope is that a relapse can be prevented or minimized, should one occur. Risky situations for each client need to be identified, and ideas developed for handling them.

When a relapse occurs, it is important to emphasize with the client that this is an opportunity for learning what did not work last time, and apply that to the next round of change. Change is not a smooth, one-shot process, but more like a serious of steps in which both forward and backward movement occurs. The client may be feeling like a failure, and the counsellor's role is to encourage them to learn from it, acknowledge the progress that has been made, and then move on.

RELAPSE PREVENTION

"Quitting smoking is easy. I've done it hundreds of times."
- Attributed to Mark Twain

Relapse prevention was formulated in the 1970s by Alan Marlatt after his observation of the high rate of relapse in the treatment of substance abuse. The model suggests that both immediate determinants (e.g., high-risk situations, coping skills, outcome expectancies, and the abstinence violation effect) and covert antecedents (e.g., lifestyle factors and urges and cravings) can contribute to relapse. Key to this model is that the individual should be able to anticipate and identify potential interpersonal, intrapersonal, environmental and physiological risks for relapse and the unique set of factors and situations that may directly precipitate a lapse. Once these potential relapse triggers and high-risk situations are identified, cognitive and behavioural skills are put into practice to implement specific interventions to prevent or manage relapses and to implement more global strategies to address lifestyle modification to strengthen the person's overall coping capacity. The goal of relapse prevention is to prevent relapse from occurring and to respond constructively when it does.

Coping Strategies for relapse prevention and management

Identifying high risk situations

- Functional analysis
- Situational analysis
- Behavioural antecedents

Refusal Training

- Identify barriers to refusal
- Identify skills to be learned
- Identify refusal situations
- Rehearse refusal
- Implement strategy
- Evaluate outcome

Coping with Cravings

- Learn to recognize cravings
- Identify triggers (feed-forward)
- Re-label cravings (hungry, angry, lonely, tired = HALT)
- Strategize to avoid triggers
- Strategize to cope with cravings
- Implement strategy
- Evaluate outcome

Developing Alternatives

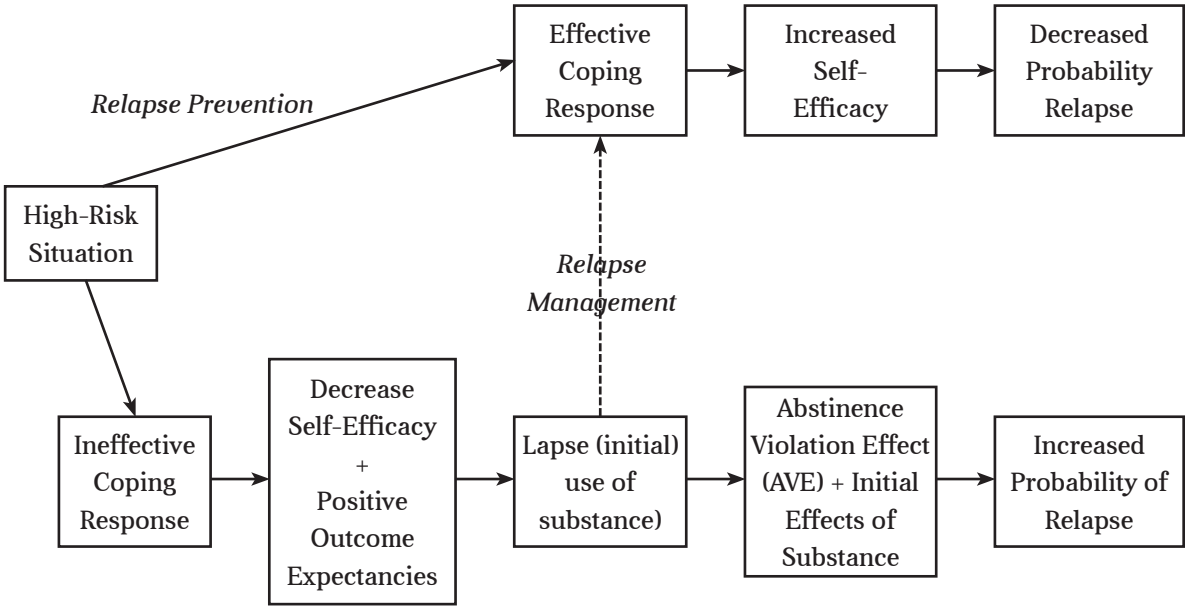
- Problem-solving skills
- Cognitive restructuring
- Social skills
- Leisure skills
- Vocational skills
- Stress management
- Wellness promotion
- Family relations

Goals for Aftercare (Maintaining Recovery)

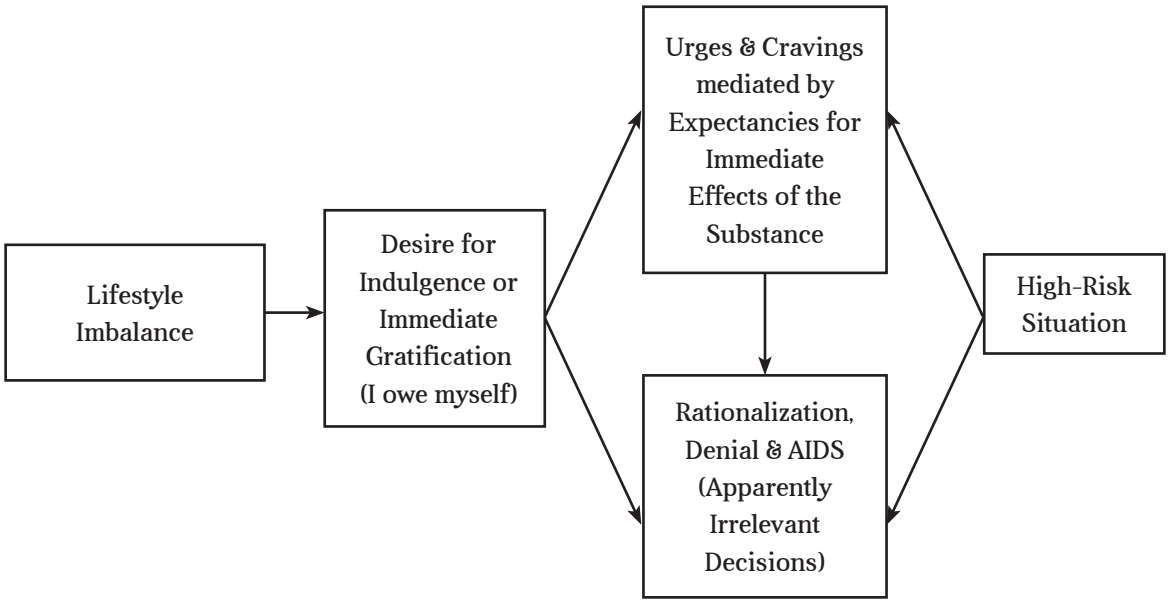
- Develop and enhance social support
- Eliminate relapse risks
- Enhance, school, work, home roles
- Develop recreation and leisure activities
-

The figures below represent relapse processes from the perspective of Marlatt et al.[ix]

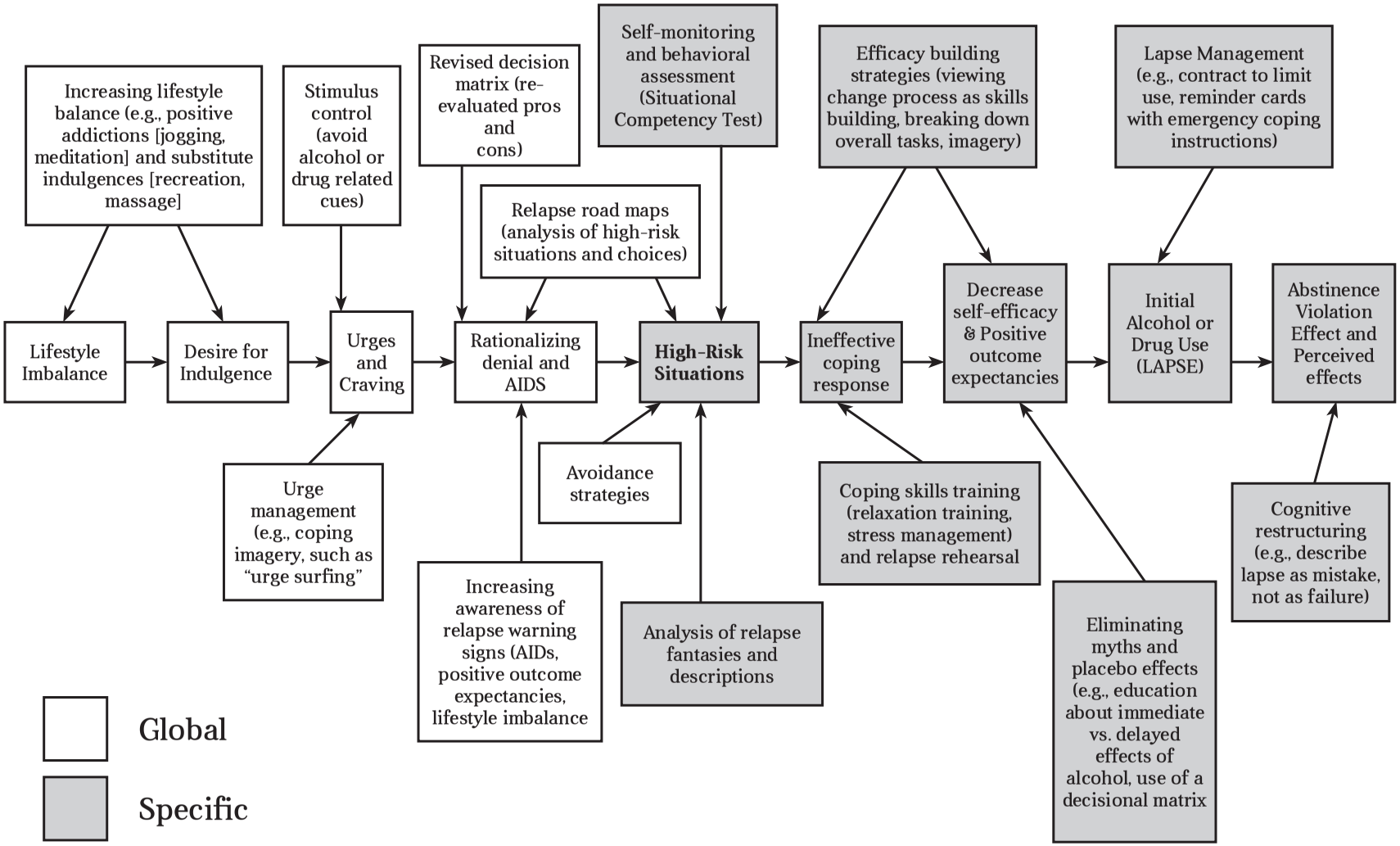
A Cognitive-Behavioral Model of the Relapse Process: Immediate Precipitants



Relapse Set-Ups: Covert Antecedents of Relapse Situations



Global and Specific Relapse Prevention Therapy Intervention Strategies



Documentation and Case Note Recording

REASONS FOR DOCUMENTATION

Anyone working in Substance Use Services will be tasked with collecting personal information and recording it in the client's file. There are three main reasons why this type of recording takes place.

1. Clinical process – Recording information about a client throughout the treatment process helps the practitioner maintain focus on the client's issues over time as well as providing up-to-date information for another practitioner to assist and support the treatment plan in the absence of the primary case manager.

2. Accountability - Documentation and case note recording allows for accountability checks such as audits and evaluations. Supervisors can also look at documentation as part of an employee's work review. Proper documentation is necessary to meet accreditation and licensing standards. Case notes also hold the practitioner accountable to the client, who can request a copy of the material on their file through the Freedom of Information and Protection of Privacy Act.

3. Legal requirements – Any client notes or file materials are considered legal documents and can be subpoenaed to court.

QUALITIES OF GOOD CASE NOTE RECORDINGS

To ensure the best quality of recorded information, practitioners should ensure that all recordings have the following qualities:

- Accuracy – Information is recorded accurately with minimal subjective interpretation, unless recorded as such.
- Completeness – Enough detail is provided so that another professional can respond if necessary to the client's needs. All clinical contact should be recorded, as well as "no shows" for appointments and follow up to such.
- Relevance – Only information relevant to the client and their involvement with Substance Use Services is to be recorded.
- Currency – Information should be recorded within a short time period of contact with the client and in chronological order.
- Confidentiality – Other than when exceptions to confidentiality apply, no information from the client's file should be shared with anyone until written consent from the client is obtained. Third-party information in the file must receive the same protection as the client's information.
- Clarity and appropriateness – Notes must be written in plain language, in as brief and accurate a manner as possible while still providing enough information to be meaningful.

[i] Duncan, B. and Sparks, J. (2010). Heroic Clients, Heroic Agencies: Partners for Change (2nd ed.) Fort Lauderdale, Florida: Nova Southeastern University.

[ii] Rush, B. et al.(2012). Development of a Needs-Based Planning Model for Substance Use Services and Supports in Canada: Interim Report. Toronto, ON:Centre for Addiction and Mental Health.(In draft at time of writing CAP module.)

[iii] Miller, S., D. Mee-Lee, B. Plum and M. Hubble. (2005). Making Treatment Count: Client-Directed, Outcome-Informed Clinical Work with Problem Drinkers. Psychotherapy in Australia (11-4).

[iv] As above.

[v] Bachelor, A. and A. Horvath. (1999) in Duncan, B., Miller, S., Wampold, B., & Hubble, M. (Eds.) (2009). The Heart and Soul of Change (2nd ed.) Washington, DC: APA Press.

[vi] Berg, I.K and Scott Miller. (1992). Working with the Problem Drinker: A Solution-Focussed Approach. New York, NY: Norton.

[vii] Miller, S., D. Mee-Lee, B. Plum and M. Hubble. (2005). Making Treatment Count: Client-Directed, Outcome-Informed Clinical Work with Problem Drinkers. Psychotherapy in Australia (11-4).

[viii] Service Model and Residential Standards for Adult Residential Substance Use Services. (2011).. and Service Model and Residential Standards for Youth Residential Substance Use Services. (2011). BC Ministry of Health. Accessed at http:// http://www.health.gov.bc.ca/library/publications/year/2011/youth-residential-treatment-standards.pdf and http://www.health.gov.bc.ca/library/publications/year/2011/adult-residential-treatment-standards.pdf

[ix] Marlatt, G.A., Parks, G., and Witkiewitz, K. (2002). Clinical Guidelines for Implementing Relapse Prevention Therapy. (Reference from 2008 CAP manual).

APPENDIX TO MODULE IV: SAMPLE SCREENING TOOLS AND WEB LINKS FOR STANDARDIZED ASSESSMENTS

Screening tools included:

MEDICAL TRIGGERS SCREENING TOOL (MTST)

Description:

The Medical Triggers Screening Tool (MTST) was developed for use in Addiction Services outpatient treatment agencies, and is in the public domain.

The tool is designed to identify individuals that may require referral to a physician for comprehensive assessment of physical health status. The 11 questions on the MTST are intended to screen for health conditions and circumstances that potentially require medical assessment or intervention.

Target Population:

The MTST is appropriate for all adult clients in the outpatient setting who present with substance misuse/affected or problem gambling/affected issues. Physicians routinely assess clients attending withdrawal management services and different scales are used to evaluate and monitor medical symptoms.

Administration:

The MTST is designed to be administered in an interview format and takes 5 to 10 minutes to complete. Counselors should ask clients about each of the 11 items on the form, and circle the appropriate box. If the client is misusing a prescription drug, record the name of the drug(s) beside that item.

The Screening Tool form should not be given to the client to fill out. Questions are not to be read verbatim; rather the information is to be arrived at with language and questions suitable to the client's level of understanding.

Scoring & Interpretation:

The number of positive items is summed to a total score. (Count the total number of shaded boxes circled). *Consultation with, or referral to, a physician is recommended If the MTST score is **one** or greater.* If a program does not have access to sessional physician services, then consultation with the client's own primary care physician should occur. A copy of the MTST screening form should accompany the referral to the physician. Agencies must obtain client consent prior to contacting the physician.

Clients with positive triggers for suicide risk and/or pregnancy should be considered in urgent need of attention.

It is recognized that several of the questions are of a sensitive nature; therefore it may take longer than one interview/session to complete the MTST screen.

Adult Medical Triggers Screening Tool

QUESTIONS	CIRCLE	RESPONSE
1. Was the client's last medical examination more than six months ago?	YES	NO
2. If the client has a physician, is the client's physician unaware of his/her addiction problem?	YES	NO
3. Is the client pregnant?	YES	NO
4. Is the client taking prescription medication? Name:	YES	NO
5. Does the client need withdrawal management services?	YES	NO
6. Does the client have a history of seizures?	YES	NO
7. Does the client have a history of a serious co-existent medical condition, e.g.: Diabetes, hypertension, G.I. bleeding, hepatitis, HIV, anorexia/bulimia?	YES	NO
8. Does the client have a history of a serious co-existent psychiatric condition, e.g. severe depression, schizophrenia?	YES	NO
9. Is the client at risk for suicide, e.g. persistent thoughts, planning, attempts?	YES	NO
10. Has the client ever injected drugs?	YES	NO
11. Does the client engage in unprotected sexual activity with high risk persons?	YES	NO
TOTAL SCORE:		

The goal of these prompts is to increase counsellors' awareness of clients' medical issues and to encourage referral to a physician, where appropriate. Some of the answers, due to particular circumstances, may require more than one visit to obtain.

Name of Client:_____ **Date:** _____

Family Doctor (if known): _____

Action Taken: _____

Outcome: _____

MICHIGAN ALCOHOLISM SCREENING TEST – REVISED (MAST-R)

The questions refer to the past 12 months. Carefully read each statement and decide whether your answer is yes or no. Please give the best answer or the answer that is right most of the time.

	YES	NO
Do you feel you are a normal drinker? ("normal" – drink as much or less than most other people?		
Have you ever awakened the morning after some drinking the night before and found that you could		
Does any near relative or close friend ever worry or complain about your drinking?		
Can you stop drinking without difficulty after one or two drinks?		
Do you ever feel guilty about your drinking?		
Have you ever attended a meeting of Alcoholics Anonymous (AA)?		
Have you ever gotten into physical fights when drinking?		
Has drinking ever created problems between you and a near relative or close friend?		
Has any family member or close friend gone to anyone for help about your drinking?		
Have you ever lost friends because of your drinking?		
Have you ever gotten into trouble at work because of drinking?		
Have you ever lost a job because of drinking?		
Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?		
Do you drink before noon fairly often?		
Have you ever been told you have liver trouble such as cirrhosis?		
After heavy drinking, have you ever had delirium tremens (D.T.'s), severe shaking, visual or auditory (hearing) hallucinations?		
Have you ever gone to anyone for help about your drinking?		
Have you ever been hospitalized because of drinking?		
Has your drinking ever resulted in your being hospitalized in a psychiatric ward?		
Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help with any emotional problem in which drinking was part of the problem?		
Have you been arrested more than once for driving under the influence of alcohol?		
Have you ever been arrested, even for a few hours, because of other behaviour while drinking?		

Scoring

This quiz is scored by allocating 1 point to each "yes" answer – except for questions 1 and 4, where 1 point is allocated for each "no" answer – and totaling the responses.

0-2, No Apparent Problem

Your answers to this alcohol screening test suggest that you are in the normal range and at low risk of problem drinking.

3-5, Early to Middle Problem Drinker

Your answers to this alcohol screening test suggest that you are at risk of problem drinking. The authors of this test would recommend that you contact your doctor about your drinking.

6 or More, Problem Drinker

Your answers to this alcohol screening test suggest that you are at risk of alcoholism. The authors of this test would recommend that you contact your doctor about your drinking.

Note: There is also a version of MAST validated for use with seniors, known as G-MAST.

For further information, conctact Fredric Blow, PhD, at University of Michigan Alcohol Research Center, 400 E Eisenhower Parkway, Suite A, Ann Arbor, MI 48101, 313-988-7952

GAIN SHORT SCREENER (GAI N – SS)

The GAIN- SS is proprietary, and therefore requires a license in order to use it.

Information about licensing, training and psychometrics are available at: **http://www.gaincc.org/**

CAGE QUESTIONNAIRE

This simple 4-question self-test may help you become aware of your use or abuse of alcohol. This test specifically focuses on alcohol use, and not on the use of other drugs. The questions refer to your feelings and behaviour over your whole life. Carefully read each statement and decide whether your answer is yes or no. Please give the best answer or the answer that is right most of the time.

	YES	NO
1. Have you ever felt you should *cut down* on your drinking?		
2. Have people *annoyed* you by criticizing your drinking?		
3. Have you ever felt bad or *guilty* about your drinking?		
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover *(eye-opener)*?		

Scoring

This quiz is scored by allocating 1 point to each "yes" answer.

0–1, No Apparent Problem

Your answers to this alcohol screening test suggest that you are in the normal range and at low risk of problem drinking.

2 or More, Clinically Significant

Your answers to this alcohol screening test suggest that you are at risk of problem drinking or alcoholism. The authors of this test would recommend you contact your doctor about your drinking.

The CAGE Questionnaire is in the public domain.

DRUG ABUSE SCREENING TEST (DAST)

The questions refer to the past 12 months. Carefully read each statement and decide whether your answer is yes or no. Please give the best answer or the answer that is right most of the time. Remember, for the purposes of this screening test, the questions do *not* refer to alcoholic beverages. For the purposes of this screening test, drug abuse refers to:

1. The use of prescribed or "over the counter" drugs in excess of the directions, and
2. Any non-medical use of drugs.

	YES	NO
1. Have you used drugs other than those required for medical reasons?		
2. Have you abused prescription drugs?		
3. Do you abuse more than one drug at a time?		
4. Can you get through the week without using drugs?		
5. Are you always able to stop using drugs when you want to?		
6. Have you had "blackouts" or "flashbacks" as a result of drug use?		
7. Do you ever feel bad or guilty about your drug use?		
8. Does your spouse (or parents) ever complain about your involvement with drugs?		
9. Has drug abuse created problems between you and your spouse or your parents?		
10. Have you lost friends because of your use of drugs?		
11. Have you neglected your family because of your use of drugs?		
12. Have you been in trouble at work because of your use of drugs?		
13. Have you lost a job because of drug abuse?		
14. Have you gotten into fights when under the influence of drugs?		
15. Have you engaged in illegal activities in order to obtain drugs?		
16. Have you been arrested for possession of illegal drugs?		
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?		
19. Have you gone to anyone for help for a drug problem?		
20. Have you been involved in a treatment program especially related to drug use?		

Scoring

This quiz is scored by allocating 1 point to each "yes" answer – except for questions 1 and 4, where 1 point is allocated for each "no" answer – and totaling the responses.

None Reported

You do not appear to be experiencing any signs of drug abuse at this time.

2–5, Low Level

You appear to be experiencing a *low level* of drug abuse. You may wish to monitor your drug use and reassess it at a later time by taking this screening test again.

6 – 10, Moderate Level

You appear to be experiencing a *moderate level* of drug abuse. You may benefit from further investigation of your drug use.

11 – 15, Substantial Level

You appear to be experiencing a *substantial level* of drug abuse. The authors of this test would recommend further investigation of your drug use.

16 – 20, Severe Level

You appear to be experiencing a *severe level* of drug abuse. The authors of this test would recommend further investigation and intensive assessment of your drug use.

DAST is in the public domain.

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

AUDIT/The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care (PDF only), developed by the World Health Organization, introduces the AUDIT and describes how to use it to identify people with hazardous and harmful patterns of alcohol consumption.

Can be accessed at **http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf**

ALCOHOL, SMOKING AND SUBSTANCE INVOLVEMENT SCREENING TEST (ASSIST)

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Guidelines for Use in Primary Care (PDF only), developed by the World Health Organization, introduces the ASSIST and describes how to use it to identify people with hazardous or harmful drug use.

Can be accessed at **http://www.who.int/substance_abuse/activities/en/Draft_The_ASSIST_Guidelines.pdf**

STAGES OF CHANGE READINESS AND TREATMENT EAGERNESS SCALE – ALCOHOL (SOCRATES 8A)

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drinking*. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for every statement.

	NO! Strongly Disagree	No Disagree	? Undecided or Unsure	Yes Agree	YES! Strongly Agree
1. I really want to make changes in my drinking.	1	2	3	4	5
2. Sometimes I wonder if I am an alcoholic.	1	2	3	4	5
3. If I don't change my drinking soon, my problems are going to get worse.	1	2	3	4	5
4. I have already started making some changes in my drinking.	1	2	3	4	5
5. I was drinking too much at one time, but I've managed to change my drinking.	1	2	3	4	5
6. Sometimes I wonder if my drinking is hurting other people.	1	2	3	4	5
7. I am a problem drinker.	1	2	3	4	5
8. I'm not just thinking about changing my drinking, I'm already doing something about it.	1	2	3	4	5
9. I have already changed my drinking, and I am looking for ways to keep from slipping back to my	1	2	3	4	5
10. I have serious problems with drinking.	1	2	3	4	5
11. Sometimes I wonder if I am in control of my drinking.	1	2	3	4	5

12. My drinking is causing a lot of harm.	1	2	3	4	5
13. I am actively doing things now to cut down or stop drinking.	1	2	3	4	5
14. I want help to keep from going back to the drinking problems that I had before.	1	2	3	4	5
15. I know that I have a drinking problem.	1	2	3	4	5
16. There are times when I wonder if I drink too much.	1	2	3	4	5
17. I am an alcoholic.	1	2	3	4	5
18. I am working hard to change my drinking.	1	2	3	4	5
19. I have made some changes in my drinking, and I want some help to keep from going back to the way I	1	2	3	4	5

See information after SOCRATES 8D regarding use of the tools.

STAGES OF CHANGE READINESS AND TREATMENT EAGERNESS SCALE – OTHER DRUGS (SOCRATES 8D)

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drug use*. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for every statement.

	NO! Strongly Disagree	No Disagree	? Undecided or Unsure	Yes Agree	YES! Strongly Agree
1. I really want to make changes in my use of drugs.	1	2	3	4	5
2. Sometimes I wonder if I am an addict.	1	2	3	4	5
3. If I don't change my drug use soon, my problems are going to get worse.	1	2	3	4	5
4. I have already started making some changes in my use of drugs.	1	2	3	4	5
5. I was using drugs too much at one time, but I've managed to change that.	1	2	3	4	5
6. Sometimes I wonder if my drug use is hurting other people.	1	2	3	4	5
7. I have a drug problem.	1	2	3	4	5
8. I'm not just thinking about changing my drug use, I'm already doing something about it.	1	2	3	4	5
9. I have already changed my drug use, and I am looking for ways to keep from slipping back to my	1	2	3	4	5
10. I have serious problems with drugs.	1	2	3	4	5
11. Sometimes I wonder if I am in control of my drug use.	1	2	3	4	5

12. My drug use is causing a lot of harm.	1	2	3	4	5
13. I am actively doing things now to cut down or stop my use of drugs.	1	2	3	4	5
14. I want help to keep from going back to the drug problems that I had before.	1	2	3	4	5
15. I know that I have a drug problem.	1	2	3	4	5
16. There are times when I wonder if I use drugs too much.	1	2	3	4	5
17.I am a drug addict.	1	2	3	4	5
18. I am working hard to change my drug use.	1	2	3	4	5
19. I have made some changes in my drug use, and I want some help to keep from going back to the way I used before.	1	2	3	4	5

SOCRATES Scoring Form - 19-Item Versions 8.0

Transfer the client's answers from questionnaire:

	Recognition	Ambivalence	Taking Steps
	1 ____	2 ____	
	3 ____		4 ____
			5 ____
		6 ____	
	7 ____		8 _____
			9 ____
	10 ____	11 ____	
	12 ____		13 ____
			14 ____
	15 ____	16 _____	
	17 ____		18 ____
			19 ____
TOTALS	Re _____	Am _____	Ts _____
Possible Range:	7-35	4-20	8-40

SOCRATES Profile Sheet - 19-Item Versions 8A

INSTRUCTIONS: From the SOCRATES Scoring Form (19-Item Version) transfer the total scale scores into the empty boxes at the bottom of the Profile Sheet. Then for each scale, CIRCLE the same value above it to determine the decile range.

DECILE SCORES	Recognition	Ambivalence	Taking Steps
90 Very High		19-20	39-40
80		18	37-38
70 High	35	17	36
60	34	16	34-35
50 Medium	32-33	15	33
40	31	14	31-32
30 Low	29-30	12-13	30
20	27-28	9-11	26-29
10 Very Low	7-26	4-8	8-25
RAW SCORES (from Scoring Sheet)	Re=	Am=	Ts=

Guidelines for Interpretation of SOCRATES-8 Scores

Using the SOCRATES Profile Sheet, circle the client's raw score within each of the three scale columns. This provides information as to whether the client's scores are low, average or high *relative to people already seeking treatment for alcohol problems*. The following are provided as general guidelines for interpretation of scores, but it is wise in an individual case also to examine individual item responses for additional information.

RECOGNITION

HIGH scorers directly acknowledge that they are having problems related to their drinking, tending to express a desire for change and to perceive that harm will continue if they do not change.

LOW scorers deny that alcohol is causing them serious problems, reject diagnostic labels such as "problem drinker" and "alcoholic" and do not express a desire for change.

AMBIVALENCE

HIGH scorers say that they sometimes *wonder* if they are in control of their drinking, are drinking too much, are hurting other people, and/or are alcoholic. Thus a high score reflects ambivalence or uncertainty. A high score here reflects some openness to reflection, as might be particularly expected in the contemplation stage of change.

LOW scorers say that they *do not wonder* whether they drink too much, are in control, are hurting others, or are alcoholic. Note that a person may score low on ambivalence either because they "know" their drinking is causing problems (high Recognition), or because they "know" that they do not have drinking problems (low Recognition). Thus a low Ambivalence score should be interpreted in relation to the Recognition score.

TAKING STEPS

HIGH scorers report that they are already doing things to make a positive change in their drinking, and may have experienced some success in this regard. Change is underway, and they may want help to persist or to prevent backsliding. A high score on this scale has been found to be predictive of successful change.

LOW scorers report that they are not currently doing things to change their drinking, and have not made such changes recently.

OVERVIEW OF TOOL:

Purpose: Measures readiness for change
Clinical Utility: Level of treatment and treatment/goal planning
Age of Target Population: Adults
Norms Available: Yes
Psychometric Properties: Test/retest; Reliability
Administration Options: Paper-pencil; Can be self-administrated
Time to Administer: 10 minutes

SOCRATES license information

SOCRATES is free to use, and may be used without permission. The form, its psychometric properties and instructions on its use may be downloaded from the University of New Mexico's Center on Alcoholism, Substance Abuse and Addictions. See the list of assessment instruments at http://casaa.unm.edu/inst.html; click on the link to SOCRATES Version 8. Credit the source as William R. Miller, PhD, University of New Mexico, Center on Alcoholism, Substance Abuse, and Addictions, 2350 Alamo SE, Albuquerque, NM, USA 87106.

Some Useful Web Links for Locating Screening and Assessment Tools

Source	Web address	Contents
Centre for Addiction and Mental Health (Ontario)	http://knowledgex.camh.net/amhspecialists/Screening_Assessment/assessment/adat/Pages/default.aspx	Information regarding assessment tools contained in CAMH's Admission and Discharge Criteria and Assessment Tools (ADAT
Alberta Health Services	http://www.albertahealthservices.ca/Researchers/if-res-review-of-assessments.pdf	A review of addictions-related screening and assessment instruments (2003-2009)
Alcohol and Drug Abuse Institute (University of Washington)	http://lib.adai.uw.edu/instruments/	On-line resource intended to help clinicians and researchers find instruments used for screening and assessment of substance use problems
Substance Abuse and Mental Health Services Administration (US)	http://store.samhsa.gov/product/TIP-31-Screening-and-Assessing-Adolescents-for-Substance-Use-Disorders/SMA12-4079	Screening and assessment tools for adolescents
Substance Abuse and Mental Health Services Administration (US)	http://www.ncsacw.samhsa.gov/files/SAFERR_AppendixD.pdf	Examples of screening and assessment tools
Substance Abuse and Mental Health Services Administration (US)	http://www.ncbi.nlm.nih.gov/books/NBK64197/	TIP 42 Appendix G: Screening and Assessment Tools for Concurrent Substance Use and Mental Health Problems

MODULE V: WHOLENESS, STRENGTH AND COMPLEXITY: SOME KEY CHALLENGES FACED BY THE PEOPLE WE SERVE

MODULE V: RESPONDING TO THE WHOLE PERSON: STRENGTHS AND COMPLEXITY

Human experience is complex. Helping people understand that complexity, and giving them skills to manage that, helps make them actors (rather than victims) in their own lives.[i]

The people we serve come to us, not simply as individuals wanting help, but with all of their "experiences, strengths and hope"[ii] as well as a mix of concerns and challenges that can co-occur with substance use problems.

Module V provides information to assist the practitioner to provide holistic, person-centred care that builds on the client's strengths while partnering with them to address all of the challenges they face in as responsive, compassionate, respectful ways as possible.

Module V is intended only to bring the learner's awareness to the identified issues and provide direction to additional learning resources.

Strength and Resourcefulness in the Face of Complex Challenges

> *A strengths based perspective does not deny that people can suffer appalling and prolonged distress; this proposition is accepted as a human given. The strengths based practitioner accepts this reality and offers compassionate empathic support whilst being vigilant and mindful of other qualities that coexist beside and within human suffering.*[iii]

In 2000, Barry Duncan and Scott Miller titled their landmark book: *The Heroic Client* [iv], reminding therapists, counsellors and other practitioners everywhere that - in the face of all the challenges encountered by the people we serve- outside our offices, they have already found ways to not only survive their experiences, but to keep going with some level of belief that their lives are worthwhile and their health important. And those strengths and resources, if respected and built upon, can serve as the foundation for the changes they choose to make.

The Importance of Context

> *Individuals turn to alcohol, drugs and tobacco, and suffer from their use, but use is influenced by the wider social setting.* [v]

The World Health Organization's primer on the Social Determinants of Health, quoted above, summarizes years of research that have led to the conclusion that a person's health status is not simply a product of genetics or factors within themselves or their family dynamic, but also – significantly – a result of contextual and social factors including:

- Environmental stressors – one of the most important of these being poverty, but also – as pointed out by Bruce Alexander – disconnection from culture, identity and/or community
- Lack of, or minimal opportunities to learn and develop in early life
- Social exclusion and/or discrimination
- Unemployment or poor quality of work life

- Lack of, or minimal social support
- Poor access to food
- Poor access to transportation

Specifically regarding substance use problems, the WHO document states that: "Alcohol dependence, illicit substance use and cigarette smoking are all closely associated with markers of social and economic disadvantage."[vi] It is acknowledged that the causal pathway can run both ways; that is, psychoactive substance use can be a means of adapting to environmental stressors and/or disadvantage, and at the same time, dependence on psychoactive substances can increase those stressors and reduce access to income, employment, and healthy social supports.

Accordingly, helping services must acknowledge and incorporate these factors into its services and activities, including addressing how they provide access, how people are engaged, how clinical processes such as assessment and collaborative care planning are done, and what activities and resources are made available to assist the client achieve their goals.

Working with Family Members, Caregivers and Peers ("Family and Friends")[vii]

Why offer programs to family members?[viii]

The developers of the Families CARE program at the Centre for Addiction and Mental Health outline three types of evidence-supported reasons for offering services to family members:

1. *Family members influence the person with a substance use problem*

- Family involvement in treatment increases the rate of treatment initiation.[ix]
- Family involvement in treatment improves treatment outcomes for the person with the substance use problem.[x]
- If family members are involved, people already in treatment demonstrate less substance use, better medication compliance, and better family and relational functioning than those whose families are not involved in treatment.[xi]

2. *Family members need treatment*

Impacts on family members from another member's substance use problems have been found to include:[xii]

- Relationship problems
- Financial difficulties
- Social isolation
- Problems at work
- Anxiety, guilt, fear and confusion
- Mental or physical health problems such as depression, panic attacks, eating disorders, ulcers, increased blood pressure
- Their own substance use problems

- These problems do not decrease or disappear when their family member becomes involved in treatment. Increased confusion and anxiety can result from changes in their family member as they make changes - whether those are seen as desirable or not. [xiii]

3. *Family members benefit from treatment*

- O'Farrell and Fals-Stewart[xiv], after reviewing a number of studies on family involvement in substance use treatment, concluded that:
    - Family members who received treatment experienced reduced emotional distress.
    - Those receiving treatment around coping skills did improve their ways and means of coping.
    - Partners who received behavioural couple's therapy experienced happier relationships, fewer separations, a lower risk of divorce, and less domestic violence than those not receiving the treatment.
- Howells and Orford[xv], found that spouses who received individual counselling aimed at improving coping, safety, relations skills, problem-solving and emotion management showed significant decreases in psychological symptoms over the course of treatment, and that those changes were maintained for 12 months after treatment.

The role of substance use service providers in working with family members

Family members can be engaged in substance use services at a number of levels.

- Assessment and treatment planning for their family member with a serious substance use problem;
- Education and support for those key support people; or
- Treatment for the support people themselves.

Historically in BC, practice has been inconsistent around involving family members and other key influencers and supporters in treatment.

At the same time, we know the importance of family involvement in a person's recovery, when acceptable to the client and possible within existing resources. The exception would be where there is known or suspected abuse within these relationships, or the family member/friend is understood to pose a risk to the client in other ways (such as supporting ongoing substance use, illegal activity, or the like.) The risks should be carefully considered when there are opportunities for family involvement.

Many substance use treatment organizations do provide services for individuals often known as "substance affected". These services commonly involve a small number of sessions of individual supportive counselling and direction to community self-help and mutual aid programs such as Al-Anon. A few others offer education and support groups as part of their regular programming.

It is outside the scope of CAP to provide more in-depth information on the "how's" of providing family services. Some resources that will be helpful in extending your learning include:

- *Recognizing Resilience: A Workbook for Parents and Caregivers of Teens Using Substances.* (2012). Discovery Youth and Family Services, Vancouver Island Health Authority. Telephone (250) 739-5790. Online through **discovery@viha.ca**
- *Family Education and Support Program.* (2009). AXIS Family Resources. Available through AXIS Family Resources, Kamloops-Thompson Branch (877)392-1003
- *Families CARE: Helping Families Cope and Relate Effectively (2008).* Available from the Centre for Addiction and Mental Health (CAMH): **http://www.camh.ca/en/education/about/camh_publications**
- *A Family Guide to Concurrent Disorders (2007).* Also available from CAMH
- *Substance Abuse Treatment and Family Therapy. (2004).* TIP 39. Available from SAMHSA: **http://www.ncbi.nlm.nih.gov/books/NBK64265**

Frequently Co-occurring Challenges

TRAUMA AND TRAUMA-INFORMED PRACTICE [xvi]

When working with individuals experiencing substance use problems, it is important to understand s/he may have experienced trauma recently or in the past, and may still be experiencing the effects of that trauma, whether the effects are known to the helper or not.
Some recent research findings:

- Among women entering residential substance use treatment at the Aurora Centre, 63% stated they had experience physical violence, and 41% had experienced sexual violence. [xvii]
- Women in treatment for alcohol problems at five Canadian residential programs, 90% reported abuse-related trauma as a child or adult, and 60% reported other forms of trauma. [xviii]
- Among youth involved in substance use treatment with Vancouver Island Health Authority's Youth and Family Substance Use Services, 25% reported a history of trauma. [xix]
- Among youth seeking treatment for co-occurring mental health and substance use problems in Ontario, 90% of females and 62% of males expressed concerns related to trauma. [xx]

In a representative sample of Canadian women[xxi], just over 76% had been exposed to at least one traumatic event in their lifetime, with just over 9% meeting the criteria for Post-Traumatic Stress Disorder.

With such a high known level of co-occurrence of trauma and substance use problems, it becomes essential that all our services be trauma-informed and that all practitioners are "trauma-competent". That is not to say that all substance use services should be able to provide trauma-specific treatment, but we must be able to work with people with an awareness of the likelihood they have experienced trauma, and with core skills for responding to all clients "as if" trauma was an issue for them.

Trauma-informed services take into account an understanding of trauma in all aspects of service delivery and place priority on the person's safety, choice and control.

Working in trauma-informed ways does not necessarily require disclosure of trauma. Rather services are provided in ways that recognize the need for physical and emotional safety, as well as choice and control in decisions affecting one's treatment. Trauma-informed practice is more about the overall essence of the approach, or way of being in relationship, than a specific treatment strategy or method. [xxii]

Sound preparation is essential for trauma-informed practice, and involves the spaces in which we work, the activities in which we ask clients to engage, and the ways in which we prepare ourselves to "walk with" the people we serve.

BC's Trauma-Informed Practice Guide

BC's Trauma-Informed Practice Guide and the partner *Organizational Checklist* are being disseminated through BC health authorities in 2013. As the material on trauma-informed practice (TIP) is covered expertly in those materials, CAP does not attempt to cover it as well. All CAP participants, substance use service practitioners and workers in other organizations that frequently serve people with substance use problems are encouraged to utilize the BC Ministry of Health *TIP Guide, as well as the Organizational Checklist.*

In the meantime, and with permission, two sections of the *TIP Guide* are provided here.

The first suggests methods for responding in situations when a client appears to be experiencing a possible reaction to past trauma, or when s/he fears they are at risk of doing so.

Supporting a client who may be experiencing a trauma reaction

As a practitioner, your own capacity to stay present and grounded is crucial when recognizing an individual's emotional reactivity, aggression, withdrawal, isolation and silence as possible trauma responses. To the individual you offer safety, hope, trauma awareness and validation by staying connected with and attuned to them. Within the limits of safety, you build collaboration and empowerment in your willingness to let them set the agenda and the pace. When a trauma response 'pulls their legs out from under them', you stay present and help them stay connected to you and your shared environment. In this 'teachable moment', they gain a direct experience of recovering when knocked off balance by emotions, sensation or thoughts. They borrow your confidence while strengthening their own. Many grounding/containment skills and self-care strategies are available and can be successfully adapted for individual and group contexts, as well as working with adults and youth. Numerous trauma-informed treatment related resources are listed in the resource section and further skills are included in the appendix (to the *TIP Guide*).

Grounding/containment skills

Grounding is the immediate therapeutic approach for dealing with any form of dissociation or flashback. The following skills were selected for their simplicity and transportability across situations and work settings.

Begin with resource-mapping by asking the individual what they are already doing in real life situations that are helpful to contain or eliminate distressing feelings, thoughts, images, sensations. What is working for them or has worked in the past? They may already have grounding strategies in place that can be built on. Ideally it is best to practice grounding skills daily, rather than only when distressed.

The goal of any grounding technique is to have less fear around emotions, establish a sense of balance and:

- reconnect the person to the present
- orient the person to the here and now
- connect the person to their body and personal control
- connect the person to the practitioner and a safe environment

As a trauma-informed practitioner, you provide safety for yourself and the individuals you work with when you maintain connection while offering containment for difficult sensations, thoughts and feelings. You send the message that the individual is neither 'broken' nor 'needs to be fixed'. When you help them stay connected to you, their own internal sensations, and your shared external environment, they have a choice and a container for overwhelming sensations. In these practice-based moments, you are teaching portable skills.

Additional methods for grounding and containment can be found in the upcoming Guide.

Responding to disclosure

Also from the upcoming *Trauma-Informed Practice Guide for BC*, guidance for handling situations when your client discloses trauma, whether it is in the past or ongoing:

Working in trauma-informed ways does not require disclosure of trauma. In fact, it is often recommended that non-trauma-specific practitioners do not solicit disclosures. However it is wise for practitioners to be prepared to respond to disclosures if they do occur.

For some individuals, this may be the first time the person has spoken of their experience out loud. Others may be in different stages of healing. Similarly, some people may find it helpful to eventually talk about what happened, while others find it is enough to have their experience recognized and validated. There is no pressure and no timeline for healing.

Healing takes many forms. In the screening or assessment phase of the conversation, the primary role of trauma-informed practitioners is to maintain safety, validate the experience, and respectfully contain the amount of information shared. It is not to delve into details. There are a number of considerations in response to disclosure:

Acknowledge the information and express empathy.

Pause the conversation and acknowledge the information has been heard through an affirmation or reflection, e.g., "I appreciate your honesty with me." Offer a sincere empathic statement without patronizing or minimizing, e.g., "You have been through so much."

Revisit confidentiality

Review the extent of confidentiality. This will differ when working with minors. If appropriate, practitioners may ask individuals what the person would like recorded in their health record, e.g., "This is a very important conversation, and I am wondering, what, if anything, you would like me to write in your file?" In situations where recording information is ethically or medically required, e.g., "I'm wondering how you would like me to note what you have told me on your health record."

Offer a larger context for the trauma

Depending on the conversation, and if it's helpful, there may be opportunity to provide a larger context to help the individual understand that they are not alone in their experience, e.g., "Many people who struggle with mental health and/or substance use concerns have had different experiences of trauma in their lives, for example violence, abuse, car accidents."

Validate what has been shared

It is important that individuals see and hear from practitioners that their experience is believed and there is appreciation of the courage it took to share their story, e.g., "I can see that it took a lot of courage for you to share this with me today and you are exhausted. I will take your lead in terms of taking a break for now, perhaps finishing another day, or continuing with our conversation."

Offer hope

Assure the person that the information they have shared will help with their care and that people do recover, e.g. "What you have shared with me today will help us determine the best way to assist you. Although it may be hard to believe right now, over time and with support people do recover."

Address time pressures.

Communicating time limits requires a balance of being respectful/honouring the person's story and at the same time containing the conversation, e.g., "This is a very important conversation for us to have and I want to be able to give you my full attention. We only have 10 minutes left for today, so I wonder about setting up another meeting to have more dedicated time."

Debrief conversation and work together to create a self-care plan for the immediate future

Depending on current functioning, resources, support etc., people respond differently to disclosure. Practitioners are encouraged to watch for signs of trauma responses and let people know that they may react in different ways to the conversation. Some people may not require any action, and others may need a more detailed self-care plan ….E.g., "People respond differently to talking about upsetting memories. How are you feeling right now? (pause)…. I encourage you to check in with yourself throughout the day and notice what is happening for you (tired, anxious, at ease, sad, etc.). What is one thing you could do today to take care of yourself?"

Respond to immediate safety concerns (threats of violence in the home, self-harm or suicidal thoughts, child safety etc.)

Practitioners use their clinical judgement to shift the conversation to more detailed safety planning and crisis intervention. Some British Columbia based resources to assist in safety planning and crisis intervention include those below.

- If any person has a concern that a child is being abused or neglected, they have a legal duty to report those concerns to the local child welfare authority. For more information, refer to *The B.C. Handbook for Action on Child Abuse and Neglect For Service Providers:* **www.mcf.gov.bc.ca/child_protection/pdf/handbook_action_child_abuse.pdf**
- To ensure the safety of the individual, help them connect to Community Based Victim Services or other anti-violence outreach program in your community. If you are unsure about what resources are available in your community, you can call VictimLink BC at 1-800-563-0808. A victim service worker can identify counselling and other services in your community.
- Ending the Violence Association of BC, Freedom from Violence: Tools for working with trauma, mental health and substance use. (2007) **www.endingviolence.org/files/uploads/FreedomViolence3.pdf**
- You are not alone: Violence, substance use and mental health – A peer approach to increasing your safety. (2009) w**ww.endingviolence.org/files/uploads/PAVEWorkbook.pdf**
- High Risk Cases of Violence Against Women in Relationships: Collaborative Safety Planning, Community Coordination for Women's Safety. (2011) **www.endingviolence.org/files/uploads/ning_in_High_Risk_VAWIR_Cases_Nov_2011_FINAL.pdf**
- BC Crisis Centre www.crisiscentre.bc.ca/
- Youth in BC, a program of the BC Crisis Centre http://youthinbc.com/

PHYSICAL HEALTH PROBLEMS INCLUDING CHRONIC PAIN

While there has been significant attention paid of late to the co-occurrence of mental health and substance use problems (see following section), physical health problems are frequently of greater, or at least equal, concern for individuals living with addiction. Psychoactive substances can affect all systems of the body, and have the potential for harm. The means of ingestion of the substance can cause physical health problems. Some of the more common co-occurring physical problems that should be considered in assessment and treatment planning include:

- Liver disease
- Heart problems
- HIV/AIDS
- Viral hepatitis
- Injuries from accidents, including brain injuries
- Skin problems

Chronic pain

> *Chronic pain is not harmless; it has physiological, social, and psychological dimensions that can seriously harm health, functioning, and well-being.* [xxiii]

Pain BC states that one in five Canadians suffer from chronic pain on a daily basis[xxiv].

For many people living with serious substance use problems, pain is a constant companion. Chronic pain is also often associated with trauma and mental health problems. For some clients, substance use has helped manage pain (often in addition to the positive effect it has for them in managing emotional distress). A variety of studies have shown that between 29% and 60% of opioid users suffer from chronic pain.[xxv] Additionally, pain can become a major factor in initiating or sustaining dependence on substances – legal or illegal – that reduce the pain.

For people entering a process of withdrawal and recovery, alternative pain management and treatment can become a central issue, or there can be a strong risk of relapse.

For substance use practitioners, the central message is to remain aware that pain may be among the challenges a client is living with, and to keep that awareness forefront in assessment, treatment planning, treatment activities, and co-ordination of care with other professionals such as physicians. Practitioners should be aware that chronic pain can be intractable, so pain-minimization approaches may prove most effective for the client.

That is not to say that suffering is inevitable. As with other co-occurring disorders, it should be assessed and treated as part of a holistic plan of care involving professionals who have knowledge and skills in the areas of both chronic pain and substance use problems.

The co-occurrence and treatment of chronic pain is an emerging focus for substance use practitioners. Some current resources that may be of use:

- The Pain BC website, at **http://www.painbc.ca/** offers a wide range of useful and plan-language resources for professionals, as well as for people living with chronic pain.
- The US Centre for Substance Use Treatment in 2012 released TIP 54: *Managing Chronic Pain in Adults with or in Recovery from Substance Use.* Accessible from **http://www.ncbi.nlm.nih.gov/books/NBK92048/**

MENTAL HEALTH PROBLEMS

Prevalence

It is estimated that 20% of Canadians will experience a diagnosable mental health problem in their lifetime.[xxvi] There is a great variation in the quoted statistics regarding the prevalence of mental health problems among people with serious substance use problems. One commonly-cited, large-scale American study by Reiger and colleagues[xxvii] found that:

- 37% of people diagnosed with an alcohol disorder (their language) will have a diagnosable mental health problem at some point in their lives.
- 53% of people diagnosed with a substance use disorder (other than alcohol) will have a diagnosable mental health problem at some point in their lives.

The most commonly-occurring mental health problems among people with substance use problems are anxiety and depression.

Studies carried out with people being treated for mental health problems generally find higher levels of co-occurring substance use problems – hence the great interest in recent years in increasing "concurrent – competence" and bringing substance use treatment resources into mental health systems.

Whatever the rates of co-occurrence or the structural strategies chosen by organizations, it is of great importance that people who work with individuals with substance use problems have a sound understanding of basic mental health concepts and approaches, and work with a view to integrating services from the client's perspective. Both mental health and substance use problems must be treated as "primary", and parallel treatment provided for both sets of problems – keeping in mind that the person's stage of change, sense of priority, and capacity may be quite different in relation to their mental health problem than it is for their substance use problem(s). Assessment, treatment planning, treatment activities and follow-up care are ideally offered through one system, with one identified primary worker who "brings on" other specialists and supports as and when needed to achieve the client's goals.

Relationship between substance use and mental health problems

The relationship between mental health and substance use is very complex and varies from individual to individual. It is difficult to disentangle this relationship to determine "what caused what". The Centre for Addiction and Mental Health[xxviii] describes six ways in which substance use and mental health problems can affect each other:

- **Create** – Substance use can create psychiatric symptoms. Example: Alcohol is a depressant – if a person uses alcohol long enough, they may develop depressive symptoms and eventually meet criteria for major depression.
- **Trigger** – Substance use can trigger the emergence of some mental health disorders if a person is predisposed to mental illness. Example: A youth whose mother has bipolar disorder may have never experienced symptoms of mania until the youth uses PCP.
- **Exacerbate** – Symptoms of mental illness may get worse when a person uses psychoactive substances. Example: A person with suicidal ideation may make an actual suicide attempt after drinking alcohol because the youth becomes more depressed and less inhibited.
- **Mimic** – Substance use can look like symptoms of a psychiatric disorder. Example: A person with no history of psychiatric symptoms can develop paranoid delusions after heavy methamphetamine use.
- **Mask** – Symptoms of mental illness may be hidden by use of alcohol and/or other drugs. Example: A person with attention-deficit/hyperactivity disorder may be less distractible when using cocaine. Psychiatric symptoms may not emerge until the person stops using substances for a significant period of time.
- **Independence** – A mental health disorder and substance abuse disorder may not be related to each other, but a common factor may underlie them both. Example: A person's genetic makeup may make them vulnerable and more likely to develop mental illness and/or substance abuse.

Impact on the person living with serious substance use problems and serious mental illness

Concurrent disorders can have a debilitating impact on individuals including:

- higher rates of relapse and hospitalization
- reduced participation in treatment programs
- exacerbated symptoms of mental illness
- unstable living arrangements and homelessness
- poor problem solving skills
- lack of educational qualifications
- greater depression and suicidality
- violence
- not taking medication, or altered effects of medication
- familial problems
- loss of support networks
- increased vulnerability to HIV infection
- contact with criminal justice system
- poor physical health
- disruptive motivation
- poor self care

Mental health practices – the basics

Given the prevalence and nature of the interactions between the two sets of problems, substance use practitioners need to have enough knowledge and training in this area to be able to screen for mental health disorders and recognize the potential for the existence of mental health issues so that appropriate resources and plans can be brought into play if needed. Being familiar with diagnostic criteria and treatments used for mental health problems will also allow substance use services' practitioners to communicate more effectively with mental health clinicians.

There is currently no provincially-supported core mental health learning program similar to CAP, and it is not the role of CAP to fulfill that function. However, due to the importance of understanding key approaches when working with people with mental health problems, some core concepts and tools are included below.

Recovery model in mental health treatment

Historically, treatment in the mental health field focussed on alleviating the signs and symptoms of the pathology. However, as noted by Anthony et al[xxix] , mental illness "… not only causes mental impairments or symptoms, but also causes the person significant functional limitations." These limitations are not necessarily alleviated when the symptoms of the mental illness are treated; and the consequences of the illness (e.g. stigma, loss of self-esteem, loss of opportunities for self-determination) are sometimes more difficult to recover from than the illness itself. [xxx]

More current strategies in mental health treatment, such as psychiatric rehabilitation, go beyond focussing on alleviating symptoms, and focus on enabling people to increase their functioning and satisfaction in the environment of their choice with the least amount of ongoing professional intervention.

Central to the psychiatric rehabilitation approach is the concept of recovery. It is important not to confuse the term "recovery" with "cure". Recovery does not mean that all symptoms have disappeared never to return, and that functioning is completely restored. In psychiatric rehabilitation, recovery refers to "… a reformulation of one's life aspirations and an eventual adaptation to the disease."[xxxi] Much like the person-centred and client-directed models used in substance use treatment, the recovery concept in psychiatric rehabilitation recognizes that recovery is not a linear process; that recovery can occur even though symptoms reoccur; and that critical to an individual's recovery is the presence of at least one person who believes in that person's ability to recover.

The DSM Classification System

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a handbook for mental health professionals that lists different categories of mental disorders and the criteria for diagnosing them, according to the American Psychiatric Association. The version currently in use is the DSM-IV-TR.

A new version, the DSM-V, is expected to be released in 2013.

The DSM-IV-TR categorizes mental health problems in five diagnostic categories called "axes": [xxxii]

Axis I	Clinical Disorders and other conditions that may be a focus of clinical attention
Axis II	Personality Disorders and Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems (i.e., stressors related to Axes I and II)
Axis V	Global Assessment of Functioning

Substance use disorders are part of Axis I. Under the DSM-IV-TR, substance use disorders refers to "a habitual pattern of alcohol or illicit drug use that results in significant problems related to aspects of life, such as work, relationship, physical health, financial well-being etc." There are two mutually exclusive sub-categories – substance abuse and substance dependence.

Common co-occurring mental health problems

The most recent Best Practices document from Health Canada[xxxiii] defines five categories as being the most common groups of presenting mental illnesses in concurrent disorders, as follows.

Mood and Anxiety Disorders

Mood Disorders

- Persistent changes in mood caused by biochemical imbalances in the brain
- Include major depression, bipolar disorder (combined episodes of both mania and depression) and dysthymia
- Individuals with mood disorders are at high risk of suicide

Symptoms	
Depression	Mania
· Feeling worthless, helpless or hopeless · Loss of interest or pleasure (including hobbies or sexual desire) · Change in appetite · Sleep disturbances · Decreased energy or fatigue (without significant physical exertion) · Sense of worthlessness or guilt · Poor concentration or difficulty making decisions	· Excessively high or elated mood · Unreasonable optimism or poor Judgment · Hyperactivity or racing thoughts · Decreased sleep · Extremely short attention span · Rapid shifts to rage or sadness · Irritability

Anxiety Disorders

- Feelings of excessive anxiety, fear or worry, causing the person either to avoid situations that might precipitate the anxiety or to develop compulsive rituals that lessen the anxiety
- Include phobias, panic disorder, obsessive-compulsive disorder, post- traumatic stress disorder

Symptoms
Anxiety Disorders
· Intense and prolonged feelings of fear and distress that occur out of proportion to the actual threat or danger · Feelings of fear and distress that interfere with normal daily functioning

Psychotic Disorders

- Active state of experiencing hallucinations or delusions and can be organic (mental illness) or psychoactive substance induced
- Includes schizophrenia

Symptoms
Schizophrenia
· Delusions and/or hallucinations · Lack of motivation · Social withdrawal · Thought disorders

Personality Disorders

- Pattern of inner experience and behaviour that is significantly different from the individual's culture; is pervasive and inflexible; is stable over time; and leads to distress and impairment
- Includes borderline personality disorder, antisocial personality disorder, dissociative identity disorder

Symptoms
Personality Disorders
· Difficulty getting along with other people. May be irritable, demanding, hostile, fearful or manipulative · Patterns of behaviour deviate markedly from society's expectations and remain constant over time · Disorder affects thought, emotion, interpersonal relationships and impulse control · The pattern is inflexible and occurs across a broad range of situations · Pattern is stable or of long duration, beginning in childhood or adolescence

Eating Disorders

- Range of conditions involving an obsession with food, weight and appearance negatively affecting a person's health, relationships and daily life
- Stressful life situations, poor coping skills, socio-cultural factors regarding weight and appearance, genetics, trauma and family dynamics are thought to play a role in the development of eating disorders
- Eating disorders carry with them a high risk of other mental and physical illnesses that can lead to death
- Includes anorexia nervosa, bulimia nervosa, binge eating disorder

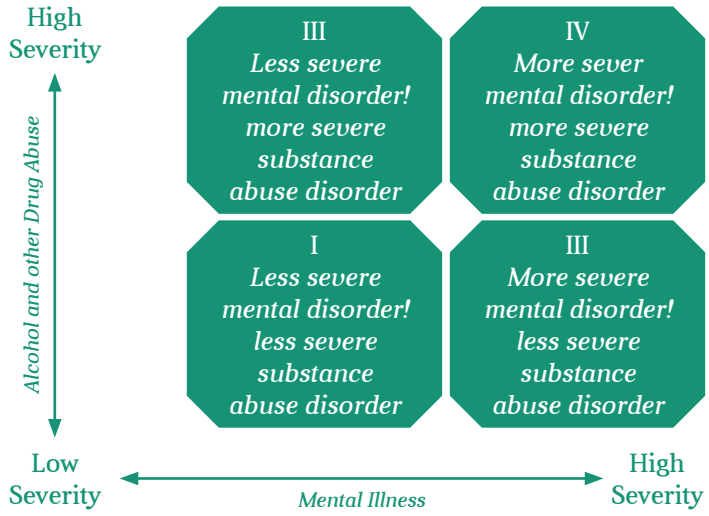
Symptoms		
Eating Disorders		
General		
· Distorted perception of the shape or size of one's own body		
Anorexia	Bulimia	Binge Eating Disorder
· Resistance to maintaining body weight at or above a minimally normal weight for age and height with an intense fear of gaining weight or becoming fat, even though underweight.	· Recurrent episodes of binge eating, accompanied by inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting, use of laxatives, or excessive exercise	· Binge eating without compensatory behaviours, such as vomiting, excessive exercise or laxative abuse · Individuals are often obese.

Other Mental Health Disorders

- Including but not limited to sexual disorders and pathological gambling

Four Quadrant Model

To assist in conceptualizing the complexities of concurrent disorders, the Four Quadrant Matrix model is often used. This model "frames systems of care in terms of the nature and severity of client symptoms, rather than diagnosis. The severity of symptoms helps guide the intensity of the service system's response."[xxxiv] Treatment services range from simple consultation with other agencies, to collaboration among agencies, to structural integration of services.



Source: NASMHPD and NASADAD, 1998.

Screening for Concurrent Disorders

As with substance use screening, screening for mental health disorders can be done in a variety of ways.

Index of Suspicion

If other methods are not feasible or appropriate, a simple checklist of behavioural, clinical and/or social indicators can be used that together raise the suspicion that the person has a mental health disorder and requires a mental health assessment. The following ABC checklist is recommended in Health Canada's best practices document: [xxxv]

Appearance, alertness, affect, and anxiety:

Appearance: General appearance, hygiene, and dress.
Alertness: What is the level of consciousness?
Affect: Elation or depression: gestures, facial expression, and speech.
Anxiety: Is the individual nervous, phobic, or panicky?

Behavior:

Movements: Rate (hyperactive, hypoactive, abrupt, or constant?).
Organization: Coherent and goal-oriented?
Purpose: Bizarre, stereotypical, dangerous, or impulsive?
Speech: Rate, organization, coherence, and content.

Cognition:

Orientation: Person, place, time, and condition.
Calculation: Memory and simple tasks.
Reasoning: Insight, judgment, problem solving.
Coherence: Incoherent ideas, delusions, and hallucinations?

b) Asking a few questions:

Asking a client a few direct questions about their mental health in a non-judgmental manner can reveal indications of possible problems. Though many people with mental health problems will still be missed, asking a few questions is better than not asking any at all. The following are possible questions that can be asked, indicating the need for further investigation if warranted by the responses:

- How are you feeling? How are you enjoying life?
- How are things going with work, with family and friends, school?
- Have you ever felt depressed or suicidal?
- Have you ever been given a mental health diagnosis by a qualified mental health professional or been treated for a mental health concern such as depression or anxiety?
- Have you ever been hospitalized for a mental health-related illness?
- Have you ever harmed yourself or thought about harming yourself but not as direct result of alcohol or other drug use?
- Have you ever been prescribed medication for a mental health issue?

c) Formal Screening Tools

There are a number of formal screening tools used in mental health field. The tools differ in many ways including what they screen for (several disorders, only one type of disorder), whether they are dimensional (measure quantity, degree or frequency of a parameter) or diagnostic (map onto diagnostic criteria of the DSM-IV-TR and indicate whether a psychiatric disorder is likely to be present or absent), the timeframe the questions refer to and their complexity. Some screening tools are simple and can be used by anyone whereas others require training and have restrictions on who can purchase, administer or interpret the results.

Screening tools should only be used as one piece of the screening process and clinicians should only choose the tools they are qualified and trained to administer and that are appropriate for their client (e.g., developed for specific target group, culturally and developmentally appropriate).

It will be important for learners to consult with their local Mental Health Services partners to determine which screening tools they recommend, especially as a fit for future joint assessments and/or collaborative care planning.

Assessing for Concurrent Disorders

Mental health assessment should only be carried out by practitioners with the specialized skills to do so. A substance use counsellor's ability to assess for a mental illness will depend on their knowledge and training in this area. Some aspects of mental health are explored in substance use assessments but only psychiatrists and registered psychologists can do assessments that result in formal diagnoses. Referrals to or (ideally) partnering with, mental health clinicians are also an option to have mental health issues assessed further.

When assessing a client for concurrent disorders, a full assessment of both disorders should be conducted with a focus on the interaction between the two. The chronology of the onset of substance use and mental health problems; the presence or absence of mental health symptoms during periods of reduced use or abstinence (these periods of time can occur at any time in the person's history after the onset of illness, and do not have to be current); effects of treatment and medications and whether there are days when the symptoms are better or worse, and if so, how it relates to the substance use; and family history of mental illness are all important areas to explore.

A selection of screening and assessment tools can be found on the Centre for Addiction and Mental Health's website at **http://knowledgex.camh.net/amhspecialists/Screening_Assessment/screening/Pages/screen_for_concurrentdisorders.aspx**

Early Psychosis Intervention

Approximately 3% of people will experience a psychotic episode at some stage in their life. Early psychosis is "the early stage of any psychotic condition that affects the mind, such as schizophrenia or bipolar disorder".[xxxvi] The first episode usually occurs in adolescence or early adult life. Studies show that the longer the illness is left untreated, the greater the risk that young people will become less responsive to treatment, and the recovery period will take longer.

Fraser Health Authority provides leadership in BC related to Early Psychosis Intervention. Resources and information are available at http://www.psychosissucks.ca/

FETAL ALCOHOL SPECTRUM DISORDER

As discussed in Module II, Fetal Alcohol Spectrum Disorder (FASD) is the non-diagnostic umbrella term used to describe a range of disabilities and diagnoses that may occur in a person whose mother drank alcohol during pregnancy. The effects on the fetus were described earlier. This section looks at the lifelong impacts of FASD.

Incidence Rate of FASD

FASD is the leading cause of developmental disability among Canadian children. It is also the most common form of preventable brain damage. Overall incidence rates of FASD are not definitely known due to inconsistent criteria for diagnosis, poor access to diagnosis, invisible nature of the disability in many cases, and the increasing challenge of diagnosis as a child or youth matures. Current estimates of FASD among newborns range from one in 1,000 births per year to one in 100 births a year.

Characteristics of people with FASD

Strengths

Individuals with FASD have many strengths and abilities that are important to focus on. It is these strengths and abilities that must be built on to accommodate for the disability.

Physical Characteristics

Only approximately 4% of those diagnosed with full FAS display characteristic facial changes. Many of the people with FASD have none of the visible physical characteristics associated with FASD. Some people may have had the physical characteristics at a younger age but grew out of them as they matured. Physical characteristics include:

- Growth retardation (both prenatal and postnatal)
- Distinctive facial features
- Decreased head size
- CNS dysfunction:
  - Impairment of fine motor skills
  - Difficulty coordinating hand-eye functions
- Malformation of the heart, kidneys, bones or vision and hearing systems
- Dental abnormalities
- Immune system dysfunction

Neurological Deficits

There is no one set of behaviours typical of FASD. Some people with FASD have only a few neurological deficits while others have more of them, or a greater degree of severity. The brain damage resulting from prenatal exposure to alcohol is irreversible and the learning, behaviour and socialization difficulties are lifelong. Some of the possible neurological deficits that may result from prenatal alcohol exposure include:

- Problems with memory, attention and judgement
- Poor capacity for abstract thinking
- Poor impulse control
- Higher than normal pain tolerance
- Higher level receptive and expressive language deficits
- IQ – may be lower in some (not all) cases
- Learning disabilities and cognitive difficulties

Social Emotional Functioning

Challenges in social and emotional functioning of individuals with FASD may include:

- Easily manipulated by others
- Seem to experience chaos in their lives
- Have learned to adapt to environment – often not understanding what that means
- Difficulty predicting/understanding consequences
- Difficulty making and keeping friends

- Overly friendly and affectionate, easily approached by strangers
- Perseverative or often seen as "stubborn"

Importance and Challenges of Diagnosis

The importance of obtaining a diagnosis of FASD is high. An accurate diagnosis allows for the planning and implementation of appropriate services and other disorders with similar symptoms can be ruled out. Misdiagnosis leads to inappropriate and ineffective services. A diagnosis of FASD can also lead to relief for both the individual and parents by explaining that the difficulties they have been experiencing may be as a result of a physiological reason. Once a diagnosis of FASD is made, realistic expectations and goals can be established and doors may open up to support services.

Getting a diagnosis of FASD can be extremely challenging, especially if maternal alcohol use is not confirmed. Diagnosis requires assessment by a multidisciplinary team and the availability of these types of teams is limited, especially in rural areas. It was not until May, 2005 that Canadian Diagnostic Standards were formally established to detail the diagnostic criteria for the range of diagnoses under FASD.

Secondary Disabilities

Secondary disabilities are not present at birth but occur as a result of complications of undiagnosed or untreated primary disabilities. Secondary disabilities can presumably be prevented or lessened by a better understanding of FASD and appropriate interventions. Therefore, the earlier the diagnosis, the better the prognosis. In the Seattle Longitudinal Study on Alcohol and Pregnancy ("The Seattle cohort"), Streissguth et al[xxxvii] found the following in a study of 415 youth and adults:

- Mental health problems (>90%)
- Disrupted school experience (60%)
- Trouble with the law (60%)
- Confinement for mental health, substance use or criminal issues (50%)
- Inappropriate sexual behaviour (50%)
- Substance use problems (30%)
- Problems with employment (79% of 90 individuals)
- Dependent living (83% of 90 individuals)
- Problems with parenting (57% of 30 individuals who were parents)

Working with Individuals with FASD

Without an understanding of what a person living with FASD is experiencing, the practitioner or advocate may find themselves responding to outward behaviours in non-effective ways, such as frustration.

The following chart was developed by the RCMP to illustrate the difference between what an officer might think is going on and what could really be going on with someone if they are affected by FASD. [xxxviii]

What you might think	What might really be going on
Won't cooperate	· Doesn't understand, or doesn't remember
Repeat offender	· May be impulsive · Not able to learn from consequences
Takes the blame	· Easily led by others · Wants to please
Lazy	· Tries and is exhausted · Can't start, disorganized · Does not want to fail again
Lies	· Fills in the blanks · Willing and compliant – tells you what he/she thinks you want to hear, i.e. *How was the doctor's appointment? It was great! Even though they may have forgotten the appointment* · Slow pace of hearing – may only get every third word · Can say words but doesn't connect words with meaning
Doesn't care/ shuts down	· Defensive · Hurt · Abused · Frustrated
Looks uncomfortable	· Can't show feelings
Resisting	· Doesn't understand · Has trouble paying attention
Trying to make others mad	· Can't remember · Over excited
Immature, acting younger	· An adult affected by FASD may have same emotional self-control skills as a normal eight year old
Thief	· Doesn't understand value and ownership · Has trouble predicting consequences

Adapting responses and services for people with FASD

Protective factors

After a diagnosis of FASD has been made, the next step to effectively responding to a person with FASD is to assess the individual's ability to function – at home, at school/work, in the community – to determine the types of supports and services needed. Some of the protective factors that contribute to preventing secondary disabilities for occurring include:

- Early diagnosis (before the age of six)
- A stable nurturing home
- Receipt of developmental disabilities services
- Having an adult (or adults) in their lives who will advocate for them and help them to get the supports and services they need
- Receiving culturally appropriate services e.g. aboriginal services
- Being protected from violence - witnessing or being a victim of violence

The CARES Approach

Anne Wright and Associates[xxxix] have developed the CARES approach in working with individuals with FASD, based on the work of Kellerman. CARES stands for:

Cues - **A**ttitude - **R**epetition - Environment - **S**tructure and supervision

A summary follows. More information is available directly from **www.annewright.ca/workshops_training/documents/weCARESFacilitatorsManualSeptember3.pdf**

Cues

- Use visual and voice cues
- Give simple, clear and concrete instruction, i.e. take a shower now; use this soap on your body and this shampoo on your hair.
- Avoid a long list of steps that may be difficult to remember. Give no more than 3 steps at a time, and only when the individual is about to undertake the activity.
- Focus on what's happening now.
- Help with list-making
- Help with transition, i.e. after you eat your ice cream, we will begin to clean up and you will sweep the floors

Attitude

- Try differently, not harder
- Drop your own assumptions and get curious
- Look for strengths
- Check your goals and expectations as you learn more about this person
- Work within your agency to develop and implement a consistent care plan. Discuss and document results with your work team and with your client.

Repetition

- Repeat yourself using the same words each time
- Probe for understanding – have them show how they understand what you've said or "Tell me what I've just said in your own words."
- Keep mood calm and distraction levels as low as possible
- Provide reminder tools and aids as needed
- Post schedules – reinforce the client to follow the schedule when they ask repetitive questions
- Keep consistent

Environment

- Keep safe spots – where someone can go to calm down
- Create special evacuation and safety procedures (alarms can be over-stimulating)
- Help community members to understand

Structure and Supervision

- Structure substitutes for supervision when you can't be there
- Be consistent
- Limit choices and the need for decision-making
- Keep to routines as much as possible – when you change routine, anticipate problems, tell your client what's happening and work with him/her to adapt
- Give immediate feedback

More information

For more information on FASD, see the following resources:

- The Asante Centre for Fetal Alcohol Syndrome: http://www.asantecentre.org/
- BC Ministry of Children and Family Development. Fetal Alcohol Spectrum Disorder Website **http://www.mcf.gov.bc.ca/fasd/**
- Canadian Centre on Substance Abuse, Fetal Alcohol Spectrum Disorder **http://www.ccsa.ca/Eng/KnowledgeCentre/OurDatabases/FASD/Pages/default.aspx**
- Healthy Choices in Pregnancy, BC: Provincial Education and Resource Development **http://www.hcip-bc.org/**
- Public Health Agency of Canada, Fetal Alcohol Spectrum Disorder Website **http://www.phac-aspc.gc.ca/fasd-etcaf/index.html**

VIOLENCE AGAINST WOMEN IN RELATIONSHIP [xl]

"Women who have experienced violence (in relationships) may use substances, legal and illegal, for a variety of reasons. Some women use substances as a way to avoid violence from an abuser who is pressuring her to use the substances. Abusers may encourage women's substance use as a means to gain control over them – by having more influence over their behaviour and/or control over their access to substances. Women may also take substances, prescribed or not, to cope with the physical and psychological effects of violence. Even when substances are prescribed, women may become dependent on them and may find it hard to cut back on, or stop, their use." [xli]

Earlier in this module, we addressed the high incidence of trauma in the past or current experience of people seeking treatment for substance use problems. Many women seeking help related to their own or a partner's substance use are currently experiencing, or are living with the effects of, physical or emotional abuse within their relationship.

Effects of violence in relationship

The causes and effects of partner violence, mental health problems and substance use problems can become interwoven and are best approached by practitioners in a holistic, integrated way.

For example, a study jointly carried out by the Atira Transition House in the Fraser Valley and the Women Abuse Response Program at BC Women's Hospital found impacts on women who have experienced violence to include: [xlii]

- Chronic pain
- Depression
- Headaches/migraines
- Digestive problems
- Confusion
- Lack of concentration
- Memory loss
- Feeling "crazy"
- Feeling suicidal
- Anxiety
- Increased smoking/drinking
- Needing prescription drugs to cope or sleep

There are multiple issues involved in both substance use and violence against women in relationship thus the relationship between the two is not causal: problematic substance use does not cause family violence nor does family violence cause problematic substance use. Not every person who experiences problem substance use will perpetrate family violence. However, when they do occur together, the impact of each problem may intensify.

Implications of substance use for women's safety

Substance use has a number of implications for a woman's safety when she is involved in an abusive relationship. The following are some of these implications:

- When intoxicated, a woman is less aware of risk and may not be able to make decisions that might protect her from the abuser.
- A woman might be reluctant to leave an abusive relationship because of her dependence on the abuser for access to drugs.
- A woman may fear that if she contacts community agencies for help, other factors in her life such as alcohol and other drug use, may be revealed and risk her children being taken into care.
- A woman with substance use problems may have, or believe they have, diminished credibility and receive less support in the community as a result.
-

Barriers to getting help

The barriers to getting help for women experiencing violence in a relationship can be divided into three categories: client, counselor, and system.

Client barriers:

- Denial
- Blocked memories
- Fear of disapproval
- Gender of service provider
- Fear of disclosure
- Self protection
- Different views of abuse
- Fatalism
- Different views of "help-seeking"
- Communication
- Shame

Counsellor barriers:

- Personal experience with violence
- Personal experience with substance use problems
- Attitudes
- Lack of training/experience
- Being too prescriptive
- Reluctance to report incidents of violence
- Communication
- Miscommunication

System barriers:

- Limitations created by agency mandates
- Inadequate referral availability
- Inadequate screening and assessment practices
- Limited services for women of diverse backgrounds and circumstances
- Conflicting visions of service delivery, including no acknowledgement of the importance of gender-sensitive services.

Implications for service providers

As a service provider, it is important to be aware of the co-existence of problematic substance use and violence against women and children in relationship. The National Clearinghouse on Family Violence[xliii] outlines the following main implications for service providers:

- Safety planning must always be the first priority when dealing with family violence and substance misuse. Workers must continually assess the level of risk for suicide, homicide and recurring violence.

- It is important that service providers look for both substance misuse and family violence and develop strategies to address both problems. The impact of these problems on all members of the family should be considered.
- Although these problems may be directly linked, we must remember that they are distinct issues. Dealing with one problem does not necessarily eliminate the other. Assumptions of this kind will lead to continued risk for all involved.
- Victims of family violence who have alcohol or other drug problems may require additional support. Dealing with both problems may make it more difficult for the victim to leave a violent relationship and/or to stop misusing substances. Special attention must be paid to safety issues.
- Family violence issues may influence decisions about treatment planning. For instance, safety may be enhanced by placing substance-misusing perpetrators in residential programs. Women, especially those who have been abused, can benefit more from specialized women's programs than from traditional male-oriented treatment programs.
- Recognition of the mental health effects of child abuse, partner abuse and abuse of seniors has increased greatly in recent years. There remains a concern that medications are often prescribed as the sole intervention for these problems. Unless underlying violence issues such as safety and victim trauma are dealt with, drug dependency may result.

Safety planning

Safety planning refers to efforts to reduce risk by working with the victim. The primary role of service providers is to provide advocacy services to the abused woman and work with the woman to assess and manager her risk, instead of simply imposing a safety plan. Therefore, the first step is a comprehensive risk assessment.

Risk assessment

There are three main steps to the risk assessment process which culminates in the development of a safety plan:

1. The first step involves a discussion regarding the extent of the abuse suffered by the woman and her children. A full history should be taken, of the physical abuse as well as other forms of abuse.

2. The second step is a consideration of various barriers to safety that might exist for the woman. These barriers could include victim vulnerability risk factors, child related risk factors, abuser related risk factors and system related risk factors. Thirdly, an evaluation of the woman's options for managing risk is undertaken.

The Safety Plan: [xliv]

The safety plan is an individualized plan abused women develop to reduce the risks they and their children face. The particulars of each plan vary depending on whether a woman has separated from the abuser, plans to leave, or decides to stay, as well as what resources are available to her. The focus of the safety plan is two- fold: first, protection strategies for escaping, avoiding and surviving the abuser's violence and second, concurrent strategies to increase the resources and support available to the abused woman. Practical suggestions, such as a list of telephone numbers and documents a woman should hide and take with her if she leaves, can also be included. The key to making an effective safety plan involves considering the woman herself as the best resource and respecting her choices as the ones best suited to her individual situation. Safety plans are fluid and change over time.

One example of a safety plan can be found on the Legal Services Society website at **http://resources.lss.bc.ca/pdfs/pubs/liveSafeSafetyPlanning_eng.pdf**

Additional resources related to serving women experiencing violence in relationship and substance use problems

BC Society of Transition Houses' Reducing Barriers Toolkit: **http://bcsth.ca/sites/default/files/publications/BCSTH%20Publication/Women%27s%20Services/ReducingBarrierToolkit.pdf**

Women Abuse Response Program, BC Women's and Children's Hospital, Building Bridges Resources: **http://www.bcwomens.ca/Services/HealthServices/WomanAbuseResponse/Building+Bridges.htm**

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[i] Dan Reist, in-person interview, March 2012.

[ii] *Big Book Online* – 4th Edition. (2001). Alcoholics Anonymous World Services Incorporated. Accessed from **http://www.aa.org/bigbookonline**

[iii] McCormack, John. (2007) Recovery and Strengths Based Practice. Scottish Recovery Network Discussion Paper Series: Paper 6. Accessed through **http://www.scottishrecovery.net/SRN/View-category.html?dir=DESC&limit=5&limitstart=25&order=name**

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[v] Wilkinson, Richard and Michael Marmot, Editors. (2003). *Social Determinants of Health: The Solid Facts – 2nd Edition*. World Health Organization. Retrieved November 2012 from **http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf**

[vi] As above, p. 24.

[vii] In this section, "family" is meant to include immediate relatives as well as caregivers, significant peers and partners: "family and friends".

[viii] This information and some of the following is based on Bubbra, S., A. Himes, C. Kelly, J. Shenfeld, C. Sloss, and L. Tait. (2008). *Families CARE: Helping Families Cope and Relate Effectively – Facilitator's Manual*. Toronto, ON: Centre for Addiction and Mental Health.

[ix] Stanton, M.D. (2004) as cited in Bubbra et al (2008).

[x] Stanton (as above).

[xi] Rowe, et al (2003) as cited in Bubbra et al (2008).

[xii] Velleman (1993) as cited in Bubbra et al (2008).

[xiii] Lewis et al (2004) as cited in Bubbra et al (2008).

[xiv] O'Farrell, T.J. and W. Fals-Stewart. (2003) as cited in Bubbra et al (2008).

[xv] Howells, E. and J. Orford. (2006) as cited in Bubbra et al (2008).

[xvi] Much appreciation is expressed to Diane Smylie, Nancy Poole and their Advisory Group for the Trauma-informed Practice Guide for BC (in draft at time of writing CAP update) for a major portion of the contents of this section of Module V.

[xvii] Poole. (2008) as cited in the above document.

[xviii] Brown, Petite, Hanstra and Stewart. (2009 as cited in the above document.

[xix] VIHA YFSUS data as cited in the above.

[xx] Chaim and Henderson. (2009) as cited in the above.

[xxi] Van Ameringen, Mancini, Patterson and Boyle. (2008) as cited in Poole and Smylie as above.

[xxii] Poole and Smylie (as above), p.8.

[xxiii] Centre for Substance Abuse Treatment. (2012). *Managing Chronic Pain in Adults with or in Recovery from Substance Use Disorders - TIP 54*. U.S. Department of Health and Human Services, Substance Use and Mental Health Services Administration: Rockville, MD. Retrieved October 2012 from **http://www.ncbi.nlm.nih.gov/books/NBK92048/**

[xxiv] Pain BC online resource. Accessed at **http://www.painbc.ca/**

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[xxvi] Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada*. Retrieved November 2012 from **http://strategy.mentalhealthcommission.ca/pdf/strategy**

[xxvii] Reiger, D.A., Farmer, M.E. & Rae, D.S. (1990), as cited in Skinner, Wayne et al (2010). Centre for Addiction and Mental Health. Retrieved November 2012 from **http://knowledgex.camh.net/amhspecialists/resources_families/Documents/concurrent_guide_en.pdf**

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[xxx] As above.

[xxxi] Pratt, C., K. Gill, N. Barrett and M. Roberts. (2002). Psychiatric Rehabilitation. San Diego, CA: Academic Press.

[xxxiii] Centre for Addiction and Mental Health. (2002). *Best Practices: Concurrent Mental Health and Substance Use Disorders*. Ottawa, ON: Health Canada. Retrieved November 2012 from **http://www.hc-sc.gc.ca/hc-ps/pubs/adp-apd/bp_disorder-mp_concomitants/index-eng.php**

[xxxiv] National Association of State Mental Health Program Directors. (2005). *The Evolving Conceptual Framework for Co-ocurring Mental Health and Substance Use Disorders*. **http://www.nasmhpd.org/index.aspx**

[xxxv] Centre for Addiction and Mental Health. (2002). *Best Practices: Concurrent Mental Health and Substance Use Disorders*. Ottawa, ON: Health Canada. Retrieved November 2012 from **http://www.hc-sc.gc.ca/hc-ps/pubs/adp-apd/bp_disorder-mp_concomitants/index-eng.php**

[xxxvi] Fraser Health Authority Early Psychosis Intervention Program. Accessed at **http://www.psychosissucks.ca**

[xxxvii] Streissguth, A., H. Barr, J. Kogan and F. Bookstein (1996). *Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE)*. Seattle, WA: University of Washington.

[xxxviii] Adapted from RCMP Division D. (2002) *Fetal Alcohol Spectrum Disorder: A Message to Police Officers about FASD*. Direct Focus Marketing Communications Inc. fas@directfocus.com and found at **http://www.annewright.ca/workshops_training/documents/weCARESFacilitatorsManualSeptember3.pdf**

[xxxix] Wright, Anne and Associates. (2004). *We Cares: Facilitator's Manual*. **http://www.annewright.ca/workshops_training/documents/weCARESFacilitatorsManualSeptember3.pdf**

[xl] Both men and women experience violence in their closes relationships, however the incidence of women experiencing violence is consistently found to be much higher than for men.

[xli] *Reducing Barriers to Support for Women Fleeing Violence: A Toolkit for Supporting Women with Varying Levels of Mental Wellness and Substance Use*. (2011). BC Society of Transition Houses. Accessed at **http://www.bcsth.ca/content/reducing-barriers-support-women-who-experience-violence**

[xlii] Adapted from Cory, J., Dechief, L., and Poag, E. (n.d.). *Advancing Health Care Practices: Exploring the Links Between Woman Abuse, Substance Use, and Pregnancy/Early Parenting*, as cited in the above.

[xliii] National Clearinghouse on Family Violence, Public Health Agency of Canada. Accessed at **http://www.phac-aspc.gc.ca/ncfv-cnivf/index-eng.php**

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MODULE VI: ETHICAL PRACTICE IN SUBSTANCE USE TREATMENT

MODULE VI: ETHICAL PRACTICE IN SUBSTANCE USE SERVICES AND SUPPORTS

Ethical Practice

Substance Use Services in British Columbia are committed to providing quality programs and services in an ethical and professional manner. Practitioners are expected to adhere to professional standards of conduct both in and outside of their area of employment and commit to continuing professional development.

Ethical practice includes:

- Understanding, being able to describe and engage in ethical conduct with all clients, their families, co-workers, and other allied professionals.
- Practicing within the scope and legal requirements of their role.
- Being familiar with the evidence base for their work, and being able to make evidence –informed decisions about how to respond to each clients' needs.
- Maintaining appropriate professional relationships and boundaries with the people served.
- Continuing professional learning and development.
- Managing stress and supporting one's own health and wellness.

Module VI covers some key components of ethical practice in the substance use treatment field: ethical decision-making, professionalism and boundaries, and stress management.

KEY TERMS

Some key terms when discussing professionalism and ethical practice include:

Ethics: Moral principles adopted by an individual or group to provide rules for right/correct conduct.

Values: What is good and desirable as opposed to right and correct. They are prized by an individual, chosen freely, committed to and acted upon.

Principle Ethics: Focus on the use of rational, objective, universal, and impartial principles in the analysis of ethical dilemmas. Answers the question: "Is this situation unethical?"

Virtue Ethics: Focus on the character of the counsellor and answer the question "Am I doing what's best for my client?"

Professionalism: A general code of conduct that an individual and/or organization adhere to in order to meet the standards of their vocation.

KEY CONSIDERATIONS FOR ETHICAL PRACTICE

Power Differentials

- Acknowledge the inherent power differential between yourself as a worker and your client, and model effective use of personal power in your work with clients. In using the power differential, it is important not to take control of power that is not rightfully yours.
- Provide the client with all the information that is necessary for his or her healing. It is not up to you to decide what information to withhold.
- Self-disclosure by a practitioner should be handled carefully and done only if in the interests of the clients you are working with. The helper's role is to support the client, not to have the client support them.
- Negotiate, review, and if appropriate, renegotiate your informal and formal contracts with your clients in an ongoing mutual process.
- Provide your clients with information on their rights as consumers of service, including procedures for resolving differences and addressing complaints, including formal processes if desired by the client.

Overlapping Relationships

- Recognize the complexity and conflicting priorities of having overlapping (personal and professional) relationships. You should monitor these relationships to prevent potential harm or abuse to your clients.
- Ensure that confidentiality is also maintained, and be aware of both your private and public statements regarding your clients and their life stories.
- Do not engage in any sexual intimacies, overt or covert sexual behaviour with a client or former client. Make sure these boundaries do not become confused.

Worker Accountability

- Work only within your own level of skill and competence.
- Recognize and act on your personal and professional needs and seek further training, supervision, evaluation, or peer support when necessary.
- Engage in your own self-care program to ensure that your vulnerabilities and needs are attended to outside of your work with your clients.
- Model self-nurturing in appropriate and empowering ways.
- Seek consultation and supervision when you are uncomfortable with aspects of your relationship with a client.

Social Change

- Question practices and policies that appear to be detrimental, stigmatizing, discriminatory or abusive to the clients you work with.
- Intervene with the system in an appropriate way when it will benefit your client.
- Explore various routes and activities that promote social change, including public education, lobbying for legislative change, and client advocacy.

Cultural Diversity and Oppression

- Increase accessibility for clients from diverse cultural backgrounds and lifestyles, through more sensitive, flexible, and culturally appropriate service delivery.
- Be aware of the meaning and impact of your own ethnic and cultural background, gender, class, abilities, and sexual orientation.
- Attempt to become knowledgeable about alternatives from sources other than your own clients.
- Uncover and respect cultural and experiential differences.
- Evaluate your interactions with your clients for any evidence of your biases or discriminatory attitudes and practice.
- Accept responsibility for taking appropriate action to confront and change any interfering or oppressing biases you may have.
- Examine your skills, and assess how they apply to your work with clients from other cultures and backgrounds.
- Determine what new skills you need to meet more effectively the needs of clients from diverse cultures and backgrounds.
- Actively seek out colleagues from diverse cultures and backgrounds to share information and learn new skills from them.
- Examine and revise existing procedures and practices that may discriminate, isolate, and dominate clients from other cultures or backgrounds.

GUIDELINES FOR ETHICAL PRACTICE

The following are the basic guidelines for ethical practice:

- Ensure client empowerment and well-being is the primary goal of the counselling relationship.
- Respect individual differences.
- Be open to challenging the oppressive aspects of your own values.
- Be aware of the impact your behaviour has on your work with clients.
- Be vigilant against inadvertently imposing your own power and agenda on your clients.
- Take responsibility for your own learning about people from different cultures or classes or with different sexual orientations, lifestyles or abilities.
- At the same time, avoid "othering". Remain aware that your commonalities (with clients) far outweigh your differences.

ETHICAL DECISION MAKING

Although day-to-day we may engage in ethical practice, for most of us ethics are in the background until an ethical dilemma arises. That is, when it is unclear, or there is a conflict in our minds or with others, about what is the "most right" or the "least wrong" thing to do in a given situation. At times, such dilemmas can be of such concern to the practitioner that they result in "moral distress". Ethical dilemmas may arise from individual client-service issues, or from systems requirements or limitations.

These situations call for clarity about how ethical decisions can be made. Resolving an ethical dilemma usually calls for a consultation or discussion with other practitioners.

What is the focus of an ethics consultation or discussion?[i]

An ethics consultation/discussion is different than a clinical or legal consultation since the focus of the discussion is on ethical concerns which are then examined using the following principles, considerations and values:

Principles for an ethics discussion

a) Autonomy - One should have respect for the person served, honour choices and avoid constraining the autonomous actions and choices of others. This includes attention to:

   i. Informed consent: One should provide the information required to make an informed choice.
   ii. Veracity: One should be honest, transparent and forthcoming with others.
   iii. Confidentiality/privacy: One should, with very limited exceptions, respect the client's right to determine to what extent information about the client should be communicated to others.
   iv. Cross-cultural awareness and sensitivity: One should seek to learn about cultural considerations important to clients or colleagues and respect these.

b) Nonmaleficence – One should do no harm to clients or others.

c) Beneficence – One should do good, prevent harm, remove harm and promote good or well-being.

d) Justice – One should be fair, treat similar cases equally, use fair procedures and aim to produce just outcomes.

- *Have all of the above principles been taken into consideration in assessing which treatment or course of care is most ethically appropriate?*

Care and relationships

One should build and maintain positive relationships, using open, respectful communication with all involved. One should seek to make the decision-making process as caring as possible by supporting clients, their families and care providers to deal with loss, grief and/or uncertainty.

- *Are we actively seeking to build positive, honest and safe relationships with all concerned?*
- *Are we treating the client as inherently worthy of our skill, attention and expertise?*

Worldview and culture

One should have understanding of one's own basic convictions (i.e. usually taken for granted or "of course" beliefs about what is true about the world and what we should value); and consider how these may influence one's understanding of a client who has different beliefs. Examples of belief systems or basic convictions that require reflection include:

- What is the worth or values of human life even when impaired?
- What constitutes full human personhood?
- When does human life begin and end?
- What is the meaning of death?
- What constitutes human well-being and health?

- Are we aware of how our own values and beliefs (including the culture of health care) are influencing our understanding of a client who has different beliefs?

Moral character and disposition

One should exhibit traits of kindness, caring, patience and courage. One should seek to have good character (i.e. the inner and distinctive core of a person from which moral decisions and actions spring); and virtue (i.e. a good disposition/trait of character that is a persistent tendency to act in a certain manner or way) even when no one else is watching. Examples of virtues in health care include:

- Kindness and caring
- Hope and patience
- Fortitude and courage
- Humour

- Out of all the available options, is the proposed treatment or course of action in accordance with the kind of person I seek to be and the kind of community I seek to foster?

THE PROCESS FOR MAKING ETHICAL DECISIONS

It is important to note that the process is not necessarily linear. The aim is for the best possible result of the ethical discussion or consultation.

1. Identify the current issue of concern.

- What is the central ethical issue?
- What is the difficulty in coming to an ethical decision? (I.e. Where is the conflict in deciding "what is right and good".)

2. Gather and study the relevant information

- Gather and interpret information relevant to the concern or situation from all relevant sources.
- Identify the practitioners involved and others in the helping system from whom input should be sought.
- Identify any assumptions made, and missing information.
- Include the perspective of the person(s) served and other key members of their social support network. Include relevant opinions and "stories" as well as facts.

- Possible issues to consider include those in the following quadrant:

Client preferences (examples): ➢ Capability and strengths ➢ Wants and needs ➢ Prior experiences with services ➢ Client informed and understands alternatives, benefits, risks	Quality of life (examples): ➢ Restrictiveness of setting for service ➢ Prospects with/without treatment or added supports ➢ Client's and practitioner's values re evaluating client well-being
Clinical, health or other service considerations (examples): ➢ Nature and severity of the problem ➢ Agreed-upon goals of treatment ➢ Availability of treatment resources ➢ Anticipated benefits and harms of treatment options	Contextual considerations (examples): ➢ Family/key supporters' perspectives ➢ Stage of life ➢ Cultural/ethnic/religions/spiritual issues ➢ Language ➢ Financial situation and living conditions ➢ Access to services ➢ Legal considerations ➢ Risk management considerations

3. Identify and be aware of your personal values, biases, self-interest, and stressors that may impact a decision – as well as those of other professionals involved in the discussion.
4. Identify all options that may help resolve the situation. Be creative. Tailor the options to the client's (or clients') circumstances.
5. Identify how various alternatives might be implemented.
6. Use the points from the section on "What is the focus of an ethics consultation or discussion" (above) to evaluate alternative courses of action.
7. Select the preferred alternative. Determine how it will be implemented.
8. Consider how the plan will be evaluated.
9. Document the plan (including evaluation and accountability) and share with all concerned.

NEGOTIATING RISK ETHICALLY[ii]

Many of the people served by substance use service providers live with a level of risk in their lives that may, by some, be considered intolerable. How do we negotiate those levels of risk with the people we serve?

Using the framework outlined above, we can say that the ethical dilemma we experience when we believe a client is living at risk is related to conflict over our: "obligation to honour client autonomy vs. obligation to provide care/benefit the client (beneficence vs. non-maleficence…)"

A number of risks may be present:

- Risks to self - including dangerous activities, self-harm, self-neglect, refusal of, or not following treatment plans.

- Risks to others - including neglect or harm to children, violence with adult family members or others, illegal activities.
- Risks from others – including abuse (physical, emotional, sexual, abuse of power), neglect, financial predation, stigma and discrimination, bullying.

Taking the first step in the Ethical Decision Making Process, the formulation of the ethical question is key in this instance. For example;

Given the uncertainty of outcomes or conflict about values, what decisions or actions related to living at risk are ethically justifiable?

OR

Given the uncertainty of outcomes or conflict about values, is it ethically justifiable to allow clients to live at risk?

OR

Given the lack of options for protecting clients being served by the Substance Use Services system from living at risk, what option/s are preferred by the person served and the practitioner?

The Ethics Committee for Coast Mental Health (Vancouver) recognizes there is a continuum of risk and harm, and a range of options for intervention related to that continuum.

Probability of risk or harm - >	***Slight*** ***Tolerable*** ***Substantial*** ***Intolerable***
Client's ability to manage	High < ----------→ Low
Client's emotional state	Stable, optimistic <----------→ Unstable, pessimistic
Harmful influences from others	Minimal <----------→ Significant
Access to information	Full ←----------→ None
GUIDANCE RE INTERVENING	Explain ←----------Persuade----------Pressure ----------→ Coerce

Risk Management Rules

1. Risk management interventions are never based on convenience or gratification.
2. Negotiating risk ethically involves the minimal use of power to attain maximum benefit and minimum in fringement on clients' liberties.
3. The more grave the potential consequences for the client or others, the greater the obligation to intervene.
4. If the client is capable, the client should be considered the decision-maker.

5. If the client is determined incapable, then family, advocate, or an identified substitute decision-maker may make decisions, using these guides:

    a. Substituted judgement – What the client would have chosen if capable.
    b. Best interest – What a reasonable person in that situation would have chosen on behalf of the client.

6. If the intervention selected has already been shown to be ineffective, too costly, and/or harmful to the client or others, or if it compromises professional integrity, the intervention may not be offered. This is called "justifiable withdrawal".

In the end, the practitioner's obligations related to risk management are broader than simple ethical considerations. They are as a whole:

- Professional: considering the therapeutic alliance and duty to serve.
- Ethical (moral): considering beneficence, non-maleficence, respect for autonomy, justice, veracity and fidelity.
- Legal: considering protection from harm, confidentiality, informed consent.

CODE OF ETHICS AND STANDARDS OF PRACTICE FOR SUBSTANCE USE SERVICE PROVIDERS

In addition to the above guidance, substance use practitioners are expected to be familiar with, and operate within the standards and ethical codes of their own profession.

For social workers, see **http://www.bccollegeofsocialworkers.ca/public-area/standards-practice.htm**

For nurses, see **https://www.crnbc.ca/Standards/professionalStandards/Pages/Default.aspx**

For clinical counsellors, see **http://bc-counsellors.org/general/code-of-ethical-conduct-and-standards-of-clinical-practice**

Legal Requirements Related to Ethics

When working with individuals who use substances, two key legal issues need to be understood: informed consent and confidentiality.

INFORMED CONSENT

Although the definition of the term "informed consent" evolved in case law dealing with medical -- and particularly surgical – practitioners and procedures, the same principles are deemed to apply to other health care professionals and other kinds of treatment.

Substance Use Services are committed to the voluntary participation of clients and to their right to have complete knowledge about what the proposed services involves, prior to their participation.

Adults who present to health authority Substance Use Services are considered to have granted implied consent for the purposes of seeking information and/or services pertaining to screening, assessment and referral.

However, in the process of creating a treatment plan, any health care professional has a duty to provide the person served with sufficient and specific information to enable him/her to make an informed choice as to whether or not to participate in the that plan. Consent is required to ensure that clients participating in substance use services understand the nature and consequences, and the reasonably foreseeable benefits and risks of participating in or refusing the treatment plan.

There must be documentation on the client file that this has been done, including the client's signature or a facsimile.

If a client refuses services, the service provider will document the discussion with the client that lead up to their refusal on the client's file.

Four essential requirements must be met for informed consent:

1. Information

The agency/program will provide a prospective client with sufficient information about the proposed treatment plan so s/he can make an informed decision as to whether or not to proceed. Information to assist the client in making an informed choice will normally include the following:

a) The nature of the services proposed, including the intended goals/objectives, expected benefits, difficulties people sometimes encounter and any costs associated with participation.
b) Any material and/or special risks involved. Material risks are those which would influence the client's consent to treatment because they carry grave consequences if they materialize. Special risks are described as "unusual or possible risks", which although considered highly unlikely, have the potential for serious consequences if they occur.
c) Any alternative services available and their intended goals/objectives, expected benefits, any material and special risks involved, difficulties sometimes encountered and any costs associated with participation.
d) What is expected of the individual and family members/friends if the client chooses to participate.
e) The scope and constraints of Confidentiality as outlined in the next section
f) Any other information that the person may reasonably need to enable him/her to make an informed choice.

2. Voluntariness

Consent must be given voluntarily. The fact of some external impetus for treatment (e.g. via a probation order) does not remove the ability or right of the client to give or refuse consent to participate in services. However, the implications of refusal to consent should be discussed with the client as part of the treatment planning process and documented in the client's file.

3. Specificity

Consent must be given to the specific types of activities involved in engaging with this service provider – not only what is generally available from the program.

4. Capacity

Agencies/programs providing substance use services will, as part of the normal assessment process, determine whether the client appears capable of making a decision about participating in the services available. An informal assessment of competency may include whether the prospective client:

- can repeat and explain the information given in his/her own words;
- is able to provide clear answers to questions regarding the treatments discussed;
- demonstrates an understanding of the consequences of consenting to or refusing treatment; and
- is able to ask pertinent questions that indicate an understanding of the proposed treatment(s) and possible outcomes.

If a client does not have the legal capacity to give informed consent, service providers will seek consent from a person who has legal status to give such consent on behalf of the client. Clients will not necessarily be denied service because they lack legal capacity to consent on their own behalf.

For a more specific discussion on consent with regards to youth, please see the CAP Supplementary Module on Youth.

CONFIDENTIALITY

Information that a client tells you about themselves, family members or other people – or even the fact that they are a client – cannot be shared with others without the permission of the client or by court order. Permission from the client should be in the form of a written consent, which specifies to whom the information can be released, what information can be released and what the time limits are. All confidentiality agreements must be reviewed at least annually.

There are a few exceptions to the rules of confidentiality, where information may be disclosed without the client's consent. It is important that these exceptions be explained to the client early so they can choose what information they wish to disclose. Exceptions to confidentiality include:

- When the counsellor or client has reason to believe that someone under the age of 19 years old currently needs protection from abuse or neglect.
- Client disclosing historical abuse that would indicate that the alleged abuser is still at large and may be in contact with children and youth and in a position to reoffend.
- Client expresses intention to harm himself/herself or someone else.
- Client appears unfit to operate a motor vehicle.
- Where there is a valid subpoena, court order, or search warrant.
- Statutes requiring disclosure:
    - Child, Family and Community Services Act
    - Freedom of Information and Protection of Privacy Act
    - Health Act Communicable Disease Regulation
    - Medical Practitioners Act
    - Workers Compensation Act
    - Motor Vehicle Act
    - Coroners Act

Professionalism and Boundaries

POWER DIFFERENTIALS IN THE HELPING RELATIONSHIP

The general assumptions that can be made about power differentials in any helping relationship between a practitioner and a client are:

- Clients enter a helping relationship trusting us to act on their behalf, simply by virtue of our role.
- The client enters the counselling relationship from a position of need.
- The client assumes the counsellor is the expert, so he/she will know what is best for the client.
- Every counselling relationship involves the process of transference and counter-transference.

All of these components interact to create disparity of power. The counsellor always has more power than the client.[iii]

BOUNDARY ISSUES

Continuum for professional boundary violations

Indifferent	***Careful differentiation***	***Fused***
· Under involvement · Neglect boundaries · Do not allow for appropriate connection	· Therapeutic Range · Boundary issues are resolved therapeutically · Boundaries allow for appropriate connection and separation	· Over involvement · Ignore boundaries · Too much connection

According to Nielsen: "Boundary problems can be defined as all of beliefs and behaviours exhibited by counsellors/ professional helpers that in some way move the client from client status while she/he maintains client vulnerability."[iv]

Professional boundary violations

Boundary violations can occur on different levels, with differing levels of negative impact on the client.[v]

Level One – Boundary issues are utilized to improve the counselling/helping relationship and to help the client meet their goals through positive resolution.

Level Two – Boundary Issues in effect immobilize the counsellor/ helper who is thus unable to utilize them toward therapeutic gain without outside consultation.

Level Three – Boundary violations include behaviour on the part of the counsellor/ helper that is therapeutically harmful to the client.

Level Four – Boundary violations occur in which the counsellor/ helper overtly exploits the client

Level Five – The counsellor/ helper rationalizes this exploitive behaviour and organizes his/ her life around it.

Counsellor vulnerabilities

At times, helpers can find themselves at risk of being drawn in too closely to a client and/or their situation.

Some areas that require watchfulness when thinking about violation of the Client's boundaries include:

- Obvious therapist distress or upset.
- Therapeutic drift – shifting style and approach to a given client.
- Lack of goals and reflection on progress in therapy.
- Therapy that exceeds normal length for a client of that type in the particular therapist's practice.
- Exceeding areas of competence, reluctance or unwillingness to refer for other services.
- Unwise techniques:
  - Routine hugs
  - Face-to-face, intimate hugs
  - Excessive touch
  - Sessions in non-traditional setting when this isn't necessary
  - Routine or common socializing with clients
  - Excessive self-disclosure by therapist
  - Direct intervention in client's life
- Becoming enmeshed in client's life – counselling close friends or family members.
- Unique vulnerabilities:
  - Attraction
  - Over-identification with client
  - Unique similar family dynamics
  - Divorce or loss in therapist's life
  - Identity disturbance in therapist

Excessive Self-Disclosure

Excessive self-disclosure is the most common boundary violation that precedes excessive intimacy with clients, and can involve:

- Disclosing current personal needs or problems.
- Disclosure as a common, rather than rare, event during sessions.
- Disclosing things not clearly connected to a client's problems or experiences, or not clearly things which would be likely to encourage or support the client.
- Self-disclosure not only frequent, but uses up more than a few minutes in a session.
- Self-disclosure occurs despite apparent client confusion or romanticization.[vi]

When Clients Challenge Boundaries

What the helper does is only one part of the equation of maintaining appropriate boundaries. Clients will also either uphold or challenge boundaries. They will do one or the other based on considerations such as:

- To keep important people responding to them (whether positively or negatively) the way they have done in the past.
- To adjust or establish a therapeutic distance that currently feels the most safe to them.
- To test and ensure that the boundaries they need to do their own healing are in place. For example, clients who survive incest may test providers by approaching them in a sexualized way.
- To mirror what they see as normal behaviour, influenced by the above factors plus peer norms and social norms.

Some ways in which clients challenge boundaries:

- Asking for your home phone number.
- Flirting with you or complimenting you.
- Asking for special favours.
- Offering personal favours to their counsellor.
- Talking negatively about another staff member.
- Asking for personal information about another staff member.
- Reading papers on your desk.
- Routinely arriving early for an appointment just to chat.
- Routinely asking for advice, e.g. "Just tell me what to do."

In order to develop and maintain a productive therapeutic alliance, it is essential to assess what needs the client is actually trying to meet through a boundary challenge. Though a client's initial reaction to a limit may be – for example, frustration and rejection – in the long term, the client is likely to feel safe and relieved.

Consider what happens when you forget to internalize the premise for a boundary. You're more likely to set a boundary with a rationale such as, "That's just the rule" or "My supervisor says so". Setting boundaries in such an indirect way can give a false impression: "If it weren't for this rule, I'd go ahead and do it." When you set a limit indirectly, clients may get confused. They may try to challenge another boundary to figure out where you stand. Remember, though the client may initiate the boundary transgression, it is always the provider's responsibility to set and uphold the appropriate boundary.

Boundary Transgressions Defy Categories

Sometimes we think of boundaries in terms of what areas they affect. These areas may include physical, emotional, psychological, or sexual factors. Consider the following examples.

Physical boundary transgressions

- A client comes into your office and picks up papers on your desk.
- You are meeting with a co-worker and a colleague opens the closed door, sits down, and begins talking about a crisis.
- Your supervisor hugs you without your permission after a negative performance review.

Emotional boundary transgressions

- A client shares her memories of sexual abuse with members of the support staff in a crowded waiting room.
- A staff member shares the gruesome details of her divorce during a staff meeting.
- A supervisor acts as therapist for a supervisee.

Psychological boundary transgressions

- A white client calls a black client a racist name.
- A staff member says, "Your present position – the way you're bending over – makes me think of my wild weekend. Let me tell you about it."
- A supervisor wants to know details about your clients' sex lives. Each time you try to discuss other relevant information, your supervisor steers the topic back to sex.

Although thinking in categories can be useful, remember that most transgressions fit into several categories. In the examples listed above, a physical or sexual boundary merges with a psychological or emotional boundary.

What is considered a boundary violation?

It must be acknowledged that boundaries and boundary violations can be much less clearly defined than it appears. In fact, there is considerable variability with the counselling field as to what is acceptable in some of the following areas:

- Accepting gifts
- Becoming friends or lovers with a client after termination of treatment
- Offering any self-disclosure or details of your personal stresses to a client
- Inviting clients to office or clinic open houses
- Going for a meal with a client after a session
- Inviting clients to your house, a personal party or social event
- Attending a client's personal party or social event
- Hugging or touching

What is your experience with this topic? You will find two Professionalism and Boundaries exercises at the end of this Module.

TRANSFERENCE AND COUNTERTRANSFERENCE

One of the ways in which boundary violations can occur in helping relationships – and at times be much less visible than others – are in the form of transference and countertransference. These have been seen by some clinical researchers as evidence of "symbolic relationship".

Symbolic Relationship – refers to the "way in which the therapist's (counsellor or professional helper's) own feelings, responses and reactions to a client as well as the manner in which they relate to, and with, that client are informed by context and personal life experiences in a continuous, interactive loop between internal and external realities."[vii]

Transference – refers to the process whereby clients project onto their therapist, counsellor or other professional support person past feelings, beliefs or attitudes they had, or have, towards people in their lives. Transference commonly originates from early childhood, and it constitutes a repetition of past conflicts.

Countertransference – manifests itself in many ways and presents an ethical issue because the counsellor or professional helper's work can be obstructed by countertransference reactions like the following:

- Being overprotective with clients.
- Treating clients in benign ways.
- Rejection of clients.
- The need for constant reinforcement and approval from clients.
- Therapists seeking themselves in their clients.
- Sexual or romantic feelings toward a client.
- Compulsively giving advice in counselling sessions.
- A desire to develop a social relationship with a client.

As with transference, countertransference often constitutes a repetition of past adaptive responses to important relationships, and that have nothing to do with the current client relationship.

Practitioner Self-Care: Managing Stress and Preventing Burnout

WHAT IS STRESS?

Stress is the normal result when a system, or person, has a demand placed on it – or is put in a situation - where known or usual means of coping cannot be used successfully.

Stress in itself is neither good nor bad. In fact, a reasonable amount of stress can be a motivator for positive change, for creativity, or for learning.

When a practitioner consistently experiences levels of stress that are beyond their ability to cope or to prevent, physical and emotional symptoms can arise. Persistent high levels of stress, where the symptoms are ongoing and serious, can result in what is known in the helping field as "burnout". It is important to note that often the people most susceptible to burnout are those who set high standards for their practice and have high expectations for client outcomes, but who are working in situations where those standards are impossible to meet for a variety of internal (personal) and/or external (systemic) reasons.

SOURCES OF STRESS

Universal stressors

In addition to high expectations of self, some situations which commonly produce excess stress for people are:

- Feeling out of control
- Feeling direction-less
- Guilt over procrastination or failing to keep commitments

- More commitments than time
- Changes not initiated or instituted by the person in question
- Uncertainty – shifting expectations or demands coming from the employer or others who affect daily work life. Lack of certainty about how one is performing or the degree to which one is valued.

Irrational beliefs that lead to stress

- I should always work at my peak level of enthusiasm and competence.
- I should be able to cope with any client emergency that arises.
- I should be able to help every client.
- When a client does not make progress it is my fault.
- I should not take time off work when I know a particular client needs me.
- I should be able to work with every client.
- I should be a model of mental health.
- I should be "on call" at all times.
- A client's needs always come before my own.
- I am the most important person in my client's life.
- I am responsible for my client's behaviour.
- I have the power to control my client's life.

Client behaviours related to counsellor stress

Researchers have studied what counsellors/ helpers have defined as the most stressful client behaviours. In a study by Farber these were the client behaviours that most commonly created stress among helpers[viii]:

- Suicidal statements
- Aggression and hostility
- Premature termination of therapy
- Agitated anxiety
- Apathy and depression

> ### *Vicarious traumatization*[ix]
> *Vicarious traumatization "refers to the cumulative transformative effect on the helper working with the survivors of traumatic life events". The impact of vicarious trauma occurs on a continuum and is influenced by a number of factors such as role and how much traumatic information a practitioner is exposed to, degree of support in the workplace, personal life support, and personal experiences of trauma.*
> *To address vicarious trauma, it is suggested to pay attention to three key areas, known as the ABC's:*
> - *Awareness of our needs, emotions and limits*
> - *Balance between our work, leisure time and rest*
> - *Connection to ourselves, to others and to something greater (e.g. spirituality) [40]*
>
> *Just as practitioners support those they are working with to stay in the present, ground and take care of themselves, practitioners also need to practice this approach. Grounding includes many strategies to help stay in the present, focus and connect to what is happening around you. These strategies could be used throughout the course of a day: as you prepare to meet with someone, when you conclude an assessment or session, as you get ready to finish your day and shift from professional role to personal life. You will know what works best for you.*

Other sources of stress

Other sources of stress cited:

- Being unable to help distressed clients feel better.
- Not liking clients.
- Having self-doubts about the value of counselling/ therapy.
- Having professional conflicts with colleagues.
- Feeling isolated from other professionals.
- Over identifying with clients and failing to balance empathy with appropriate professional distance.
- Being unable to leave client concerns behind when away from work.
- Feeling sexual attraction toward a client.
- Not receiving expressions of gratitude from clients.

MANAGING STRESS AND ITS SYMPTOMS

Some symptoms of excess stress[x]

It is important to be aware of some possible symptoms of excess stress in order to take action prior to their becoming more serious.

- Headaches
- Sleep disturbances
- Anxiety
- Anger
- Concentration problems
- Depression
- Lack of, or increased, appetite
- Run-down immune system, and increased susceptibility to colds and other infections

Effective stress control skills

- Clarifying your personal values, priorities and daily satisfiers.
- Being able to use personal relaxation techniques, such as meditation or relaxation breathing.
- Developing rewarding relationships.
- Having an understanding of change management in the workplace and being able to engage in problem-solving with colleagues and supervisory/management staff.
- Eating nutritious meals and snacks and drinking water.
- Exercise.
- Religious or spiritual practice.

BURNOUT PREVENTION

The Merriam-Webster's Collegiate Dictionary defines burnout as "exhaustion of physical or emotional strength or motivation usually as a result of prolonged stress or frustration."

Causes of Burnout

Farber and Heifetz[xi] found that therapists had the following perceptions of the causes of burnout:

- Lack of therapeutic success (73.7%)
- No reciprocated attentiveness; giving and responsibility demanded by the therapeutic relationship (54.7%)
- Overwork (22.2%)
- The general difficulty in dealing with the client's problems (20.4%)
- The tendency of therapeutic work to bring out their own personal conflicts (13%)
- The general passivity of counselling work (13%)

Counsellors/ helpers said that their own family problems lowered their threshold for the demanding work they do and impaired their ability to attend effectively to the needs of their clients.

Common signs of burnout[xii]

Negative emotions

It's normal to feel frustrated, angry, depressed, dissatisfied or anxious occasionally. But if you're caught in the burnout cycle, you usually will experience these negative emotions more and more often, until they become chronic. Eventually, you will feel emotional fatigue.

Interpersonal problems

When you feel emotionally drained, it becomes harder to deal with people at work and at home. When the inevitable conflicts arise, you're likely to overreact with an emotional outburst or intense hostility. This makes communicating with co-workers, friends and family members increasingly difficult. Some burnout victims are also apt to withdraw socially. The tendency to withdraw is most pronounced among "helping" professionals, who often become aloof and inaccessible to the very people they are expected to help.

Health problems

As your emotional reserves become depleted and the quality of your relationships deteriorate, your physical resilience declines. You may frequently experience minor ailments, such as colds, headaches, insomnia and backaches. In general, you feel tired and rundown.

Below-par performance

During the burnout process, you may become bored with your job or lose enthusiasm for your projects. Or you may find it difficult to concentrate. You become less productive and the quality of your work declines.

Excessive substance use for coping

To cope with the stress associated with job conflict and declining performance, you may find yourself drinking more alcohol, using more drugs, eating more (or less), drinking more coffee and/or smoking more cigarettes. Increased substance abuse further compounds your problems.

Feelings of meaninglessness

More and more, you find yourself thinking "so what" and "why bother?" This is particularly common among burnout victims who were once very enthusiastic and dedicated. Your enthusiasm is replaced by cynicism. Working seems pointless.

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Some exercises to help you identify if you are at risk of burnout are included at the end of this Module.

Tips for a less-stressed workday[xiii]

Alter your physical environment - Even if you only have a cubicle, you can control some aspects of your physical space by paying attention to lighting, air quality, and pleasing colours.

Reduce background or open-office noise - Eliminate distractions by wearing earplugs, listening to music on headphones, etc.

Cut down or quit using stimulants like caffeine (coffee, tea, carbonated beverages), sugar (chocolate, candies) and nicotine (cigarettes). These popular 'drugs' are addictive and increase stress levels. Drink water, breathe deeply to increase oxygen, eat a nutritious snack, exercise.

Complete an ergonomic assessment to assess things like the angle of your chair, position of your keyboard, or the type of seat cushion. These factors can contribute to stress and injuries.

Allow time for some fresh, unrecirculated air. If opening a window is not a possibility, take at least part of your break outdoors.

Take breaks or quick power naps to overcome the post-lunch slump and improve both mood and productivity.

Learn some desk exercises to relieve stiff muscles and improve circulation.

Reduce email overload by limiting the frequency and time you check and respond to e-mail using a good program.

Refresh your workplace time management skills and find those few extra minutes in the workday you never knew were there.

Don't go hungry. Skipping meals only leads to after-work binges and overdoses of fast food when your energy plummets. To deal with a stressful day, you've got to have fuel and energy. Keep yourself nourished and don't wait for the hunger pangs.

Exercise A - Professionalism and Boundaries

Read the examples below, placing yourself in the role of a provider. Note whether the professional is too close (TC), too distant (TD), or balancing distance appropriately (BD). Complete your answers, then discuss them with a partner.

****

1. You think about clients as cases to get through, as charts to "finish."
2. While eating lunch with colleagues in a full cafeteria, you talk about a client's emotional pain.
3. You speak with a client about your personal pain.
4. You ignore a therapeutic confrontation because you don't want the client to feel uncomfortable.
5. You ignore a therapeutic intervention because you have an agenda you always follow at this particular time.
6. You nod slightly when a client puts down your colleague.
7. A client says, "I'm not ready to look at my sexual abuse." You ignore this comment and keep pushing the client for memories of abuse.
8. You don't have time for clinical supervision this week because you're determined to finish your paperwork.
9. You don't have time for clinical supervision this week because a client needs a special one-to-one meeting.
10. You instruct a colleague to ignore a client's complaint: "That client is always whining. She's just a manipulator. I can't stand working with her."
11. You say to a client: "Your journey is just like mine. Let me tell you what helps when I'm feeling down."
12. You find yourself thinking: "Only I can help this client. This client has no one else to count on."
13. During a group session, you ignore an aside (giggling between two group members) while another client is talking.
14. An entire group session consists of conversation about old cars because a charismatic client just bought a 1962 Thunderbird.
15. Because a group session is going so well, you ignore the fact that it's 15 minutes past ending time, and you decide to go for a while longer. You do this without telling your group.
16. You are offering an educational component and ask the group if they mind staying an extra 20 to 30 minutes.
17. As a member of a Twelve Step group, you agree to sponsor an ex-client.
18. A client makes a racial slur and you ignore it.

List three of *your* behaviours that may signal when you are too distant from your client (under involved):

1. _____

2. _____

3. _____

List three *client* behaviours signaling that you may be too distant:

1. _____

2. _____

3. _____

List three of *your* behaviours that signal when you are too close to your client (overinvolved):

1. _____

2. _____

3. _____

List three *client* behaviours signalling that you may be too close (e.g. a seemingly unrelated burst of anger to a minor comment or request. Clients might use anger to push you away if you have crossed their previous boundaries and are in too close):

1. _____

2. _____

3. _____

Reminder: You are only human. None of us can balance boundaries perfectly every day. If we're human, we're inconsistent. There is a myth that a competent provider never breaches the therapeutic space and thus never commits boundary transgressions. Show us such a provider, and we'll show you a fictional character!

Competent providers are people who:

- receive routine clinical supervision and study their code of ethics.
- Accept the complexity of maintaining boundaries.
- Admit they have boundary dilemmas.
- Wrestle with these dilemmas and discuss them with colleagues.

Exercise B: Clues to Possible Boundary Problems

If boundaries are so fluid, then how do you know when there is a boundary concern? One answer is to create checklists of your own thoughts, feelings and behaviours – especially those that signal vulnerable boundaries. This checklist can tell you when it's time to pull out your process for making ethical decisions and talk to someone.

Consider the following list of behaviours. How do they relate to you? Do you see them as signals for potential boundary problems? Rate each item using this scale:

N= Never indicates a potential boundary problem

S= Sometimes indicates a potential boundary problem

A= Almost always indicates a potential boundary problem

_____ 1. I avoid a particular client or situation.

_____ 2. I find myself working harder than a client.

_____ 3. I'm lax about following through on my commitments at work.

_____ 4. I act in ways that undermine organizational rules, expectations and values.

_____ 5. I scrutinize my clothing on the days when I meet with a certain client.

_____ 6. I avoid clinical supervision. Or I attend but avoid discussing "that particular case".

_____ 7. I reverse roles, such as asking the client to be in charge or seeking emotional understanding from the client.

_____ 8. I give clients gifts or accept gifts that go beyond acceptable policy limits.

_____ 9. I hold one client accountable in a unique way, even when this is not part of the treatment plan (this includes special treatment in any form).

_____ 10. I take a client's feelings "home" with me.

_____ 11. I practice extended self-sharing with a client.

_____ 12. I talk more during a session than the client does.

_____ 13. I get more personal satisfaction from my work than from my life outside of work.

_____ 14. I continue the helping relationship with clients outside my unit or agency walls, even when doing so is not part of my job.

_____ 15. I seek personal friendships or sexual relationships with clients or ex-clients.

_____ 16. I stop attending conferences and seminars that challenge my methods of treatment.

Exercise C: How Do You Cope with Stress in your Life?

Follow the instructions for each of the 14 items listed below. When you have completed all of the items, total your points.

1. Give yourself 10 points if you feel you have a supportive family around you.
2. Give yourself 10 points if you actively pursue a hobby.
3. Give yourself 10 points if you belong to some social activity group that meets at least once a month (other than your family).
4. Give yourself 15 points if you are within five pounds of your "ideal" body weight, considering your height and bone structure.
5. Give yourself 15 points if you practice some form of "deep relaxation" at least three times a week. (Deep relaxation exercises include meditation, imagery, yoga, etc.)
6. Give yourself 5 points for each time you exercise 30 minutes or longer during the course of an average week
7. Give yourself 5 points for each nutritionally balanced and wholesome meal you consume during the course of an average day.
8. Give yourself 5 points if you do something you really enjoy which is "just for you" during the course of an average week.
9. Give yourself 10 points if you have some place in your home you can go to in order to relax and/or be by yourself.
10. Give yourself 10 points if you practice time management techniques in your daily life.
11. Subtract 10 points for each pack of cigarettes you consume during the course of an average day.
12. Subtract 5 points for each evening during the course of an average week that you take any form of medication or chemical substance (including alcohol) to help you sleep.
13. Subtract 10 points for each day during the course of an average week that you take any form of medication or chemical substance (including alcohol) to reduce your anxiety or just calm you down.
14. Subtract 5 points for each evening during the course of an average week that you bring work home with you, work that was meant to be done at your place of employment.

Now calculate your total score.

A "perfect" score would be 115 points. If you scored in the 50-60 range, you probably have an adequate collection of coping strategies for most common sources of stress. However, you should keeping mind that the higher your score, the greater your ability to cope with stress in an effective and healthful manner.

Source: This stress management test was created by Dr. George S. Everly Jr., University of Maryland and Loyola College of Maryland. Originally created for the US Department HEW.

Exercise D: Burnout Potential Inventory

How often do these situations bother you at work? Use the scale below to rate how often you are bothered by each situation described in the quiz. Then add up your points when you're done.

Rating Scale: (Rarely) 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 (Constantly)

Powerlessness

___ 1. I can't solve the problems assigned to me.

___ 2. I am trapped in my job with no options.

___ 3. I am unable to influence decisions that affect me.

___ 4. I may be laid off and there is nothing I can do.

No Information

___ 5. I am unclear about the responsibilities of my job.

___ 6. I don't have information I need to perform well.

___ 7. People I work with don't understand my role.

___ 8. I don't understand the purpose of my work.

Conflict

___ 9. I am caught in the middle.

___ 10. I must satisfy conflicting demands.

___ 11. I disagree with people at work.

___ 12. I must violate procedures to get my job done.

Poor Team Work

___ 13. Co-workers undermine me.

___ 14. Management displays favoritism.

___ 15. Office politics interfere with my doing my job.

___ 16. People compete instead of cooperate.

Overload

___ 17. My job interferes with my personal life.

___ 18. I have too much to do in too little time.

___ 19. I must work on my own time.

___ 20. My workload is overwhelming.

Boredom

___ 21. I have too little to do.

___ 22. I am overqualified for the work I actually do.

___ 23. My work is not challenging.

___ 24. The majority of my time is spent on routine tasks.

Poor Feedback

___ 25. I don't know what I am doing right or wrong.

___ 26. My supervisor doesn't give feedback on my work.

___ 27. I get information too late to act on it.

___ 28. I don't see the results of my work.

Punishment

___ 29. My supervisor is critical.

___ 30. Someone else gets credit for my work.

___ 31. My work is unappreciated.

___ 32. I get blamed for others' mistakes.

Alienation

___ 33. I am isolated from others.

___ 34. I am just a clog in the organizational wheel.

___ 35. I have little in common with people I work with.

___ 36. I avoid telling people where I work and what I do.

Ambiguity

___ 37. The rules are constantly changing.

___ 38. I don't know what is expected of me.

___ 39. There is no relationship between performance and success.

___ 40. Priorities I must meet are unclear.

Unrewarding

___ 41. My work is not satisfying.

___ 42. I have few real successes.

___ 43. My career progress is not what I'd hoped.

___ 44. I don't get respect.

Values Conflict

___ 45. I must compromise my values.

___ 46. People disapprove of what I do.

___ 47. I don't believe in the company.

___ 48. My heart is not in my work.

SCORING: Your Risk of Burnout

48 – 168 Low. Take preventive action.
169 – 312 Moderate. Develop a plan to correct problem areas.
313 – 432 High. Corrective action is vital.

[i] The section on an Ethical Decision-Making Framework is primarily taken directly from Vancouver Coastal Health's best practice document:
Anderson, T., B. Everett, R. Starzomski, J. Young. (2012). *Ethical Decision-Making Framework*. VCH Professional Practice Office. Vancouver Coastal Health Authority.

[ii] This and following section based on a presentation at the 2011 Conference of the Journal of Ethics in Mental Health: Zaleska, Beata. (2011). *Negotiating Risk Ethically.* [Power Point slides]. Coast Mental Health Ethics Committee. Retrieved December 2012 from **http://www.jemh.ca/conferences/2011/index.html**

[iii] Nielsen, Lindsay A. (1988). Substance Abuse, Shame and Professional Boundaries and Ethics: Disentangling the Issues. *Alcoholism Treatment Quarterly,* 4(2). New York: Hawthorne Press.

[iv] As above.

[v] Model developed by Nielsen, Peterson, Shapiro and Thompson for the Minnesota Task Force on Sexual Exploitation by Counsellors (1986). F*urther information not provided in CAP 2008.*

[vi] Exploitation Index, for clinicians to use in evaluating their own boundary maintenance:
Epstein, R. and R. Simon (1992). The exploitation index. *Bulletin of the Menninger Clinic*, 56, pages 1-21.

[vii] This section derived in large part from:
Brown, Laura S. (2001). Feelings in Context: Countertransference and the Real World in Feminist Theory. *Journal of Clinical Psychology. 57(8).*

[viii] Farber, B.A. and L.J. Heifetz. (1982). The process and dimensions of burnout in psychotherapists. *Professional Psychology,* 13 (2), 293-301.

[ix] This section from Poole, Nancy and Diane Smylie. (2013) *Trauma-informed Practice Guide for BC (in draft at time of writing CAP update).* Vancouver, BC: BC Centre for Excellence in Women's Health.

[x] This and next two sections are taken from:
Addiction Prevention Services. (n.d.). Health Tips for Managing Stress Contributing to Mental Health and Addiction Concerns in the Workplace. Mental Health and Addiction Services, Vancouver Island Health Authority.

[xi] As above.

[xii] Reproduced by permission from Dr. Beverly Potter. Source:
Potter, B. (2005). *Overcoming Job Burnout: How to Renew Enthusiasm for Work.* Oakland, CA: Ronin Publishing.

[xiii] Adapted from Melissa C. Stoppler, MD – Canadian Institute of Stress

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WEB-BASED RESOURCES FOR ONGOING LEARNING

2Spirits re Aboriginal LGBT resources (Ont.)	http://www.2spirits.com/
BC Medical Association re improving substance use treatment in BC	https://www.bcma.org/files/Addiction_Stepping_Forward.pdf
BC Medical Association re Problem Drinking Guidelines	http://www.bcguidelines.ca/pdf/problem_drinking.pdf
BC Ministry of Children and Family Development re FASD	http://www.mcf.gov.bc.ca/fasd/index.htm
BC Ministry of Health, Mental Health and Substance Use Services. Publications and best practice guides	http://www.health.gov.bc.ca/mhd/
BC Ministry of Health re Harm Reduction	http://www.health.gov.bc.ca/cdms/harmreduction.html
BC Ministry of Health re residential treatment standards – youth and adult	http://www.health.gov.bc.ca/library/publications/year/2011/adult-residential-treatment-standards.pdf http://www.health.gov.bc.ca/library/publications/year/2011/youth-residential-treatment-standards.pdf
BC Partners for Mental Health and Addictions Information	http://www.heretohelp.bc.ca
BC Society of Transition Houses re substance use, mental health and women who experience violence	http://www.bcsth.ca/content/reducing-barriers-support-women-who-experience-violence
BC's Ten-Year Plan to Address Mental Health and Substance Use	http://www.health.gov.bc.ca/healthy-minds/
Best Start re alcohol and pregnancy	http://www.beststart.org/resources/alc_reduction/index.html
Canadian Alcohol and Other Drug Use Monitoring Survey (CADUMS)	http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/cadums-esccad-eng.php
Canadian Centre on Substance Abuse	http:// www.ccsa.ca
Canadian Centre on Substance Abuse re Concurrent Disorders	http:// www.ccsa.ca/Eng/KnowledgeCentre/OurPublications/ConcurrentDisorders
Canadian Centre on Substance Abuse re Low-Risk Drinking Guidelines	http://www.ccsa.ca/Eng/Priorities/Alcohol/Canada-Low-Risk-Alcohol-Drinking-Guidelines

Canadian Centre on Substance Abuse re Student Survey	http://www.ccsa.ca/Eng/KnowledgeCentre/OurPublications/Research
Canadian Mental Health Association re understanding mental illness	http://www.cmha.ca/mental-health/understanding-mental-illness/
Canadian Network of Substance Abuse and Allied Professionals	http://www.cnsaap.ca/Pages/index.aspx
Canadian Pain Society	http://www.canadianpainsociety.ca
Centre for Addiction and Mental Health (Ontario)	http://www.camhx.ca/Publications/Resources_for_Professionals
Centre for Addiction and Mental Health (Ontario) re trauma tx.	http://knowledgex.camh.net/amhspecialists/specialized_treatment/trauma_treatment/first_stage_trauma
Centre for Addiction and Mental Health (Ontario) re LGBTTQ	https://knowledgex.camh.net/amhspecialists/Screening_Assessment/assessment/ARQ2/Pages/arq2_question_a4.aspx
Centre for Addiction and Mental Health (Ontario) re stigma	http://knowledgex.camh.net/ke_workspace/oih/mha_capla/chile2011/Shared%20Documents/Componente%20Presencial/Stigma%20-%20Estigma/CAMH%202005%20Beyond%20the%20Label%20Toolkit.pdf
Centre for Addictions Research of BC	http://www.carbc.ca
Centre for Addictions Research of BC re Alcohol and Other Drug Monitoring Project	http://carbc.ca/FactsStats.aspx
Centre for Addictions Research of BC re Low-Risk Alcohol Drinking Guidelines	http://www.carbc.ca/HelpingCommunities/ToolsResources/LowRiskDrinkingGuidelines.aspx
Coalescing on Women and Substance Use	http://www.coalescing-vc.org
Coalescing on Women and Substance Use re Trauma-informed Online Tool	http://www.coalescing-vc.org/virtualLearning/documents/trauma-informed-online-tool.pdf
College of Family Physicians of Canada re Alcohol Screening, Brief Intervention and Referral	http://www.sbir-diba.ca/
Community Head Injury Resource Services (Ont.)	http://www.chirs.com/resource_links.html
Domestic Violence BC	http://www.domesticviolencebc.ca/

Duncan, Barry re Client-directed Outcome-informed Treatment	http://heartandsoulofchange.com/
Fraser Health re Early Psychosis Intervention Program	http://www.psychosissucks.ca/
Harm Reduction International	http://www.ihra.net/what-is-harm-reduction
Health Canada re Substance Abuse Prevention and Treatment Publications	http://www.hc-sc.gc.ca/hc-ps/pubs/adp-apd/
Health Canada re CADUMS	http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2011/summary-sommaire-eng.php
Health Canada re FASD Initiative	http://www.phac-aspc.gc.ca/hp-ps/dca-dea/prog-ini/fasd-etcaf/index-eng.php.
HealthLinkBC re Harm Reduction	http://www.healthlinkbc.ca/healthfiles/hfile102a.stm
BC Partners for Mental Health and Addiction re fact sheets and public information	http://www.heretohelp.bc.ca/publications/factsheets
McCreary Centre Society re Adolescent Health Surveys	http://www.mcs.bc.ca
Miller, Scott D. re Feedback-informed treatment:	http://scottdmiller.com/
Miller, William re Motivational Interviewing	http://www.motivationalinterview.net/
National Clearinghouse on Family Violence	http://www.phac-aspc.gc.ca/ncfv-cnivf/index-eng.php
National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs in Canada	http://www.nationalframework-cadrenational.ca/
Pain BC re Chronic pain	http://www.painbc.ca/
Substance Abuse and Mental Health Services Administration/ Centre for Substance Abuse Treatment – US (SAMHSA/CSAT) Treatment Improvement Protocol (TIP) Series	http://www.ncbi.nlm.nih.gov/books/NBK82999/
SAMHSA's National Registry of Evidence-Based Practices	http://www.nrepp.samhsa.gov/