INTEGRATING ADDICTION AND MENTAL HEALTH SERVICES IN ALBERTA

By

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ABSTRACT

Most people who experience co-occurring addiction and mental health addiction problems do not have access to an integrated treatment service that addresses both issues simultaneously and effectively. Coordinated efforts to enhance the capacity of these two distinct systems to provide integrated treatment for concurrent addiction and mental health issues are more feasible within the new organizational structure of Alberta Health Services, undertaken in 2009. This emerging area of practice can significantly improve service outcomes for Albertans who simultaneously experience co-occurring issues.

Part 1 of this paper begins by defining concurrent disorders and integrated treatment. Policies in place in the former Alberta Alcohol and Drug Abuse Commission (AADAC) and one health authority are described, focusing on their clinical procedures for treatment of addiction and mental health issues, along with the national and provincial contexts in which Minister Liepert’s announcement occurred. A summary of the best practice literature for the treatment of concurrent disorders is examined, along with an analysis of how best clinical practices fit with current practices in treatment. Where gaps exist, a process for facilitating change is suggested. This analysis reveals many potential strategies to improve services for those who concurrent disorder services while also identifying significant gaps. Part 2 of this project explores the way an effective, evidence-based system of service delivery might evolve, considering where we are and where we need to go. For effective, system-wide change to occur policy, funding, program, clinical, client and family barriers must be addressed. The transition to a new organizational structure in health services in Alberta provides an important opportunity to do just that.

Keywords: mental health, mental illness, concurrent disorders, integrated treatment, addiction
PART 1: WHERE WE ARE AND WHAT WE KNOW

Introduction

In Alberta addiction and mental health services have historically been offered by two distinct organizations with separate funding, administrative and policy structures. In May 2008, Ron Liepert, then Minister of Health made an announcement that the Alberta government planned to establish a new health system governance model. The members of Alberta’s nine regional health authority boards, the Alberta Cancer Board, the Alberta Alcohol and Drug Abuse Commission and the Alberta Mental Health Board have been replaced by a single provincial health services board effective May 15, 2008 (Liepert, 2008).

Addiction and Mental Health Services, officially formed in April 2009, now has the mandate to provide these services within the newly created organizational structure of Alberta Health Services. Health information, prevention, health promotion, and treatment services for those with addiction or mental health issues continue to be provided in much the same way, from the client’s perspective, two years into the process, despite significant organizational and administrative changes. The impact of these administrative changes does not directly impact client experience, although from the perspective of staff, work life, beyond interaction with clients is very different.

Research suggests system and service integration initiated by this process is necessary and cannot happen quickly enough. The Canadian Centre on Substance Abuse, an organization supportive of a shift to an integrated service model, indicates that up to half of people who deal with substance abuse also have a mental illness. Despite the high prevalence of concurrent disorders, many of clients access one type of service but not the other, and rarely an integrated service.

While the two conditions often share common biological, psychological and social antecedents that are not easily dissociated, those people with concurrent disorders are infrequently treated using an integrated and unified approach for the two disorders. (Canadian Centre on Substance Abuse, 2009). It is this gap in services that the integration of addiction and mental health services is intended to close.
Alberta government ministers heard about the need for a different service delivery model, when, in October 2008 the Auditor General recommended that the newly formed “Alberta Health Services strengthen integrated treatment for clients with severe concurrent disorders (mental health issues combined with addiction issues)” (Government of Alberta, 2008, p. 162). Government ministers received the following response:

Alberta Health Services’ responsibility for the Alberta Alcohol and Drug Abuse Commission and the Alberta Mental Health Board has enhanced the opportunity to integrate services for these clients. Alberta Health Services will further develop best practices based on the good models that already exist within the service delivery system. (Government of Alberta, 2008, p. 162).

Coordinated efforts to enhance the capacity of these two distinct systems to provide integrated treatment for concurrent addiction and mental health issues are more feasible in a new organizational structure and there is more opportunity to achieve meaningful change. This emerging area of practice can significantly improve service outcomes for Albertans who simultaneously experience co-occurring issues. Organizational restructuring on such a massive scale provides a rare opportunity to leverage staff and other stakeholders to rethink beliefs about addiction and mental health and the systems that provide treatment services.

Part 1 of this paper begins by defining concurrent disorders and integrated treatment, concepts with variable meanings in the literature. Policies in place in the former Alberta Alcohol and Drug Abuse Commission (AADAC) and one health authority are described, focusing on their clinical procedures for treatment of addiction and mental health issues, along with the national and provincial contexts in which Minister Liepert’s announcement occurred. A summary of the best practice literature for the treatment of concurrent disorders is examined, along with an analysis of how best clinical practices fit with current practices in treatment. Where gaps exist, a process for facilitating change is suggested. This analysis reveals many potential strategies to improve services for those who concurrent disorder services while also identifying significant gaps. Part 2 of this project explores the way an effective,
evidence-based system of service delivery might evolve, considering where we are and where we need to go.

Definitions

*Concurrent Disorders* refers to “any combination of mental health and substance use disorders” (Health Canada, 2002, p. 10). Because there are a large number of mental health issues and types of substances to which one may become addicted, there are many potential combinations represented within this definition. This reality of concurrent disorders makes the development of integrated treatment challenging, since there are many combinations of substances and mental health issues, with variable symptoms. The diverse potential presentation highlights the need for thorough, ongoing assessment to ensure treatment is tailored to the complex needs present in individual situations.

*Substance use disorders* “include both substance abuse and substance dependence, and can also refer separately to many different psychoactive drugs, including alcohol” (Health Canada, 2002, p. 10). Stimulants, depressants and hallucinogens, three broad categories of substances, each create very different physiological and emotional responses, and interact with mental health issues in a variety of ways, including various types of psychoses.

*Integrated Treatment* occurs at two levels: program and system. Although many different definitions exist, within this paper, those used by Health Canada are explored. *Program integration* is present when:

- mental health treatments and substance abuse treatments are brought together by the same clinicians/support workers, or team of clinicians/support workers, in the same program, to ensure that the individual receives a consistent explanation of illness/problems and a coherent prescription for treatment rather than a contradictory set of messages from different providers (Health Canada, 2002, p. vii).

*Service integration* is present when:

- the development of enduring linkages between service providers or treatment units within a system, or across multiple systems, to facilitate the provision of service to individuals at the local level. Mental health treatment and substance abuse treatment are, therefore, brought together by two or more clinicians/support workers working for different treatment units or service providers. Various
coordination and collaborative arrangements are used to develop and implement an integrated treatment plan (Health Canada, 2002, p. vii).

Ideally, both levels of integration are achieved, creating a seamless, accessible treatment service system for those who require assistance in managing addiction and mental health issues simultaneously.

**Former Aspen Regional Health Authority’s Approach to Mental Health Treatment**

Community mental health services in Alberta were offered through nine regional health authorities until April 2009 when this responsibility was transferred to Alberta Health Services. Because Addiction and Mental Health Services has not yet provided policies and procedures for mental health outpatient treatment services, this paper examines the principles that guide clinical work for staff of the former Aspen Regional Health Authority (RHA). This rural-based RHA provided health services from Cold Lake to Jasper, along the Highway 16 corridor in central Alberta, not including the City of Edmonton and covers three of the four communities that I am now responsible for (Edson, Hinton and Jasper).

Community mental health clinics serve as a first point of contact for people with questions or concerns regarding mental health and offer a variety of services including:

- **Consultation:** staff provide information, education and referral information regarding mental health prevention, promotion and treatment services;

- **Children’s Mental Health Services:** Specialized services for clients under the age of 18 years may be provided by a dedicated children’s therapist, a generalist therapist who provides services to people of all ages or through a partnership agreement such as Student Health Initiative Program (SHIP);

- **Adult Short-Term Therapy** provides therapeutic services to adults 18 years and older who have a mental illness diagnosis but are not likely to require services for more than six months. Stability and skill development are offered to resolve the presenting problem(s);

- **Adult Long-Term Therapy** is provided to individuals with severe, persistent mental illness to enhance their functioning and ability to live in the community;

- **Geriatric Mental Health Services** are provided when individuals over the age of 65 have complex medical and geriatric issues. In some communities, home and institutional assessment and consultation are provided, and a geriatric specialist works collaboratively with other service providers;

- **Psychiatrist Consultation:** On a once or twice per month, visiting basis, psychiatrists provide consultation to assist with diagnosis, treatment and ongoing case management of children, adults and seniors;
Telepsychiatry is an alternate way to provide client access to a psychiatrist via videoconferencing. Resources to provide these services are available in healthcare centres in the three communities I work with (Aspen Regional Health Authority, 2005, summarized from pp. 13-14).

Risk assessment is an essential component of assessing client safety, during a first contact, and on an ongoing basis. This is done by “asking specific and pointed questions related to the probability of harm to self and others” (Aspen Regional Health Authority, 2005, p. 23). Assessment tools used by the clinicians vary, based on the respective therapist’s discretion and preference. Where it is determined there is high or imminent risk, assessment by a doctor or psychiatrist is required. When a client is unwilling to access this service, law enforcement personnel may become involved to transport him/her to a hospital for a more thorough assessment and/or observation.

When eligibility for mental health treatment is determined through the intake process, the first task for the therapist is to “elicit written informed consent from the client” (Aspen Regional Health Authority, 2005, p. 24). This involves a description of the process of therapy, the client’s rights, and potential risks and/or benefits of treatment, as well as an opportunity for the client to ask questions.

A Mental Health Assessment is completed by the assigned therapist, using a standard structured interview format covering the following areas: identifying information (age, gender, marital status, occupation and ethnic origin when clinically relevant); presenting problem; history and present functioning including psychiatric and medical history, psychosocial and developmental history, present social functioning, spiritual well-being; mental status and functional inquiry; risk assessment; formulation, “a concise analysis of the client’s problems from the therapist’s point of view”; an initial diagnosis; and a treatment plan which “shall specify the treatment goal(s), the modality and who is to be involved in the treatment” (Aspen Regional Health Authority, 2005, p. 30). The mental health assessment process does not include a formal screening for addiction issues, although this information may be disclosed when exploring current functioning.
Based on the client’s description of symptoms, the therapist’s observations and information gathered from other sources, the therapist arrives at a preliminary diagnosis using the most current edition of DSM (Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association), using the five designated Axis. The written assessment included on the client file clearly articulates the symptoms present that support the diagnosis or diagnoses (summarized from Aspen Regional Health Authority, 2005, p. 31). To complete the assessment process the therapist and client negotiate the treatment approach to be followed, including a discussion about estimated length of treatment. “This [treatment planning process] should be driven by the presenting problem, diagnosis and by clearly delineated client and therapist goals” in order to ensure the treatment provided assists the client in addressing his/her presenting concerns effectively (Aspen Regional Health Authority, 2005, p. 31).

The specific psychotherapy used in a client’s treatment is based upon a therapist’s clinical training and background rather than being prescribed by organizational policy. There is an expectation that “the methods and the modality of treatment employed be mainstream, such as cognitive, cognitive behavioural, supportive, psycho-educational and solution-focused (Aspen Regional Health Authority, 2005, p. 32). The use of other modalities must be approved by the clinical lead of the therapist and the modality must be evidence based.

A clinical resource available to clinical staff and clients is the consulting psychiatrist, for “a one-time patient consultation or assessment...ongoing, regular follow-up such as for medication management and symptom stabilization ... [or] one-on-one professional case consultation to [clinical] staff about clients” (Aspen Regional Health Authority, 2005, p. 35). In rural areas, psychiatric services are provided on a contract basis one to two days per month, or through the use of a telepsychiatry, a private videoconference available by appointment with a psychiatrist in another community. This alternative is available seven days per week and is often used to assist clients who cannot wait until the visiting
psychiatrist is back in the community. It is also used by physicians wishing to consult with a psychiatrist about managing symptoms or medications.

All therapists are required to be registered with their professional licensing body, to provide services within their scope of practice and to comply with the Code of Ethics outlined by that body. The licensing bodies include the Alberta College of Social Workers, The Alberta College of Psychologists, the College of Registered Psychiatric Nurses Association of Alberta and Alberta Association of Registered Nurses.

**Former AADAC’s Clinical Approach to Substance Abuse Treatment**

Within the organization formerly known as the Alberta Alcohol and Drug Abuse Commission (AADAC), people presenting with a wide variety of substance use problems, ranging from misuse to addiction, request services. The trans-theoretical model of change (Prochaska, DiClemente, & Norcross, 1992) and the process of motivational interviewing (Miller & Rollnick, 1991) are used extensively to engage clients, regardless of their motivation to change, and to determine the most appropriate level of service and kind of therapeutic intervention. Addiction counsellors are trained to use a bio-psychosocial approach to assessment and treatment planning with clients. This approach “identifies biological, personal (or psychological) and social (or environmental) factors with immediate or more distant influence on substance use and other addictive behaviours, and examines the interaction between these factors (Harrison & Carver, 1997 as cited in Alberta Alcohol and Drug Abuse Commission, 2007, p. 1). This is contrast to mental health therapists who use a medical model of diagnosis and treatment.

A client-centred approach to treatment planning and long-term recovery is supported by this holistic approach to understanding client needs and strengths. Individuals and family members interested in their own recovery or supporting their loved one’s recovery, are encouraged to explore ways to develop skills to support the accomplishment of treatment goals. “There is also benefit in examining the relationship between addiction and the broader determinants of health (for example, ethnicity, early childhood development, education, income and social status)” as these may contribute to the issues
and/or impact recovery (Alberta Alcohol and Drug Abuse Commission, 2007, p. 1). For example, living in chronic poverty creates many barriers to accessing medical or social supports to achieve and maintain a healthy lifestyle. Poverty may also contribute to financial or emotional (dis)stress from which one chooses to escape by using substances.

For clients who are dependent on alcohol or other drugs, the goal of abstinence is promoted as most appropriate, although signs of positive change in a client’s life also provide an equally important measure of treatment success. Within AADAC change is viewed as a process, rather than an event and there may be many steps in the treatment journey. To support this reality, “AADAC recognizes that harm reduction strategies have an important place in the continuum of interventions... A harm reduction approach can engage clients who are unwilling or unable to achieve abstinence, and help them to improve their health, safety and functioning in major life areas” (Alberta Alcohol and Drug Abuse Commission, 2007, p. 2). Engagement and hope, built on small successes, create the foundation for further movement towards a healthier lifestyle and, hopefully in time, abstinence.

The long-term goal of all treatment services is “to assist people to manage their lives without relying on alcohol, other drugs or gambling” (Alberta Alcohol and Drug Abuse Commission, 2007, p. 2). This is accomplished with a focus on the following aims:

1. Increase clients’ understanding of the role alcohol, other drugs and gambling play in their lives and develop clients’ commitment to change.
2. Enhance clients’ ability to function well without using alcohol or other drugs or participating in gambling activities.
3. Improve clients’ family and social relationships, as these relate to recovery.

Regardless of the type of service requested, respect for the client is essential in developing an important therapeutic tool: the relationship between the counsellor and the individual requesting services. Each client is entitled to receive confidential services, free of charge, as outlined in the (former) Alcohol and Drug Abuse Act and now in the Health Information Act. Motivation and the
potential for success are enhanced through a process of treatment planning that builds on the partnership developed between a client and those who provide services (Brown, Dongier, & Graves, 2005 as cited in Alberta Alcohol and Drug Abuse Commission, 2007, p. 2). Ensuring treatment goals are the client’s creates a focus on his/her primary concerns and enables that individual to determine priority areas on which to work. Tension between the client’s goals and the expectations of a referral source (the courts or Child and Family Services) is often present. Because the services provided are voluntary, the goals and motivation of the client dictate the treatment plan and goals, following a frank discussion about the potential implications of alternatives available.

To ensure treatment is effective for all clients, a continuum of services is needed to meet a wide range of needs, including crisis intervention and detoxification (where required), engagement of the client, comprehensive and ongoing assessment, treatment planning, therapeutic intervention, aftercare planning, and evaluation of progress toward treatment goals. Each level of service must be accessible to those who need it, must be integrated within the substance abuse and other community treatment services available locally and provincially and must be sustainable. Addiction services are only one of many resources and addiction counsellors are expected to case manage their files, consult with other community and professional resources and make appropriate referrals.

The treatment process is based on a comprehensive and ongoing individual assessment that allows treatment goals to be matched to stated need(s). Addiction counsellors throughout the province use the same assessment tool. “It recognizes the complexity of the individual and addresses clients’ alcohol, other drug and gambling problems specifically, while also focusing on improving other aspects of their lives” (Alberta Alcohol and Drug Abuse Commission, 2007, p. 2). A significant percentage of people who present for addiction treatment also have a co-existing mental health issue, and vice versa. In these situations more comprehensive treatment may be required and “effective treatment is
provided though a co-ordinated system where treatment providers emphasize engagement with the client” (Health Canada, 2001a as cited in Alberta Alcohol and Drug Abuse Commission, 2007, p. 3).

Treatment services offered must be “grounded in theory, goal-oriented and responsive to client needs” (Alberta Alcohol and Drug Abuse Commission, 2007, p. 3). The treatment modality chosen is based on each client’s motivation and stage of change. Health Canada cites “evidence that people exposed to some types of treatment will benefit by reducing their consumption of alcohol or drugs or participation in gambling activities and show improvements in other major life areas” (Health Canada, 1999 as cited in Alberta Alcohol and Drug Abuse Commission, 2007, p. 3).

To access addiction services in rural communities a person must contact an outpatient office to make an appointment with an addictions counsellor. During the first appointment demographic, referral and substance use information are provided by the client through the completion of several forms. Following this, an intake assessment interview is undertaken, gathering the following information: reason(s) for accessing services, preliminary goals, substances used, patterns of use, positive and negative impact of use in major life areas (physical health, emotional health, family relationships, social life, employment and/or school, finances, legal, spiritual and leisure), screening for mental health issues, a client’s perception of the problem(s) and his/her readiness for change. Based on this information, a discussion about potential treatment alternatives (outpatient; addressing medical needs; detoxification; short-term, long-term or concurrent disorder residential; referral to other services including mental health) occurs and a treatment plan is developed. Referrals are made, as agreed upon in the session, and may include written applications for residential treatment programs or community resources that enable a client to access supports for finances, seeking employment, medical needs, social supports, self-help and/or parenting. Follow-up is negotiated based on a client’s willingness to engage in ongoing outpatient treatment.
Because people are part of social systems and these systems influence success, substance abuse treatment may include family members and significant others when it is appropriate to include these individuals. Having family involvement is especially important with youth clients, when this is possible. When involvement is not possible, youth are still invited to participate in treatment (Health Canada, 2001c as cited in Alberta Alcohol and Drug Abuse Commission, 2007, p. 3). Information about addiction is offered to family members, along with brief treatment that enables them to “improve their ability to function in a relationship affected by substance abuse or problem gambling and to support the client’s recovery” (Alberta Alcohol and Drug Abuse Commission, 2007, p. 3). This may include information about communication strategies; setting healthy emotional, financial and social boundaries with a person who is actively using, either daily in or in a binge cycle; the need for self-care and/or the change process and how to enhance motivation, rather than entrench someone in his/her current unhealthy patterns.

In keeping with Health Canada recommendations, any pregnant woman who is using alcohol or other drugs who requests substance abuse treatment is provided with priority access to this treatment, both in the community and in residential settings (Health Canada, 2001b as cited in Alberta Alcohol and Drug Abuse Commission, 2007, p. 3). Priority access means an outpatient appointment is provided within a day or two and admittance to residential treatment occurs with a week to ten days of first contact with the treatment facility.

To facilitate positive treatment outcomes, and regardless of the treatment approach used, counsellor characteristics such as “strong interpersonal skills and ...the ability to forge a therapeutic alliance with clients” are key to engaging clients and fostering successful change (Health Canada, 1999 as cited in Alberta Alcohol and Drug Abuse Commission, 2007, p. 3). Evidence-based treatment practices used in (former) AADAC service settings include:

- Motivational interviewing “a treatment approach with enduring effects...[that] is a directive, client-centred method for enhancing intrinsic motivation to change by exploring and resolving
ambivalence” (Brown, Dongier, & Graves, 2005; Miller & Rollnick, 2002 as cited in Alberta Alcohol and Drug Abuse Commission, 2007, p. 3).

- Cognitive behavioural therapies such as relapse prevention, marital therapy and stress management training to “help clients to focus on the dynamics of addiction and to develop specific skills to deal with a wide variety of personal and interpersonal problems” (Brown, Dongier, & Graves, 2005; Miller & Rollnick, 2002 as cited in Alberta Alcohol and Drug Abuse Commission, 2007, p. 3).

- Brief interventions of up to eight outpatient counselling sessions provide effective treatment those “with low to moderate dependence who are socially stable and attending outpatient counselling. More severely dependent clients with complex problems require longer treatment” (Brown, Dongier, & Graves, 2005; Health Canada, 1999 as cited in Alberta Alcohol and Drug Abuse Commission, 2007, p. 3).

- Group treatment is used for skill development, support and psycho-education, recognizing that this method of treatment delivery may be contraindicated by unique client needs (Health Canada, 1999 as cited in Alberta Alcohol and Drug Abuse Commission, 2007, p. 4).

- It is critical that integrated treatment services are provided for clients with concurrent disorders for ensure clients “achieve the best possible outcome. Strategies such as case management and consultation, cross-training and shared consent forms enhance collaboration between service providers” (AADAC, 2005; Health Canada, 2001a as cited in Alberta Alcohol and Drug Abuse Commission, 2007, p. 4).

- Methadone maintenance is recommended by Health Canada as an effective treatment for opioid dependence. “Treatment effectiveness is enhanced when methadone is delivered in conjunction with counselling and ancillary health and social support services. Treatment of co-existing addictions is provided while the client is maintained on methadone” (Alberta Alcohol and Drug Abuse Commission, 2007, p. 4).

In the absence of updated clinical processes and procedures these guidelines continue to the context for services delivered in Addiction Services offices. While this complement of services is effective for some of the clients served, I go on to argue accessible concurrent disorder treatment services are needed to assist those who are challenged by co-occurring moderate to severe addiction and mental health issues.

The Context

On both the federal and provincial levels there is a growing recognition that the traditional methods of providing treatment for addiction and mental health issues are not as effective as they might be. In this section of the paper a summary of some recent, influential documents released in Canada is provided.
A National Perspective

Toward recovery and well-being: A framework for a mental health strategy for Canada provides a vision of a transformed mental health care system in which “all people have the opportunity to achieve the best possible mental health and well-being” (Mental Health Commission of Canada, 2009, p. 13). While the document acknowledges the challenges of coping with concurrent disorders for individuals, their families and communities, it is silent about how the systems to treat and support people might be enhanced.

The National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada, released in 2005 makes several observations about concurrent disorders. First, there is a much that is not known about concurrent disorders in Canada as the Canadian Addiction Survey, last completed in 2004, did not include these issues as part of its research (Drug Strategy and Controlled Substances Programme, 2005, p. 5). Second, “treatment for those with concurrent disorders may currently be inadequate or non-existent, even in large urban centers” (Drug Strategy and Controlled Substances Programme, 2005, p. 20). This inadequacy in concurrent treatment continues to occur despite the fact there is research that confirms that providing a variety of treatment options for harmful substance is cost-effective. To realize fiscal savings it is necessary to provide the level of care, ranging from information to residential services, at the time it is needed.

If these [addiction] services and programs could be better integrated within the ... mental health... systems, then a healthier Canada would result. With integration, many more Canadians would be able to access suitable treatment options (Drug Strategy and Controlled Substances Programme, 2005, p. 19).

Better education for policy makers, service providers and the public regarding concurrent disorders is recommended as a first step in the process of moving the important issue of integrated treatment for concurrent disorders forward. Enhanced knowledge results in a better understanding of needs and strengths of those requesting concurrent disorders services (Drug Strategy and Controlled Substances Programme, 2005, p. 19).
This knowledge that simultaneous treatment of concurrent disorders is effective needs to be translated in useful actions.

*A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy*, released in 2008, proposes a National Treatment Strategy. A comprehensive system of services to provide a continuum of support from prevention to intensive intervention is articulated, recognizing that people in different stages of substance use and/or mental illness require different levels of services.

There are five tiers in National Treatment Strategy model, with each tier “representing logical groupings of services and supports...that offer similar levels of access or eligibility, that address problems of similar severity, and that are of similar intensity and specialization” (National Treatment Strategy Working Group, 2008, p. 13).

Each tier is designed to address broad goals that provide a full continuum of services when delivered simultaneously. In tier 1 the focus is on enhancing existing networks of supports for individuals, families and communities, to ensure the foundation for a healthy population is developed and/or sustained through information services, health promotion and prevention programmes and projects. Wide-ranging eligibility criteria ensure as many people as possible have access to these opportunities to enhance well-being. A wellness fair, showcasing recreation, non-credit learning opportunities and sporting activities is an example of a tier 1 service.

Activity in tier 2 focuses on ensuring the early identification of problems occurs, and that linkages to services that provide early intervention to address these needs prior to the development of more serious issues are made. Screening, brief intervention and referral all occur in this tier. Routine screening for substance use in pregnant women is an example of a tier 2 service.

In tier 3 programming is intended to engage people who are experiencing substance use problems and who are at risk of secondary harms such as victimization or exposure to HIV. Examples of activities in
this tier include outpatient counselling, withdrawal management, outreach in partnership with other sectors (e.g., housing), and supervised injection sites.

More intensive, specialized services for people with substance use problems occur in tier 4. For example, intensive day programs for those in early recovery and intensive outreach services to provide medical services provide the level of support needed by those who present with multiple problems that require support from more than one tier or sector, such as housing, employment, or mental health. Service coordination and collaboration by service provide providers ensures people who are too ill to advocate for themselves find the right service regardless of where the first request for service is made. Residential treatment programs are an example of tier 4 services.

Tier 5 provides supports and services for people with highly acute, chronic and complex substance use and other problems for which lower-tier services and supports are inadequate. For example, long-term residential programs where clients stay for six months to two years while learning life skills and receiving support to transition into more independent living offers the level of support sometimes required to develop stability and maintain recovery (summarized from Canadian Centre on Substance Abuse, 2009).

The National Treatment Strategy is built upon eight guiding concepts that inform its approach. First, there is no wrong door, meaning someone can request services in any tier and be linked to those supports and services which address his/her needs and concerns. Second, services and supports are accessible and available within a reasonable distance and travel time and within a reasonable wait time. Third, services and supports offered and provided are matched to the individual’s needs and strengths. Fourth, when more than one option would meet an individual’s needs, the individual may select the one he/she wishes. Fifth, movement between the tiers is normal and necessary, to ensure the individual’s changing needs are met over time. Sixth, treatment offered is responsive and ultimately helps individual move to lower tiers where services are less intrusive. Seventh, there is collaboration between all levels of supports and services to ensure quality treatment is provided and to facilitate smooth transitions.
between the levels. Finally, services are coordinated to allow for easy sharing of information between
the systems in the continuum (paraphrased from Canadian Centre on Substance Abuse, 2009).

The tiered model articulated in the National Treatment Strategy is not currently in use in Alberta, although within the Addiction and Mental Health program, services are being mapped within the framework, to assess where there adequate levels of services available and where gaps exist. This process informs decision makers about areas where innovative projects to guide future direction are needed.

A Provincial Perspective

Prior to former Health Minister Liepert’s 2008 announcement about restructuring Alberta’s health system, work was already underway to support closer working relationships between the addiction and mental health fields, within existing structures. For example, in 2004 the Provincial Mental Health Plan for Alberta articulated the need to increase “service delivery system capacity to respond to the needs of people who have concurrent disorders” (Alberta Alcohol and Drug Abuse Commission, 2006, p. 3). At that time the Alberta Alcohol and Drug Abuse Commission (AADAC) provided leadership in a collaborative working group made up of AADAC and health region representatives as well as other key stakeholders. This work resulted in a provincial framework for service, Building capacity—a framework for serving Albertans affected by addiction and mental health issues. This document “outlines a seamless system of care that emphasizes collaboration amongst service providers...in which addiction and mental health service providers have a shared responsibility for flexible and cohesive service to clients who have concurrent disorders” (Alberta Alcohol and Drug Abuse Commission, 2006, p. 3). In this model, each staff member, regardless of position, training or employer is expected to cultivate a “fundamental level of ‘concurrent disorder capability’ for providing service” to people who present with concurrent disorders” (Alberta Alcohol and Drug Abuse Commission, 2006, p. 3). To support the attainment of this expectation, professional development opportunities to build this capability were
offered by the former AADAC’s Learning Unit. Transition activities included the dismantling of this unit and so learning opportunities are no longer available consistently to former AADAC staff. There was no equivalent course in the mental health system.

Vision 2020 outlines an Alberta government vision of healthcare to be strived for over the next decade and “sets the course for a health system that is first and foremost geared toward the needs of the patient” (Alberta Health and Wellness, 2008, p. 2, emphasis in original) by identifying five strategic goals to address these needs. Three of the five goals have actions that are directly relevant to the provision of addiction and mental health services, including treatment for concurrent disorders and are discussed further below.

Goal one, providing the right service in the right place and at the right time, identifies a required action as: “Address the need for more mental health and addictions services in non-hospital facilities and community settings” (Alberta Health and Wellness, 2008, p. 8). Some recent actions undertaken in the province to achieve this goal include:

- The Mental Health Amendment Act allows earlier intervention for individuals with mental illness by changing the criteria used to determine when someone can be committed to institutional care. It also allows service providers to negotiate and request a Community Treatment Order that clearly outlines the conditions someone with severe, chronic mental illness must follow in order to remain in the community. This helps individuals receive a higher level of support in the community, rather than having them remain in an institution. It also assists service providers in facilitating compliance with treatment in the community.
- As part of Alberta’s Safe Communities initiative, 20 new addiction recovery residential treatment beds were announced and opened for young adults who have mental health and substance abuse issues to help keep them out of the justice system.
- The Government of Alberta announced $50.5 million to improve equitable access to children’s mental health services across the province and to address the mental health needs of children and youth at risk between 2009 and 2011.
- Each initiative is an attempt to reduce risk, to build individual and community capacity to address needs and to enhance support and treatment for those with mental health problems (adapted from Alberta Health and Wellness, 2008, p. 6).

In theory the goal of providing the right service at the right time appears reasonable. However, in rural and remote areas of the province access to services continues to be different than in urban communities. Difficulty recruiting and retaining qualified professionals is a persistent challenge since
many people are unwilling to accept access to less professional development opportunities or work in isolation. This reality contributes to inequitable staffing levels and degree of expertise in rural and urban areas. To date, strategies to address the needs of Albertans in rural and remote areas are not entirely successful. Additionally, changes to the Mental Health Amendment Act state a client cannot be released back into a community unless there are adequate supports available there to support him/her there. Since January 2010, when the legislation took effect, the vast majority of clients are released to urban communities that have appropriate support services available and none are presently in communities north of Edmonton.

Goal four, improving co-ordination and delivery of care, includes two actions specific to addiction and mental health services: “Prioritize improvements in service co-ordination starting with...mental health and addictions, including the use of technology to monitor wait times [and] Address unique service gaps for mental health, addictions and seniors’ care” (Alberta Health and Wellness, 2008, p. 14). Unfortunately, current technology used across the province does not meet this expectation of improved co-ordination and delivery of care. Each former health region and AADAC has a unique information technology system and these systems are incompatible with one another. As well, no system has the capacity to meet the diverse needs of Addiction and Mental Health Services. Although work is underway to create a province-wide system, the human, technological and financial resources to accomplish this goal are not available to complete this project quickly.

It is hoped service gaps are identified through the tier mapping process currently underway. Once a better understanding of the gaps exists, planning to fill these gaps can occur. Organizational commitment is required to ensure this process results in the development and implementation of services which span all of the tiers to provide an effective continuum of services.

Goal five is building a strong foundation for public health with recognition that “[t]he healthy mental development of infants, children and youth cannot be overstated. Families, schools, communities and
government share the responsibility to ensure that infants, children and youth have access to the resources that promote optimal mental health and well-being” throughout their early and school years (Alberta Health and Wellness, 2008, p. 15). The blueprint for building a strong foundation for healthy child development is supported through the Children’s Mental Health Plan for Alberta: Three Year Action Plan (2008-2011). Resources attached to this initiative are intended to increase mental health services in schools and communities, reduce risk factors for special populations, and implement early intervention strategies for children and youth at risk (Alberta Health and Wellness, 2008, p. 16). New services are being developed by community driven, school based Mental Health Capacity Building projects and innovative ways to support staff in rural areas are being piloted, using the expertise available in some urban agencies. In a situation that defies logic, the professional development resources required to train mental health therapists to work with infants, children and youth are not readily available to support this goal. This means that in theory all mental health therapists are able to work with children, but in reality many have not been trained in play therapy, the preferred treatment modality for working with children who are non-verbal or developmentally unable to benefit from talk therapy. Hopefully this changes soon. The preceding section provides a brief summary of what federal and provincial organizations recognize provides the best outcomes in the treatment and prevention of concurrent disorders. These documents are intended to assist political and health leaders create a more effective system in which to provide necessary services. Unfortunately, despite Alberta’s wealth, barriers to achieving these ideals remain. No clear vision of what a made in Alberta concurrent disorder treatment system is, inadequate human and financial resources, a lack of professional development opportunities for clinical and support staff, along with the an increasingly urban service delivery model applied to rural and remote service delivery sites all contribute to a less than ideal system. The next section of the paper considers what research indicates is needed to treat and support those who live with concurrent disorders.
**Best Practices Research**

This section of the paper summarizes key findings of Health Canada’s research into ways to enhance and support recovery for people who experience concurrent addiction and mental health issues. There are exciting findings in this recent research, including descriptions of practices that occur in other provinces and countries that could inform how effective treatment services are delivered in Alberta. Fifteen Health Canada recommendations are presented, followed by a discussion of how these recommendations are either being implemented or are lacking within Addiction and Mental Health Services systems. It is clear there are many areas for development.

**Health Canada Recommendations**

At a systems level, Health Canada provides fifteen useful recommendations about ways to enhance the services provided to people who require concurrent disorder treatment. First, when a client presents for treatment, regardless of the setting, screening for concurrent disorders is recommended, followed by comprehensive diagnostic assessment for those who flag for any addiction or mental health issues. To implement this recommendation fully, clinical staff working in hospitals, outpatient clinics and community settings screens everyone who presents for treatment for both addiction and mental health issues. Practically, this is expectation is unrealistic and challenging, given the volume of people seen in many clinics and offices.

Presently all new clients requesting Addiction Services are screened for mental health issues using a 20 question evidence-based interview tool. When potential issues are identified, these are explored further to determine the need for referral to Mental Health Services for a more in-depth assessment.

Unfortunately, mental health therapists do not consistently screen for addictions, nor does the mental health program provide a tool or training to encourage the practice of screening for the presence of concurrent addiction issues.
Outpatient clinics for both programs complete an assessment focussed on their area of expertise and refer to the other program, as needs are identified. Obviously improved screening for mental health clients is required. A potential solution to this issue is the development and implementation of a screening tool that is consistently used by addiction counsellors, mental health therapists, physicians and nurses in both inpatient and community settings. Many opportunities to discuss addiction and mental health issues with people are missed because the service provider does not ask questions which probe these areas.

The second Health Canada recommendation encourages all service providers to approach mental health and substance use issues candidly and honestly. Like the National Treatment Strategy, Health Canada also suggests no door is the wrong door. Rather than automatically referring to addiction or mental health services for specialized treatment options, Health Canada suggests it is essential that engagement and support be provided in all services settings. A welcoming environment in which trust is built and a service delivery system that accepts the person where they are at, and provides respectful service with the amount of program or system integration the individual is comfortable with at that time all contribute to achievement of treatment goals (paraphrased from Health Canada, 2002, p. 75). Successful implementation of this recommendation requires the attitudes and expectations of service providers be modified. Informal feedback from clients indicates they do not presently perceive all services settings as non-stigmatizing and trustworthy.

Perhaps because of the lead role taken in implementing the Building capacity—A framework for serving Albertans affected by addiction and mental health issues, at this time it appears the former AADAC has developed more openness towards collaborative practice, in part because this method fits better with a bio-psychosocial model of treatment than the medically based model practiced by many mental health therapists, doctors and nurses. An important step in the process of enhancing collaborative practice is the development of and implementation of one screening tool for both the addiction and mental health
programs. This common tool creates opportunity for discussion with staff members about the importance of collaborative practice, while simultaneously providing a method by which to accomplish this recommendation. This step is in process within Alberta Health Services, although no date for beginning its use is known.

The third recommendation is to reduce wait times and “[improve]... access to information about what services and supports are available in the community” (Health Canada, 2002, p. 75). Part of meeting a client where he/she is at, involves being available when the desire to make changes is present. Since most people do not seek out information about treatment services unless it is needed, ensuring it can be easily found is essential. Areas in which improvements might be made include ensuring allied professionals are aware of the services available and that contact information for clinics is displayed in public places (i.e.: in waiting rooms, on public bulletin boards and in local newspapers).

The average wait time for an appointment with a mental health therapist in the communities that I am most familiar with is three to four weeks, while for an addictions counsellor, the wait is one to five working days. The wait to see an adult psychiatrist is four to six weeks, while to see a child psychiatrist, the wait is expected to be six to eight weeks. Although when compared to urban clinics, these times are relatively short, continuing to find ways to reduce these wait times is essential in improving treatment outcomes. Reducing wait times provides opportunity to engage clients when they are most receptive to receiving service: at the time of their initial contact. Because the communities that I work in are small and rural staff members generally have an excellent working knowledge of the other support services available, allowing them to make appropriate prompt referrals at the time of first contact and as new issues are identified.

Health Canada’s fourth recommendation is to create more effective connections between services to improve coordination and ensure there are smooth transitions between various services. In addition, finding ways to improve the continuity of the caregiver enhances client trust and the likelihood there is
complete disclosure about the kind and severity of substance use and mental health problems. This
coordinated service system regards assessment as an ongoing process, responsive to evolving needs,
Presently, in the communities I manage, when a client requests addiction services, he/she is assigned to
a counsellor at the time an appointment is requested. Unless there is conflict of interest or the client
wishes to see someone else, he/she continues to work with that counsellor to receive outpatient
services the screening, assessment and treatment processes. Where referrals to other levels of service
are needed, the counsellor facilitates that process to ensure transitions occur as smoothly as possible.
The process of accessing mental health services is more varied. In some offices this assignment of client
to counsellor occurs based on which counsellor is assigned to do intake that day, while other offices
have an intake therapist who assigns the case to a casework therapist once the screening in completed.
This second process requires someone to repeat their story at least twice. When referrals are made to
other levels of service within Alberta Health Services and the community, as needs arise, potentially
requiring more service providers to become involved. Developing processes which are welcoming and
support clients from the time they request services is vital since many clients report that repeating their
story to more than one person does feel unsupportive.

The fifth Health Canada recommendation acknowledges that people with concurrent disorders often
have significant psychosocial needs, in addition to addiction and mental health issues. For example,
substandard housing, unreliable or non-existent childcare options and a lack of affordable, accessible
transportation make it difficult to access treatment or support for any issue. Community outreach
services are necessary to provide support for individuals to effectively address these needs (paraphrased

Health Canada encourages a holistic approach to treatment and recovery in this recommendation. It
is essential to ensure support and treatment for concurrent disorders is provided, along with access to
appropriate housing, reliable childcare and a stable, adequate source of income to build potential for success. Unfortunately, few tangible supports exist to ensure these varied needs are addressed consistently and adequately. Problem solving with a client about addiction or mental health issues is not likely to be successful if the basic resources to resolve these challenges independently are not available. When someone is hungry or has no place to sleep tonight, relapse prevention or information about an AA meeting is not a high priority.

Addressing these complex social needs requires a multi-sectoral approach. For example, meeting housing needs is beyond the mandate and expertise of most addiction and mental health agencies. However, input from these agencies, as well as other community partners, can move this agenda forward constructively. Other resources such as additional staff time with individual clients, outside of a clinical setting are also needed to address child care and transportation issues.

Health Canada’s sixth recommendation also presents challenges to implement. It suggests “better training of mental health professionals in substance abuse and of substance abuse professionals in mental health [is required]. The family physician can also play a key role in helping the person navigate the local network of services and needs to be well informed and trained to do so” (Health Canada, 2002, p. 75). In a system that uses specialists, this recommendation encourages a generalist approach. Unfortunately, cross training does not often occur. In recent years, the former AADAC developed a concurrent disorders course for staff that attempted to begin to bridge this gap. Unfortunately, with the transition to Alberta Health Services the former AADAC’s learning unit was dismantled and this course is no longer available. There is no equivalent in place in the mental health structure, in the past or present. Increasing the skill and knowledge of all staff who work directly with clients (including the administrative assistants) is necessary and represents an important area for development.

The seventh Health Canada recommendation is to ensure service planning and delivery for concurrent disorders involve people who experience addiction and mental health issues, and their
family members (Health Canada, 2002, p. 84). Seeking out and using input from recipients of services and their family members provides insight about how these services are experienced and inform how service delivery evolves.

There is presently no system in place to solicit this input from clients and/or former clients, although Alberta Health Services is in the process of creating regional Health Advisory Committees. Part of the role of these new committees is to seek input from community members generally, but it is not clear that those who seek/sought addiction and/or mental health services are specifically asked for feedback and recommendations. For this consultation process to be meaningful and to inform frontline work, purposeful action is required to ask the right questions, to gather feedback and then to implement changes based on the issues identified.

The eighth recommendation identifies the need to synthesize information from research findings and learning from within the organization into evolving practices, and to develop a mechanism that allows innovative solutions and lessons learned to be shared with those who might benefit (paraphrased from Health Canada, 2002, p. 84). Unless there is a way to share information about lessons learned or to apply research findings to clinical practice regularly and consistently, the findings are meaningless.

Nationally, the Canadian Centre on Substance Abuse fulfills some of this collaborative sharing role through its website and professional development opportunities. There is no parallel process locally or provincially. Challenges to implementing this recommendation include the vast size of Canada and difficulty reaching practitioners in rural/remote areas. As well, the effort required to remain current is sizeable. Effort and commitment required to share learning(s) with colleagues is even more substantial.

In the past fiscal year Alberta Health Services made an internally controversial decision that severely restricted organizational support, in the form of paid work time and expenses, for all staff attendance at most conferences and training events as a way to manage budget issues. This one decision contributed to the growing gap between what is known and what is practiced in Alberta. Providing opportunities for
practitioners to share and learn is an essential part of ensuring staff skill and knowledge remain current. Ensuring this happens consistently requires loosening the purse strings so that managers have the ability to encourage staff to develop or maintain competencies in key areas. Fortunately, some authority is back in the hands of managers, due to a directive issued in late June.

“A healthy mix of top-down commitment from funders, senior administrators and Executive Directors and bottom-up exploration of linkages by front-line staff based on individual cases,” the ninth Health Canada recommendation, seems ideal but is certainly not the reality in Alberta (Health Canada, 2002, p. 85). As was discussed earlier in this paper, Minister Liepert made the announcement that changes to the provincial health system would occur without consulting any stakeholders involved. Currently, work to create a synthesis of the Addiction and Mental Health system is occurring at the vice-president level and above, as well as within a specialized provincial unit, with minimal input solicited from front-line staff or stakeholders about clinical issues or how to manage an ill-planned transition. As well, there is little communication about the vision of how integrated services are to be delivered or short term goals that will move the organization in a positive, constructive direction, from the perspective of clients and staff. These gaps in understanding create difficult working conditions for front-line staff members, who develop their own interpretations of what it means to be integrated. Time will tell whether these are in line with the corporate vision.

A tenth recommendation is not presently being implemented, although in some communities the structures are in place to begin effective interagency work. The recommendation is to develop “a joint inter-agency planning committee... to start the local system integration process with reasonable goals and time frames in order to maximize the chance of success and build motivation to continue the change process” (Health Canada, 2002, p. 85). Many communities do not have the resources to provide “a dedicated resource person” who helps to sustain focus and enthusiasm for the process of evolving the system, despite recognition that these resources would alleviate system pressures and save money.
in the long term (Health Canada, 2002, p. 85). The complex process of cross-sectoral integration is a lofty, but attainable goal that “must be seen as evolutionary, non-linear and requiring time and patience,” as well as expertise, leadership and resources, both human and financial (Health Canada, 2002, p. 85). The political and organizational motivation to move this agenda forward appears to be lacking at the present time.

The eleventh recommendation is used extensively by mental health services providers in the area I manage, although this is not the case in all areas of Alberta. It identifies the “need for clinical case consultation, including a potential role for telepsychiatry to program and system integration in rural and remote areas” (Health Canada, 2002, p. 85). Using videoconferences to consult with a psychiatrist on complex cases enhances service in rural areas. When clients have access to this resource, it reduces wait times and provides opportunity for those without the ability to travel to larger centres to be seen more quickly and more regularly. Feedback from clients is generally positive, although the process of communicating between the psychiatrist and the community team (physician, therapist) requires improvement. Enhancing access to include referrals from addiction counsellors is a key to improving integrated service.

The twelfth Health Canada recommendation articulates the need for shared data systems. The former AADAC does have a provincial system that is user friendly and able to provide useful reports. All front-line staff, supervisors and managers have access to this system. Unfortunately, the mental health system does not have a provincial method to collect data, nor is there a linked system between the two programs. Additionally, there are no links between the interventions provided by doctors, psychiatrists and other medical staff. While this is recognized as an area for action, no concrete plans to develop an integrated system or to integrate the existing systems have been announced.

“Widespread adoption of blended service delivery teams such as the Assertive Community Treatment teams which include a substance abuse counsellor” (Health Canada, 2002, p. 85) fill a
significant gap in services for people with severe, persistent mental illness who may have difficulty functioning in the community. Assertive Outreach workers provide social support, life skills coaching, advocacy, problem solving support and local transportation to clients referred by a mental health therapist. Assertive Outreach services are available in some parts of Alberta for those with mental health issues only but are not provided by team and so do not include a substance abuse counsellor. Assertive Outreach positions in smaller communities are usually part-time, creating some challenges for clients who require more intensive supports.

Presently, a central intake model for clients who require information or outpatient treatment does not exist, although in its fourteenth recommendation Health Canada correctly states there “is ...value in developing improved access models, including basic information about services and supports that are available, which span substance abuse and mental health” (Health Canada, 2002, p. 85). Given the central organization of these two programs there is potential for this type of process to evolve, particularly in those communities considering co-location of addiction and mental health services.

With some success in Alberta, the fifteenth Health Canada recommendation was implemented in 2006. Funding for demonstration projects that allowed communities to develop services or programs to meet the needs of residents with concurrent disorders was provided (Health Canada, 2002, p. 85). Upon evaluation, “the concurrent disorders demonstration projects identified a number of positive strategies that have been taken and can be taken to provide meaningful and supportive services to Albertans affected by addictions and mental health issues,” suggesting these types of projects have the potential to enhance the lives of those living with concurrent disorders, as well as working relationships between service providers (Alberta Alcohol and Drug Abuse Commission, 2006, p. 19). It is important that these projects be supported to grow and evolve over time.

Health Canada’s fifteen recommendations provide many insights into how an effective concurrent disorder treatment system might be structured and into the types of supports and services this client
group benefits from. Despite the fact eight years have passed since the report was released, the
discussion of current practices in Addiction and Mental Health Services in Alberta illuminates the fact
many gaps remain. Informed leadership, a commitment to excellence and adequate human and
financial resources are needed to make the systemic changes required to resolve longstanding issues in
the treatment of concurrent addiction and mental health issues.

Case Management

In the previous section systemic issues were considered, using Health Canada’s recommendations as
the foundation for a provincial system for concurrent disorder treatment. While change is certainly
necessary at this level, it is also important to consider how programs are structured and managed as a
way to deliver effective treatment and prevention programs for individuals and communities. While the
content of those programs varies to meet unique needs there are over-arching principals which must be
considered and implemented to ensure services offered promote successful recovery.

At a program level, clinical case management is “the core service delivery intervention” for clients
with concurrent issues (Alberta Alcohol and Drug Abuse Commission, 2006, p. 6). Specifically, this
involves six key activities:

1. **Assessment**: gathering information about circumstances, problems, needs and goals;
2. **Planning**: identifying activities that further the achievement of the client’s goals, promote
   problem solving, meet needs; identify who will do what;
3. **Implementation**: may involve linking to services, providing services and recommending services
   on behalf of the client;
4. **Monitoring**: ongoing regular contact with the client;
5. **Evaluation**: assessing the effectiveness of the plan and activities based on achieving the goals
6. **Involvement**: staying involved with the client in a helping relationship while acknowledging the
   parameters of that relationship and the client’s wishes and needs and agency mandate (Alberta
   Alcohol and Drug Abuse Commission, 2006, p. 5).

A case management model enables all facets of treatment to be co-ordinated at the same time as
clinical services are provided. This is significant from the perspective of the client, who does not
differentiate between an addiction and a mental health problem. This approach encourages the case
manager to be focused on the needs of client, rather than the needs of the organization(s). Researchers
also note that “because more clinical services are provided directly, the chances of clients not receiving critical services because of poor follow-through on referrals [is] minimized—an especially important concern” (Alberta Alcohol and Drug Abuse Commission, 2006, p. 6). Clinical case management requires the use of generalists, who have the ability to provide support in many areas, rather than specialists who focus on just one issue.

In addition to case management, research shows that screening and assessment for concurrent disorders, individual counselling for substance abuse, and group counselling for substance abuse are other components of an effective continuum of services for people with both addiction and mental health issues. A coordinated approach to case managed, client centred treatment services must support the client, in that individual’s home community. Representatives from a variety of sectors including health care providers (physicians, addiction counsellors, mental health therapists, nutritionists, and others), the education system, self-help and advocacy groups, the judicial system, services for children and families, spiritual resources and supportive housing resources must work collaboratively with the client and his/her natural supports of family and friends (Alberta Alcohol and Drug Abuse Commission, 2005, p. 19). Recognition of the need for each client to access services in a way that acknowledges his/her unique needs and competencies is essential. One service provider may be involved, or there may be a seamless service provided by several professionals and/or lay people. A client may access services at any point along this continuum, and move between the domains as his/her needs change. Clients may enter through services other than addiction or mental health since involvement with service providers is driven by client needs. Multiple service providers are not always needed, since “this would be neither clinically, programmatically nor financially feasible” (Alberta Alcohol and Drug Abuse Commission, 2005, p. 20). Instead each clinician, in the context of his/her role and organization provides services which incorporate the needs of clients with a concurrent disorder. This requires building capacity within all organizations through staff and volunteer training, strategic hiring to bring cross-
trained staff to the organization, consultation and collaboration with other service providers to deliver concurrent disorder capable service, and/or mentoring through clinical supervision or job shadowing” (paraphrased from Alberta Alcohol and Drug Abuse Commission, 2005, p. 20).

Potential benefits of this approach include the ability to “reduce the redundancy in interactions and transactions” and a focus on “a person-centred approach in which the client brings his or her personal strengths and is surrounded by a variety of formal and informal supports [that] wrap... around the person in a way that complements his or her strengths” (Alberta Alcohol and Drug Abuse Commission, 2005, p. 21). As well, the client has access to the type of service required (lay support groups, detoxification, outpatient services, group treatment, short or long term residential, hospital and/or specialized services), regardless of age or location. The goal is to create synergy between the collaborating agencies and community resources, creating a sense of shared responsibility and ownership that is focussed on helping the client achieve success through a “model of shared caring” for individuals and their families (Alberta Alcohol and Drug Abuse Commission, 2005, p. 21).

Potential challenges to successfully implementing this type of model include creation of policies to support this level of collaboration and a culture that enables meaningful “sharing of clinical information, the commitment required of service partners, and the need for an infusion of resources to achieve this model of shared caring...all partners... need to prioritize and commit their energy, their time and their resources” (Alberta Alcohol and Drug Abuse Commission, 2005, p. 21).

Within the context of a case management system that uses a holistic view of a client and his/her needs, it is clear changes to treatment service delivery models are needed. Shifting the focus from clinical expertise to human need requires purposeful effort. Fortunately, there are good models and research to guide these efforts. Part 2 of this paper examines how this process of the integration, at the system and program levels, might unfold to achieve effective treatment of concurrent disorders.
PART 2: WHERE WE NEED TO GO

Introduction

While there is an enormous amount of information about how to provide excellent services to the concurrent disorder population, there are many barriers that require attention in order for an effective, evidence-based delivery system for the treatment of concurrent disorders to evolve, in the context of Alberta Health Services, Addiction and Mental Health Services. Most important is the need for this evolution to become a political and organizational priority that translates into adequate research, human, technical and financial resources that are required to ensure successful implementation of concurrent disorder treatment services. It is not enough to know what the challenges are and what the productive possibilities (like Health Canada’s recommendations) for sound treatment are. It is essential that useful action be taken.

In Alberta’s current climate of economic downturn and fiscal restraint, understanding the needs of this complex, heterogeneous client population becomes more urgent as the chronic issues with which these clients present with may be viewed as an unnecessary drain on already limited resources. Recent estimates suggest that “in established market economies such as Canada and the US, mental health disorders account for 43% of disability and 22% of the total burden of disease (the sum of premature death and years lived with disability),” providing ample financial and humanitarian incentive to create a system of care that works (Canadian Centre on Substance Abuse, 2009, p. 7). Unfortunately, “while rates of professional care for mental health disorders and substance use disorders have increased over the past 30 years; unmet need for care still remains a significant public health concern” (Canadian Centre on Substance Abuse, 2009, p. 7). To complicate matters further, “current research is telling us that ...poly-substance use is exceedingly common—perhaps making it the rule and not the exception” (Canadian Centre on Substance Abuse, 2009, p. 7). Clearly public policy and treatment services must
adapt to these changes and challenges, and political and financial resources must be dedicated to the implementation of policy and treatment.

Understanding the complex needs of people with chronic addiction(s), co-occurring mental health problems and the accompanying physical health problems, marginalization, trauma and homelessness that are associated with the lifestyles of people with concurrent disorders is a daunting, but necessary step in facilitating change. A shift in the way we think about addiction and mental health treatment, along with innovative approaches to service delivery to enhance access and retention in treatment are essential to ensure the available resources are used effectively. Single model of care, a primary disease and treatment approach, presumes that when the mental health issue is addressed, the substance use diminishes. Personal and professional experience, along with credible research tells us that for the majority of clients, this is not the case. Self-medication as an explanation for addiction when a mental health issue is present is too simplistic and ignores the biological and neurological nature of addiction. As well, “there is a growing consensus...that sequential treatment (treatment from one provider, then treatment from another) or parallel treatment (treatment by two different providers at the same time) has been a failure with people who have a co-occurring problem with mental illness and substance abuse” (Clement et al. 1993 ad cited in Cherry, 2008, p. 410). Changes are needed to the philosophical underpinnings of the current fragmented, unresponsive and compartmentalized system. It is not acceptable that “treatment programs often exclude either those with substance use or mental health disorders—despite the disorders being closely connected” (Canadian Centre on Substance Abuse, 2009, p. 8). Insisting that someone address their addiction issue(s) before mental health treatment can begin (or vice versa) creates unnecessary barriers and a cycle of failure for those who live this reality; and, indeed from a pragmatic fiscal efficiency perspective, the repetitive failures of a system that does not simultaneously address concurrent disorders wastes already limited resources allocated to treatment.
An evolving approach to addressing the treatment failures and frustration of both practitioners and clients dealing with concurrent disorders is integrated treatment, “based on concomitant treatment, using the concept of treatment stages in treatment planning, and employing interventions derived from the fields of mental health and substance abuse” (Cherry, 2008, p. 410). This shift in beliefs and treatment approach enables people who are viewed as treatment resistant by both fields to receive effective treatment, tailored to address the unique needs that are present when addition and mental health issues co-exist. The transition of nine regional health authorities, the Alberta Mental Health Board, the Alberta Cancer Board and the Alberta Alcohol and Drug Abuse Commission, currently underway in Alberta Health Services, provides opportunity to nurture a major transformation in how addiction, mental health and concurrent disorder treatment are viewed and delivered.

In part two of this paper I argue there is promising research that challenges many assumptions about outpatient, community-based treatment for people who have concurrent disorders. Creating an effective treatment system requires that these ineffective ideas and systems be replaced with practices and policies that support, rather than further marginalize, vulnerable people in our society. This support of people with concurrent disorders is possible through the development and implementation of an integrated treatment system that “involve[s] members of treatment team working together to cover both mental health and substance use disorders within a single treatment location, episode, record, and experience” (McGovern M., 2008, p. 15). Additionally, “biological, social, and cultural factors, as well as the influence of other co-occurring psychiatric disorders, must now be key features to models...of the relapse to substance use and its prevention” (McGovern, Wrisley, & Drake, 2005, p. 1272). In this section, I specifically address how leadership, along with system and program level changes can be used to create an effective treatment system. With political and organizational will, it is possible for Alberta Health Services to constructively influence the development and implementation of a continuum of
services that purposefully address the unique needs of concurrent disorder clients, in philosophy and program structure.

**Leadership**

Rising to the daunting task of providing leadership to shape a responsive concurrent disorder treatment system from the remnants of former AADAC and RHA systems first requires a re-thinking of what leadership is and how leadership becomes action. It is essential to prevent the sense “the leadership challenge is so important and its magnitude so daunting that there is no way we can act upon it; or whatever action we can take is insignificant as to have no appreciable impact on resolving the issues...Who among us want to risk failing at something so important?” (McGill & Slocum, 1998, p. 42).

Although the issues to be addressed are complex, and responses must consider multiple, competing organizational interests, as well as staff, client and stakeholder needs, it is essential to cultivate a vision of leadership that is “a balance between managing up and managing down” and encourages staff at all levels to “anticipate [leadership opportunities] and meet it half way” (Tait, 1996, p. 46). Mobilizing the expertise and knowledge of the entire workforce, not just managers and directors, is essential to ensure Addiction and Mental Health Services is collectively able to meet the challenges the organization faces.

What is needed in this new organization and structure is leadership that recognizes the importance of relationships. A useful definition is:

The process where in an individual member of a group or organization influences the interpretation of events, the choice of objectives and strategies, the organization of work activities, the motivation of people to achieve the objectives, the maintenance of cooperative relationships, the development of skills and confidence by members and the enlistment of support and cooperation from people outside the group or organization” (Yukl as cited in Bratton & Chriaramonte, 2007, pp. 486-487).

Although the Alberta Health Services transition began without recognizing the need for this relational style of leadership, it is still necessary for people in leadership positions to begin by conceptualizing the tasks and building relationships between levels of the organization. Developing an organization which values a collaborative leadership style helps to make issues and their solutions more manageable in size
and scope since it engages all of the people who are part of the process, eliminating the distinction between us and them. Addressing some important “little” questions discussed below provides a simple template that moves the leadership process forward.

1. What situations face our organization now? What leader behaviours are required? Do we have the people who can provide that kind of leadership?
2. What situations will we face in the future (time specific)? What leadership capabilities will be needed?
3. How can we find and/or develop the leadership needed now and in the future? (McGill & Slocum, 1998, p. 45).

Unfortunately, the planning process that would find answers to these important questions did not occur prior to the transition of nine former health regions, the Alberta Mental Health Board, the Alberta Cancer Board and the Alberta Alcohol and Drug Abuse Commission into Alberta Health Services. Rather these issues were overshadowed by the need to fill positions in a new organizational structure quickly in the first half of the 2009/2010 fiscal year. Even now, it would be prudent for senior leaders in the restructuring process to be more realistic about the amount of time required to complete large projects associated with transition and to develop thoughtful contingency plans that are in turn communicated to staff to assist them in the interim. One of the most pressing issues, from the perspective of staff, is the need to build effective internal communication networks and to simplify the processes to do routine administrative tasks. Creating tools such as good search tool that allows staff to find contact information for people working in various departments seems an obvious need but one that is not yet met. Delegating the details is a leader behaviour that is desperately needed.

As the previous example indicates answers to these ‘little’ questions are still necessary, and work to find answers and solutions must remain a priority, should the organization wish to find and maintain a healthy, functional structure in which employees are engaged and productive. Delegating down the ability to identify organizational priorities for which staff support is needed to address constructively is one activity that managers could use to encourage a sense that each individual is an active participant in the process of change. This would, I believe, be preferable to the sense currently present, that
individual actions are irrelevant in the bigger organizational picture. While there are efficiencies of scale that can be realized by standardizing processes, leaders in the organization need to find ways to enable staff working in particular areas to deal with local needs effectively, as well.

Regarding leadership as “an exchange relationship between those who chose to lead and those who decide to follow... in the context of a specific organization between specific individuals, many of whom have differing goals” is helpful in recognizing the “locus of leadership” and understanding who is being led and what to do to lead them (McGill & Slocum, 1998, pp. 45-46). From this position trust can be built, based on what and how a leader does things. First, to lead effectively, a leader must have a thorough knowledge of the job at hand, both the details and the big picture. Second, a leader is willing “to set the example by behaving in ways that are consistent with the organization’s shared values and to create a climate for others to do the same” (McGill & Slocum, 1998, pp. 46-47). Third, listening to employees is crucial. This involves “giving someone the chance to be heard [and]... registering the content and the character of their concerns... listening that enhances leadership and builds commitment takes place in conversations, not in convention halls, or through email and voice mail” (McGill & Slocum, 1998, p. 47). Fourth, it important for leaders to “create a context of choice” in which those who choose to follow are given “opportunity for the display of knowledge, openness to input and listening—the little acts that build leadership” (McGill & Slocum, 1998, p. 48).

Again the lack of time and opportunity to adequately plan for the complex process of transition to become Alberta Health Services means leaders, and consequently staff, lack a clear vision for the future. Twelve former entities each had individual direction. In the two years since former Minister Liepert’s announcement that these are to be dissolved to create one enormous organization, no clear direction for addiction and mental health is yet articulated. As a result, managers and directors struggle to create a compelling vision for both the organizational units and employees to follow. Also, given the massive number of employees to communicate with, senior leaders cannot practice effective leadership, as
described in the paragraph above, since it is not possible to have relationships with 90,000 people. The move towards standardization of process for purchasing, hiring, and programs provides those at the front line with less opportunity for choice or creativity at a site level. A recent staff engagement survey clearly identified the lack of vision and poor communication processes as significant issues, impacting morale and motivation.

Challenges evident in the organizational structure and leadership culture points to a larger issue: competing organizational theories and the ethics that underline them create uncertainty within the organization as well as for the public that the organization is to serve. The organization of Alberta Heath Services exists “to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans” (Alberta Health Services, 2010). This mission is to be accomplished by working towards three goals:

- Quality: health care services are safe, effective and patient-focused
- Access: appropriate health services are available
- Sustainability: health care services are provided within available resources both now and into the future (Alberta Health Services, 2009).

This mission and goals represent the “constrained optimization” of Alberta Health Services, “the operating and at least implicit primary purpose or reason for being of an organization” that brings with it “some contention and motivation about what should be optimized” (Nielsen, 2003, pp. 476-477).

Unfortunately for the employees “what are constrained are often the needs and desires of constituencies such as employees...that can help and/or block what an organization is trying to optimize” (Nielsen, 2003, p. 477). The ethics of the organization (to be efficient, accessible and provide effective services) are currently in conflict with the needs of employees (to be respected, trusted and valued), creating tension and conflict. Alberta Health Services ’ approach to transition and creation of new organizational structure “ignores the legitimate needs of multiplicity and diversity of groups and their interests in the service of optimizing the need satisfaction of one priority group,” the Alberta Health Services board that answers to Alberta Finance and “since ‘they’, the powerful supporters of ...
capitalism care only or primarily about [budgetary] interests, then ‘we’ and ‘our’ multiplicity groups are justified in not caring about ‘their’ interests and may express....loyalty not to the organization, but instead to my personal career, my portfolio” (Nielsen, 2003, pp. 494-495). In the past year, the organizational focus is on reducing spending, so that “efficiency becomes an end in itself without ethical content but nonetheless having unexamined ethical and unethical effects” (Nielsen, 2003, p. 495). An example of these unexamined effects is that in an effort to reduce costs, the clinical lead position for mental health staff in my area was eliminated without consideration for the implications this decision has on staff accountability and ethical practice in social work, nursing or psychology. Reconciling the need to be efficient and cut costs with the need to motivate and retain staff is a challenge for which a solution has not yet been negotiated.

Alternatively, an effective model of leadership with which to view the evolution of concurrent disorder treatment is present in the National Evidence-Based Practices Project, which suggests tiers of responsibility for modifying attitudes, knowledge and behaviour regarding addiction and mental health.

On the front-lines clinicians, clients and family members all have responsibility:

- To believe in the potential for recovery from concurrent disorders
- To recognize and embrace ownership of their piece(s) of the process
- To take initiative to develop the skills and supports required for recovery to occur
- To be empowered to help to plan and direct the changes required.

Program managers, supervisors and trainers have a leadership role:

- To carefully plan modifications required to the programs and policies which they oversee;
- To facilitate learning for all staff.

At the level of director and governance, leaders must be able:

- To articulate vision, values and commitment;
- To direct the strategy to insure that organizational structures and finances support the changes (Adapted from Drake, Mueser, & Brunette, 2007, p. 133).

It is clear that without support from all tiers within the organization, making the paradigm shift required to improve the treatment systems for concurrent disorder clients is not possible. Little acts of
leadership: a clear vision; developing trust; listening to concerns and integrating feedback; and providing choice, all provide effective tools to move this process forward constructively. Senior leadership clearly has an important role in setting the organizational tone and in providing the human and financial resources to assist managers, supervisors and front-line workers to implement a viable, effective concurrent disorder treatment program that meets the needs of the clients it intends to serve. As well, all Alberta Health Services staff members have a responsibility to share constructive ideas, engage in discussion and provide feedback about both the process and the results of change.

Organizational Assessment of Capacity to Provide Concurrent Disorder Treatment

Research in the United States confirms that “the high prevalence of co-occurring disorders in all service populations and service settings indicates that this high priority population will never be adequately served by implementation of a small number of ‘programs’” (Minkoff & Cline, 2004). Rather, it insists “properly matched services and interventions must be provided for individuals with co-occurring disorders wherever they present, not only in specialized ‘programs’ [and]... recognition of the need for system level change strategies to improve services for individuals with co-occurring disorders” (Minkoff & Cline, 2004). The situation is similar in Alberta, where the development of an integrated concurrent disorder treatment service system is in its infancy.

Fortunately, the need to change is being recognized and “systemic motivation for improvements in services to persons with co-occurring disorders” is being developed simultaneously at the federal and provincial levels (Lehman et al., 2002 as cited McGovern, Xie, Segal, Siembab, & Drake, 2006, p. 274). However, before an organization such as Alberta Health Services can effectively implement a concurrent disorders program, it is necessary to consider where on the scale of concurrent disorder severity it provides services. To assist in assessing this organizational capacity, a group of researchers developed taxonomy of addiction treatment programs based upon concurrent disorder capability. The model assists an organization to identify and classify the type(s) of services provided on the continuum of
addiction only to dealing with concurrent disorder issues capably to dealing with them effectively (McGovern, Xie, Acquilano, Segal, Siembab, & Drake, 2007, p. 27). Where it is used, “this framework appears promising, user-friendly, and relatively simple to translate from concept to real world practice” (McGovern, Xie, Acquilano, Segal, Siembab, & Drake, 2007, p. 35). A shift in the way service providers think about how to successfully provide services is required: concurrent disorders are an expectation, rather than an exception (Drake, Mueser, & Brunette, 2007, emphasis added). Rather than representing a complex or unusual presentation, concurrent disorders are common, more common than most realize.

There is broad range of severity and acuity in both addiction and mental health issues. For this reason it useful to provide a continuum or services in which all services are dual diagnosis capable (DDC) and some services are dual diagnosis enhanced (DDE) “to provide access to episodes of addiction treatment for individuals who would be unable to receive treatment routinely in DDC programs” (Minkoff, 2008, p. 320).

Currently within Alberta Health Services, the most commonly available treatment is Addiction Only Services (AOS) to address the needs of those who dealing with substance abuse issues but who have no or minimal psychiatric issues (McGovern, Xie, Acquilano, Segal, Siembab, & Drake, 2007, p. 27). Not surprisingly, those who present with concurrent issues do less well and are unlikely to achieve or sustain long-term recovery. Less financial investment into appropriate resources means less success. Minkoff predicts that over time, as practitioners become more concurrent disorder capable “fewer and fewer programs [can] maintain themselves as ‘addiction only’” since, when given a choice, clients choose those programs that enhance success (Minkoff, 2008, p. 321).

Within Alberta, modifying services and programs to become Dual Diagnosis Capable (DDC) programs is a preliminary goal that is achievable, with coordinated leadership and resources. Clients in this level of care have mental health symptoms that are generally quite stable and less severe (McGovern, Xie, Acquilano, Segal, Siembab, & Drake, 2007). A DDC program recognizes and addresses the needs of
clients with concurrent disorders in every aspect: through its policies and procedures, assessment, treatment planning, program content, and discharge planning, which all incorporate the themes of recovery from both addiction and mental health issues (American Society of Addiction Medicine, 2001, p. 362; Center for Substance Abuse Treatment, 2005, p. 33 as cited in Minkoff, 2008, p. 320). DDC is regarded as the minimum standard to which any treatment program can and should aspire. In Alberta this requires awareness, education and resources to achieve.

There are many assessment tools to assist organizations in determining a process to move towards capably providing services to client with concurrent disorders. It is important that administrators and health leaders consider how to incorporate research findings that indicate those with low to moderate levels of psychiatric symptoms and drug use are able to make positive changes when involved in non-specialized treatment programs. Interestingly, these studies also show the value of specialized programs for those with moderate to several mental disorders. So, to ensure limited resources are used wisely, substance abuse treatment programs must be able to identify and refer “for specialized treatment those [concurrent disorder] clients whose disorder is of a severity and type that justify the use of those resources” (Flynn & Brown, 2008, p. 44).

In the same way that some clients are able to achieve recovery with no or minimal intervention, there are others that require a substantial investment of resources to achieve recovery. Dual Diagnosis Enhanced (DDE) programs are those able to respond effectively to clients who present with psychiatric issues, regardless of their acuity or stability (McGovern, Xie, Acquilano, Segal, Siembab, & Drake, 2007, p. 27). DDE programs provide substance abuse treatment to clients who present with, as compared to those routinely treated in DDC programs, more symptoms and a higher degree of impairment related to their concurrent disorder (paraphrased from American Society of Addiction Medicine, 2001, p. 10, Center for Substance Abuse Treatment, p. 33 as cited in Minkoff, 2008, p. 320).
Clearly describing the type of program being offered, is helpful to staff. Both staff and clients develop clear, more realistic expectations about who is targeted by the program and the types of treatment interventions available. The organization develops awareness of the level of human and financial resources required to offer an effective program, as well as the type and number of staff required and education and training staff members are expected bring to their roles (paraphrased from McGovern, Xie, Acquilano, Segal, Siembab, & Drake, 2007, pp. 27-28).

Presently there are very few DDE programs in Alberta, a gap in intensive supports for a most vulnerable group of Albertans. Political and organizational commitment is needed to address these needs in the long-term, as historically this support has not been present consistently.

**Integrated Treatment: Effective Concurrent Disorder Treatment Principles**

Throughout Europe and North America, promising new models of specialized, integrated treatment are being developed. Treatment approaches include motivational group interventions, assertive case management, a stage-based approach, and long-term treatment. Observation and research have identified predictable stages in people's responses to concurrent disorders treatment and confirmed that “a consistent long-term program of specialized, integrated [concurrent] disorders treatment can increase the rate of remission from substance use disorder, leading to reduced use of the hospital and crisis services” (Mercer, Mueser, & Drake, 1998, p. 149). Concurrent disorder treatment program development must be guided by what research shows works and by consistently applying best practice principles to all aspects of this process.

Ten key principles to guide this program development are discussed in the following section. Ensuring these tenets are incorporated into all aspects of services is vital to ensuring client, not system needs are met effectively. Although many of these principles appear to be based on common sense ideas, implementing them is challenging. The next section considers each principle more completely.
Integration of substance abuse and mental health treatment

This first principle explores the importance of consistently providing a full continuum of integrated treatment services for substance abuse and mental health issues. It is essential that proper prevention, screening, assessment, treatment and relapse prevention services are available to support clients throughout their recovery journey. Addiction only or mental health only services are not adequate to meet the needs of clients with a concurrent disorder. “Clients with [concurrent] disorders are the norm rather than the exception. Every mental health [and addiction] clinician and every mental health [and addiction] program should embrace this reality and adopt reasonable modifications” (Drake, Mueser, & Brunette, 2007, p. 133). It is necessary to eliminate the bouncing between systems with “no definitive locus of responsibility” accepted by either mental health or addiction services (Sciacca, 1997, p. 41).

Addiction and Mental Health Services is in a position to remove systemic barriers for service access and to develop a locus of responsibility within each site and staff member working within the system.

To assist in clearly articulating what is meant by integrated treatment, the definition of Integrated Treatment presented earlier is reintroduced, as it assists in recognizing how the ten principles can be applied to the organizational restructuring, as well the development of innovative new programming alternatives. Program integration is present when:

mental health treatments and substance abuse treatments are brought together by the same clinicians/support workers, or team of clinicians/support workers, in the same program, to ensure that the individual receives a consistent explanation of illness/problems and a coherent prescription for treatment rather than a contradictory set of messages from different providers (Health Canada, 2002, p. vii).

Service integration is present when:

the development of enduring linkages between service providers or treatment units within a system, or across multiple systems, to facilitate the provision of service to individuals at the local level. Mental health treatment and substance abuse treatment are, therefore, brought together by two or more clinicians/support workers working for different treatment units or service providers. Various coordination and collaborative arrangements are used to develop and implement an integrated treatment plan (Health Canada, 2002, p. vii).
The restructuring process underway within Addiction and Mental Health Services provides unprecedented opportunities to develop the type of integrated treatment services system these definitions aspire to provide for clients with concurrent disorders. Developing and communicating this vision of service delivery throughout Alberta requires that those in positions of provincial leadership embrace and communicate their hopes and expectations for staff who work within the system. It is endlessly challenging to reconcile the need to be fiscally prudent while simultaneously addressing the multiple, complex needs of a vulnerable sector of our population. One of the ongoing tensions present in the Alberta system is the fiscal restraint required during a recession, while attempting to be responsive to growing social needs by developing effective programs. A good first step is to reconcile the visions of financial managers and front-line health care service providers about what are priorities. In spite of these discussions, I anticipate consensus might be difficult to achieve. However, the process of attempting to reconcile divergent perspectives creates a more realistic understanding for all involved. Add in public opinion and the awkward reality of managing public service systems becomes very clear.

While undertaking this restructuring process, it is vital to recognize the importance of the entire systematic infrastructure that supports integrated programming, including:

- system policies, procedures, and processes that determine how the system functions within each of its component subsystems, and how the different components function in relationship to each other.
- ... from mission statement and values, to administration and oversight, quality management and advocacy, funding mechanisms, requirements, and certification standards, intersystem and inter-program care coordination, collaboration, and referral, program design, licensure, and monitoring, clinical practice requirements and guidelines, and clinician credentialing, competencies, supervision, and workforce development (Minkoff, 2006, p. 137).

Development of integrated services requires that every detail of the system be examined through the lens of effective concurrent treatment; a process that needs time and the ongoing infusion of human, financial and capital resources. Minkoff astutely reminds us that “systems integration as defined here is distinct from ‘administrative integration’ of behavioural health subsystems... It cannot be stated strongly enough that...‘administrative integration’ does not equate to or automatically result in systems or
services integration” (Minkoff, 2006, p. 138). Therefore, exploiting the opportunities present in the current merger requires more than integration of administrative systems, the current focus of activity in Alberta Health Services. More focus and work is needed to ensure that currently disconnected parts of the systems begin to work together differently so that “each component of the system [can] recognize its partnership with the other components, to have specific instructions for mutual collaboration and support... to facilitate the success of... other programs in working with their populations of clients, and to ensure that no client or family is lost” (Minkoff, 2006, p. 139).

This effective reorganization includes better linkages between prevention, outpatient and residential programs as well as non-traditional health care settings such as schools, shelters, and prisons. It is not enough to develop better referral systems. “Systems integration is always related to a population, not to a particular program or practice... efforts always must address a wide range of program settings, clinical practices, and clinicians” to ensure this is accomplished (Minkoff, 2006, pp. 139-140).

Within the group of clients with concurrent disorders there are numerous substances and mental health issues present, along with varying levels of severity for each. For this reason a single program or intervention response is not adequate. Within the tiered model discussed in section one, services and programs to address these variable needs can be provided, assuming there is a motivation to ensure the full continuum of services is developed and delivered. Both addiction and mental health issues are regarded as primary issues and so treatment of both areas of concern is vital for recovery to be achieved. Movement between the tiers is expected as improvement or deterioration occurs within the individual. The type of treatment required may, as a result, shift to meet fluid needs. An integrated service system is welcoming and engaging to clients who have concurrent disorders. This system is staffed by knowledgeable and skilled individuals, able to work collaboratively as one team “with ‘one plan’ for ‘one person’ that addresses each of the person’s primary problems in a person-centered manner, and [provides a] full array of programming... designed to address routinely mental health and
substance disorder issues in any combination as appropriate for clients and families” (Minkoff, 2007b, p. 189). Developing and accepting an integrated system of services poses challenges for practitioners in both the addiction and the mental health fields. Each field brings philosophical and practice strengths, as well as areas that need to be reconsidered and perhaps discarded. Again, opportunities for discussion to reconcile divergent perspectives are an essential part of the process that moves an integrated treatment for clients with concurrent disorders agenda forward constructively. The next few paragraphs discuss some of the strengths of addiction field and then mental health field. Although the two areas of practice evolved in very different ways, advances in science and our understanding for addiction and mental health issues mean it is time to reconcile those differences and to develop different ways of working with each other and concurrent disorder clients.

Within mental health, the practice of articulating symptoms in order to develop a diagnosis, the foundation of an effective treatment plan is valuable, as is recognizing the stages of mental illness progression and the role of medication in stabilizing and treating a client. Alternatively, in the addiction field, a philosophy of recovery and the practice of being responsible for one’s behaviour offer useful concepts for engaging and managing interactions with clients who are working to change the unhealthy patterns that are part of a concurrent disorder. Psycho-educational groups, a treatment approach used extensively in addiction treatment to teach and practice skills, provides clients with the opportunity to explore new information in the context of a social setting: a skill that is useful and transferable to family and employment situations. Both fields bring empathy and non-judgmental treatment approaches to working with people, as well as recognizing relapse as one of the steps in a recovery journey. In different ways, both fields also incorporate lay supports. In the addiction tradition, self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) provide a useful adjunct to professional support and opportunity to learn about how one can live in recovery within a community
setting. In the Mental Health tradition, peer support is used to model how one can live with a mental illness. Building on these strengths in an evolving system is important.

Unfortunately there are also less positive aspects of the treatment traditions. Within the addiction treatment tradition there are treatment methods which are overly confrontational and intense, intended to break down a client’s denial and resistance to change, as perceived by the service provider. Rather than reducing resistance and enhancing motivation these interventions tend to increase defensiveness and entrench someone in his/her current behaviour patterns. For example, the reality TV show “Intervention” popularizes a technique most addictions professionals avoid because of its ineffectiveness. The expectation an individual can achieve immediate, sustained abstinence in response to a group meeting intended to highlight the negative impact of his/her use, as promoted on the show, does not acknowledge the reality that learning skills is a process and perfecting those skills requires practice. In the same way that people do not learn to ride a bike the first time they get on one, substance users making changes to their habits and patterns do not succeed the first time. Instead, getting back on the bike or recovery path each time a mistake is made gets one to the intended goal. Similarly, the wish that someone seek treatment for addiction, mental health or concurrent disorder issues in response to feedback from family and friends with is unlikely. In my experience the more common response is for the person using substances to become angry, isolate from friends and family and to become even more entrenched in an unhealthy pattern, vowing never to ask former social supports for anything again.

Within the mental health tradition, the lack of attention to someone’s substance use patterns in therapy may maintain already fragile defences, but it does little to assist an individual to advance through the process of making change. Advising someone to address addiction issues before seeking mental health treatment, a common practice, is also ineffective.
Alternatively, let’s consider what research tells us does work. “Treatment success involves formation of empathic, hopeful, integrated treatment relationships” between services providers and clients (Drake et al, 1993, 2001 Minkoff, 1998 as cited in Minkoff, 2001, p. 2). Rather than prescribing a treatment process, integrated treatment requires “the capacities, in the primary treatment relationship, to integrate appropriate diagnosis-specific interventions for each disorder into a client-centered coherent whole, with the ability to modify interventions for each disorder to take into account the other” (Minkoff, 2001, p. 2). This process “begin[s] by assessing the client's readiness to engage in treatment. Readiness levels are accepted as starting points for treatment, rather than points of confrontation or criteria for elimination” from the treatment program (Sciacca, 1997, p. 41). In practice, this means that a client is not expected to deal with addiction issues before receiving mental health therapy and vice versa, as treatment providers accept the client’s current reality as the starting point for the process.

A screening process identifying clients with a concurrent disorder may be the catalyst for beginning individual counselling or a referral to a treatment group that focuses on engagement, “to develop comfortable and trusting relationships and... to expose the client to information about the aetiology and processes of these illnesses in an empathic and educational manner” (Sciacca, 1997, p. 41). Without expectation of self-disclosure, the client is encouraged to critique the information provided. Movement from exploration to acknowledgment of use and symptoms is the goal of this intervention and support is provided to assist the client to make this shift, rather than denying service until this occurs.

The following characteristics are present in an integrated approach to treatment:

- Replace traditional treatment-readiness criteria with the client's stage of readiness and/or motivation and/or degree and severity of symptoms.
- Eliminate the use of intense, confrontational interventions in response to denial or resistance.
- Advocate the need for the development of trust as essential to the treatment process.
- Advocate acceptance, empathy and respect for the client's perceptions, beliefs and opinions. Tolerate disagreement and dispel moral and judgmental beliefs.
- View relapse as a learning opportunity, not treatment failure. Eliminate punitive consequences.
- Convey and/or provide a hopeful vision, a belief in the possibility of change, and support self-efficacy (adapted from Sciacca, 1997, p. 42).
Applying these principles consistently in current mental health treatment settings does not occur and a change process requires leadership through policy changes and training for staff to become a routine expectation.

Integration requires the presence of both pharmacological and psychosocial interventions aimed at controlling or eliminating symptoms of clients with concurrent disorders. Additionally, it requires rehabilitation interventions, opportunities for clients to “enhance skills and supports to enable persons to overcome the disabilities associated with illness or disorder” (Drake, Mueser, & Brunette, 2007, p. 131). It is essential that effective, practical treatments and rehabilitation interventions being developed and researched for the heterogeneous variations of concurrent disorders become available to clients in both urban and rural treatment settings through the effective translation of research into practice.

Effectively addressing these complex issues is an area requiring consistent effort and purposeful activity. Developing processes to ensure effective concurrent disorder treatment systems evolve must be a high priority for Addiction and Mental Health Services.

While system level integration is essential, integration is also necessary at a policy level. While parallel systems of treatment that offer addiction or mental health specific services may still have a place, there is a need to revise accreditation standards to reflect the reality of concurrent disorder treatment as well. Addiction and mental health knowledge can no longer remain separate. “Clinical practice guidelines and standards in the substance use disorder and mental health fields need to be integrated and should reflect a unified national approach for the treatment and care of those suffering from concurrent disorders” (Canadian Centre on Substance Abuse, 2009, p. 60). As discussed earlier, finding ways to translate and communicate research outcomes, clinical practice guidelines and practical experiences requires development.
Flexibility and specialization of clinicians

Another key principle is the need for well-trained, non-judgemental clinicians and support staff who bring flexibility, along with specialized knowledge and skills to their roles, regardless of where in the continuum they practice. Clinicians require to a specialized repertoire of practices and approaches they use to address concurrent disorders, along with a willingness to participate in an ongoing revision of these approaches in response to feedback from clients about their effectiveness in facilitating change.

A sometimes overlooked issue is the attitudes of the staff members who deliver services and programs. There is potential for some staff to view clients as ‘them’ or to personalize the symptoms of illness. Some studies indicate it is possible to create more positive staff attitudes by increasing the number of facets of clients staff have the opportunity to observe. This can be done by increasing the number and type of contexts where staff members interact with clients, perhaps through client “involvement in organizing and providing training, on committees, at meetings and at interviews” (Bowers et al., 2005 as cited in Ralley, Allott, Hare, & Wittkowski, 2009, p. 156). These opportunities blur the distinctions between who is a client and who is a staff member and encourages the recognition that clients are individuals, an attitude that “has been demonstrated to be associated with a more positive attitude towards clients” (Bowers et al., 2005 as cited in Ralley, Allott, Hare, & Wittkowski, 2009, p. 156). This innovative form of staff development “encourages staff to think differently and therefore improve the quality of care for clients and reduce feelings of frustration” (Carroll, 1995 as cited in Ralley, Allott, Hare, & Wittkowski, 2009, p. 156, emphasis in original). The observation, made by Harry Sullivan Stack in 1947 remains true: clients and service providers have more similarities than differences. Making a shift to view clients as human beings on their journey, rather than flawed, difficult and different others changes the way in which interactions occurs, making it more positive, particularly from the perspective of clients.
At a systems level, a “common educational platform with new specialized training programs” is an important priority to “help achieve a common foundation of understanding and would help facilitate the integration of system services” (Canadian Centre on Substance Abuse, 2009, p. 61). It is essential to develop best practices on an ongoing basis, as new knowledge develops, with a “focus on bridging the knowledge in the substance use disorder and mental health fields towards the development of a common, unified approach” (Canadian Centre on Substance Abuse, 2009, p. 61). This kind of integrated knowledge development and sharing is revolutionary and would require “a major reorganization of our approach to education” as it trains “professionals who have a common understanding of concurrent disorders and who work within a framework shared by other trained professionals in the field” (Canadian Centre on Substance Abuse, 2009, p. 61). Developing the systems to sustain this knowledge exchange is an important part of retaining and motivating those practitioners who share the common purpose of working with concurrent disorder clients and their unique clinical challenges.

**Assertive outreach**

When clients involved in an integrated treatment program require assertive outreach to assist them to cope with day-to-day challenges that occur, these services must be available to them consistently, rather than just during office hours. Assertive outreach for those with severe, persistent issues means reaching out to meet and understand the client on his/her own terms, with relevant, accessible services that provide tangible, concrete assistance in the client’s own community. Assertive outreach requires a different style of working with clients, since its overarching goal is to enhance an individual’s functioning to the degree possible in his/her own home and community, rather than achieving recovery that requires no further intervention. Changes in the settings for service delivery (the client’s home and community rather than an office), a greater investment of staff time per client, and access to concrete resources including transportation and money for food and other basic needs are also required in order for assertive outreach to be effective.
Many clients with concurrent disorders struggle with social awkwardness and a sense of not fitting into social groups. Unfortunately, the pervasiveness of social skills deficits makes the social facilitation associated with alcohol and other drugs even more reinforcing. The clinicians’ perspectives... is consistent with information obtained from psychiatric outpatients, who cite the value of alcohol, nicotine, and caffeine in promoting social interaction (K. B. Carey et al., 1999 as cited in Carey, Purnine, Maisto, Carey, & Simons, 2000, p. 196).

Providing adequate supports to enhance social skills and interaction, to build meaningful social roles and confidence in social situations, helps to build positively reinforcing reasons for an individual to reduce and or quit using substances to manage strong emotions in these settings. To provide this support, in its most basic terms, means “having sufficient funds to support social activity groups, time and money to assist with activities of daily living, and funds for incidental expenses (e.g., coffee)” to support socialization activities (Carey, Purnine, Maisto, Carey, & Simons, 2000, p. 196).

It is important that Assertive Outreach be one piece of a larger system of support for clients with concurrent disorders, as a review of recent research concluded that “intensive case management, including assertive community treatment, consistently improves residential stability and community tenure, but does not consistently impact substance use” (Drake, Mueser, & Brunette, 2007, p. 132). Another study indicates that long term positive outcomes for substance abuse treatment are more likely to occur when clients receive long-term continuing care and monitoring, focused on recovery, rather than short-term acute care focused on remission (McGovern, Wrisley, & Drake, 2005, p. 1271).

When continuing care is paired with harm reduction strategies, there are opportunities that help a client move towards abstinence. These strategies are important steps in reducing the harm associated with substance use as they provide many teachable moments and opportunities to develop insight into what is not working. As discussed earlier, assertive outreach is available for mental health clients only at this time. Based on the research, this appears to be a good use of resources, although adding a substance abuse counsellor and using a team approach could improve its effectiveness. Any expansion
to include addiction clients requires additional program and human resources, along with a different kind of support services to meet diverse needs.

**Recognition of client preferences**

The next principle examines the importance of providing services which are perceived by clients as offering the kind and level of support they require, rather than expecting they will fit the services offered. This means identifying the client’s personal preferences regarding goals to focus on and the process to achieve these milestones through ongoing dialogue. As well, it involves helping him/her to creatively express preferences in ways that are personally relevant and meaningful by ensuring treatment planning is consistently client-centred. This requires that the paternalistic and/or punitive attitudes and approaches to care, so dominant in both addiction and mental health fields in the past be discarded, and replaced with empathy and empowerment.

Programs have clear mandates, admission criteria and processes that are intended to streamline workload while providing a particular service. Unfortunately, at times these structures feel unwelcoming and/or daunting to navigate. For example, having to leave a phone number for an intake worker to return a call may not feel welcoming to many new clients who would prefer to speak directly to a therapist, preferably in person. Yet most addiction and mental health offices do provide this alternative, in spite of the desire of staff to provide a quality service.

One way to determine what might work better, from the perspective of the client, is to create meaningful opportunities for feedback to be provided and then to implement the suggestions about would work better. This kind of input has the potential to yield creative solutions to prickly issues, if the organization is prepared to listen and be open to the idea of changing some long-standing practices. As well, staff must have the managerial support to be responsive to the expressed of those requesting services so that the presenting needs are met respectfully.
Close monitoring

The principle of close monitoring involves creating and sustaining external structures in the client's environment to help him/her achieve reliable control over the use of substances to build the potential for success. Again this may require services that are available beyond regular working hours. It is essential that all practitioners have access to professional development programs that teach techniques and strategies that help them to teach their clients how to balance the use of external structures while continuously cultivating self-motivation and self-control, attributes which require consistent nurturing and reinforcement. Implementing this principle requires a paradigm shift to a focus on building supports for recovery rather than cultivating dependence and the need for life-long treatments.

As new medications are developed it is also essential that close monitoring occur, both to ensure side effects are manageable, from the client’s perspective, and also that potential drug interactions are managed. This is especially important for those who have other medical needs such as hepatitis C, HIV or diabetes, all common within this vulnerable population. For many non-medically trained therapists and counsellors, this is new territory and professional development opportunities are needed to nurture effective, informed monitoring.

Comprehensiveness of services

Multiple needs require a range of services to address all of these concerns in a coherent, respectful way. A holistic approach, rather than a focus on reducing symptoms, is needed to ensure all the rehabilitative needs of the client, as well as support for his/her family members and significant others is available so they can effectively support their loved one are provided, where this is possible. Knowledge of and referral to community services that complement concurrent disorder services ensures all needs are addressed as completely as possible.

Through their limited ability to cope with everyday challenges and the stigma attached to their conditions, these individuals may become homeless, socially marginalized and criminally involved and only when ALL of the presenting needs are acknowledged and addressed will successful change be possible (Canadian Centre on Substance Abuse, 2009, p. 10).
Long-term abstinence requires a stable life-style. Clients must be willing to make significant changes to their habitual ways of handling stress, in their social networks, in their willingness to seek professional health care, and in patterns of daily living in order to attain and sustain a healthy lifestyle free of substances.

“Integrated dual primary diagnosis-specific treatment interventions are recommended” for clients with concurrent disorders (Minkoff, 1998 as cited in Minkoff, 2001, p. 3). This requires accurate diagnosis of both addiction and mental health issues so that appropriate evidence-based treatment options, including medications, can be applied for each separate primary disorder that requires treatment. “In addition...there is increasing evidence of the value of trauma-specific interventions being combined with interventions for other psychiatric disorders as well as for substance disorders” since exposure to trauma is common, both through childhood experiences and a using lifestyle (Harris, 1998; Evans and Sullivan, 1995, Najavits et al, 1998 as cited in Minkoff, 2001, p. 3).

At this time, providing some aspects of a comprehensive range of services is a new way of practicing within Addiction and Mental Health Services. Leadership and support to achieve required skills, competencies and attitudes are all essential to enable these ideals to become reality. Delegating the authority required by managers to identify and address these needs is essential and urgent.

*Stability of living situation*

To build on the principle of providing comprehensive services, the next recommendation states clients require access to suitable living situations consistently. This means ensuring each client has a decent, safe, and stable place to live and that his/her living situation supports the achievement of substance abuse treatment goals. Without adequate accommodation, a client continues to struggle to attain even small successes. The current economic situation in Alberta has exacerbated many vulnerable people’s ability to find and maintain a home. While addiction and mental staff have a role to play in moving this agenda forward, this issue requires a multi-sectoral response and a significant,
sustained commitment from all levels of government, non-profit groups and community members. Leadership is needed to influence policy and enhance the ability of stakeholders to make positive changes to the housing situations in many rural areas. Little leadership strategies discussed earlier are urgently required to address this basic need that remains unmet for many.

*The long-term perspective*

The eighth principle examines the importance of the long-term perspective in creating and planning the continuum of treatment services. Recovery is a process that may take months or even years to achieve consistently and the service system must anticipate the need to provide ongoing services to enable individuals to reach and sustain the goal of stable, sustained recovery from harmful substance use. Because initial interventions focus on engagement and enhancing motivation rather than achieving abstinence, system administrators must recognize the importance of these early stages, recognizing change is a process, sometimes a life-long process. Those who provide funding and access to resources must be cautioned against concluding early on that substance abuse treatment services are helpful and should be withdrawn too soon. A more helpful approach encourages the relationship between clients and their service provider to be used as a source of support whenever needed and definitely when symptoms re-appear and/or relapse or the potential for relapse occurs, perhaps for many years.

*Stage-wise treatment*

The importance of stage appropriate treatment options cannot be overstated. Offering information when intensive intervention is required is ineffective, in the same way residential treatment is not required by the majority of clients. Each client responds to concurrent disorders treatment in predictable stages. Within the continuum of treatment options offered, service providers must ensure the alternative chosen is appropriate for each stage the client moves through. Recognizing the stage a client is at results in appropriate treatment being offered, a strategy that encourages client engagement
and active participation in the change process. Mismatched treatments create resistance and non-compliance, attributes guaranteed to result in ineffective treatment and disappointing results. Therefore, enhancing motivation and building the opportunity to learn how to make change successfully is crucial to recovery.

Motivation can be broadly described as “an individual’s concerns about or interest in the need for change, his or her goals and intentions, the need to take responsibility and make a commitment to change, and sustaining the behaviour change and having adequate incentives for change” (DiClemente, Schlundt, & Gemmell, 2004; Miller & Rollnick, 2002; Vuchinich, 1999 as cited in DiClemente, Nidecker, & Bellack, 2008, p. 25). Helping a client understand and practice tasks that need attention in each stage is an effective way to build confidence to try to make changes and then to stick with the process over the long term. Frequently, it is necessary to recycle through the changes to ensure the new behaviours become established as a new normal. Motivation “requires individuals to engage in enough cognitive and experiential activities to move through early stages and to engage in behavioural activities to initiate and sustain the change. This is an arduous and rather cognitively complex process” that a using and/or actively mentally ill person may not be capable of undertaking (DiClemente, Nidecker, & Bellack, 2008, p. 27). To enhance the potential for success, using techniques such as motivational interviewing and/or a cognitive–behavioural approach, may be more effective since these strategies are client-centred. Focusing on the client’s stated concern(s) encourages collaborative goal-setting. When a service provider supports harm reduction strategies as a way for the client to reach larger goals, trust is built and learning through experience is validated. The relationship between the client and service provider includes

- recognition of personal concerns, values and considerations, lack of confrontation and excessive pressure, creating personalized planning, finding and providing [reinforcements] that can support the accomplishment of the various tasks of the treatment stages of change, providing structure and constructive monitoring of the goals and behaviours, and building skills that are needed to complete the tasks of change (DiClemente, Nidecker, & Bellack, 2008, p. 31).
The model of change currently used in addiction services is the trans-theoretical model of change, developed by Prochaska and DiClemente, initially to help people quit tobacco use, and now broadly applied to any processes requiring change. It is based on a “wheel of change” that involves six distinct stages:

- **Pre-contemplation**: the time before someone recognizes that there is a problem that requires change, in spite of feedback from family or friends who recognize issues and encourage change. “If you would just leave me alone, everything would be fine.”
- **Contemplation**: Recognizing something is a problem but experiencing ambivalence about making a change. “Yeah, but…”
- **Preparation**: Getting ready to make a change by developing a plan and building a support system.
- **Action**: Making the change. This is not an event, but is viewed as a stage that takes up to six months to move through.
- **Maintenance**: Staying quit. Maintaining the change(s) needed to be successful.
- **Relapse**: Returning to the previous behaviour patterns and abandoning the new ones. This can occur at any stage in the change process.

It is important to note that the first three stages are pre-action and require a “focus on the tasks needed to prepare for taking action including creating concern, goals, intentions, plans, and commitment for engaging in a specific behaviour change” (DiClemente, Nidecker, & Bellack, 2008, p. 25). When these matters are adequately addressed the action of making the change occurs. Life circumstances influence motivation, potentially causing it to wax and wane, moving through the stages, not necessarily in the same order each time. For example, someone may move through the stages of pre-contemplation, contemplation, preparation and then slip back to contemplation before deciding that action is now possible. Once action has been taken, someone may become discouraged and slip back to contemplating if the change is really worth it. When the challenges experiences are addressed in a preparation phase, action may again be possible. Someone may remain in a contemplation stage for a long time and then, in what appears a sudden shift, move quickly through preparation and into action. This model, applied to real life, shows change is not a linear, straight forward process, but rather that one can move from stage to stage, back and forth, in an often messy process (Sciacca, 1997, p. 43). It also helps to explain why using a treatment intervention better suited for action (where family and
friends generally want a substance user to be) is usually unsuccessful. Recognizing the stage a client is in helps the service provider or family member to tailor questions and responses in a way that enhances, rather than deflates, motivation. The model is research-based and provides “stage specific treatment within the context of the trans-theoretical model of change” facilitating positive treatment outcomes that make the person involved in changing, those who support him/her, the service provider(s) and the program administrators happy (Prochaska & DiClemente, 1992, as cited in Minkoff, 2001, p. 3).

As well, the model suggests “less motivated individuals need more proactive and intense interventions. Case managers have to be more active to prevent less motivated individuals with [severe mental illness] and [substance use disorder] from falling through the cracks in the mental health care system” (DiClemente, Nidecker, & Bellack, 2008, p. 32). For example, these individuals may not be consistently oriented to time and space and so may require assertive outreach support to attend scheduled appointments consistently. Routine and structure are also helpful, so meeting with support service providers at the time, on same day of the week enhances successful participation.

Currently very “few guidelines exist for the selection or staging of treatment goals for this population. Treatment providers may benefit from guidelines from the research community regarding the implementation and outcomes of abstinent and non-abstinent treatment goals” to guide the conversations with individuals about the path recovery takes (Carey, Purnine, Maisto, Carey, & Simons, 2000, p. 197). Organizational support from Alberta Health Services, in the form of a community of practice that focuses on sharing clinical information and experience, enhances the potential for improved collaboration between clinical staff in small, rural offices.

**Optimism**

Finally, the value of an attitude of optimism is a vital, although intangible, characteristic an effective treatment system. It provides encouragement, not judgement, when someone reaches out for help. Change is not a simple process with success guaranteed in fixed amount of time. It is easy to become
discouraged about one’s potential to reach a goal and about the future. “Support to remain focused and hopeful about one’s future and sustaining motivation to quit or stay quit are important components of achieving and maintaining successful change” (Mercer, Mueser, & Drake, 1998, p. 153). For many clients this support is sporadic or non-existent. Family, friends and even service providers may develop perspectives that get in the way of effective treatment. It is not surprising that at times, the supports underestimate the ability of people with concurrent disorders to participate “in an intentional change process or to respond to motivational and cognitive–behavioural strategies” (DiClemente, Nidecker, & Bellack, 2008, p. 32). Client dropout and caregiver burnout may result in the use of poorly monitored medication regimes or the “use weak forms of education and social support to manage” chronic concurrent disorders, rather than more intensive, comprehensive programs (DiClemente, Nidecker, & Bellack, 2008, p. 32).

Considering the severity of each of the concurrent issue, as well as the motivation to change each helps to ascertain the kind of treatment needed. For example, an individual who is precontemplative about his/her stimulant use (cocaine or methamphetamine) and who requires medication for schizophrenia, likely benefits from residential support to create the structure needed to comply with the medication regime. Additionally, residential support provides opportunity to work on motivational tasks related to stimulant use, despite the fact residential treatment is not normally recommended for individuals who are precontemplative about substance use.

It is also important to be clear about what recovery actually is. In this paper, recovery refers to “a process of overcoming illness...moving beyond illness to pursue a satisfying and meaningful life... and implies functional outcomes, such as personally meaningful activities and relationships, but also refers to an individual’s process of building hope and autonomy” (Drake, Mueser, & Brunette, 2007, pp. 131-132). This definition of recovery supports the use harm reduction strategies as a part of the process of change, not as the end result. There are positive outcomes in the process, along with the potential for
crisis and challenge. At the times these problems occur, service providers can provide information and
treatment, as well as hope for long-term recovery. Research results affirm the importance of an
attitude of hope in the recovery process. Care providers have

an ethical imperative to provide education and hope... Accordingly, hopefulness and a realistic expectation of [concurrent disorder] recovery inform the philosophy of...treatment. All clients can be seen as having potential to recover, and all clinicians can be helpful by conveying a realistic message of optimism regarding long-term recovery (Drake, Mueser, & Brunette, 2007, p. 133).

This hopefulness is also based in research findings, not merely a clinician’s wishful thinking. For example, a recent study shows progress towards health is the most common path. Clients view recovery as “living independently, working in a competitive job, having regular contact with friends who were not substance users, expressing positive quality of life, actively managing substance use disorder, and controlling psychiatric symptoms” (Drake, Mueser, & Brunette, 2007, p. 133). Addiction and Mental Health staff members can and do positively influence the lives of those they serve by sharing their hope and knowledge of how to successfully navigate a change process. Continually exploring ways to enhance this success is essential as our understanding of the issues underlying concurrent disorder treatment evolve.

To successfully implement the ten principles discussed in this section, purposeful action and a long-term of commitment of resources are required. Choosing this option enhances the quality of life of some of the most vulnerable people in our society.

Program Components

An analysis of some of the components that comprise best practices for concurrent disorder treatment programs follow. What becomes clear is that

there is no single correct [concurrent] diagnosis intervention, no single correct program. For each individual, at any point in time, the correct intervention must be individualized, according to subgroup, diagnosis, stage of treatment or stage of change, phase of recovery, need for continuity, extent of disability, availability of external contingencies (e.g., legal), and level of care assessment (Minkoff, 2001, p. 3).
There are numerous opportunities for the organizational system evolving within Addiction and Mental Health Services to build on existing programs and to create innovative new alternatives to better meet the needs of those who seek treatment for concurrent disorders. Eleven facets of an effective concurrent disorder treatment program are considered, providing a glimpse of the comprehensive range of services needed to begin to address the needs of this population in meaningful ways that encourage individuals to lead healthier, more satisfying lives, despite the challenges that must be overcome.

**Concurrent Disorder Assessment**

Proper treatment services begin with a comprehensive assessment to determine areas of strength and need and to form the basis of a treatment plan that is relevant to the client. The integration of Addiction and Mental Health Services into one administrative structure provides an excellent opportunity to create an assessment process that recognizes and addresses the potentially complex issues that must be unravelled to encourage, support and sustain recovery from concurrent disorders.

It is essential that concurrent disorder assessment “involves the ongoing detection of substance use, the continuous specialized assessment of an individual’s substance use problems, and individual treatment planning that includes substance abuse treatment goals” (Mercer, Mueser, & Drake, 1998, pp. 153-154). Researchers recommend that substance use be monitored by a combination of self-report, laboratory testing and regular reports from a close family member or friend, reducing the potential for one to *fake good* or report abstinence when this has not actually occurred, to *fake bad*, awful zing one’s situation in order to elicit sympathy and care-giving from others. It is important the assessment include a “thorough analysis of substance-related problems, including the severity of the disorder, the stage of treatment, and the bio-psychosocial factors that appear to sustain the substance-related problems” to ensure a treatment plan addresses the range of needs requiring change (Mercer, Mueser, & Drake, 1998, pp. 153-154).
Even now mental health assessments do not always include substance abuse screening. “Because these disorders are prevalent, as a basic practice, standardized screening measures and assessments should be in place to systematize a program’s capacity to reliably identify and begin to address patient needs” (McGovern, Xie, Segal, Siembab, & Drake, 2006, p. 274). In the same way that family physicians routinely screen for hypertension and diabetes, addiction and mental health services must screen for the presence of both addiction and mental health issues, and assess the need for treatment, as well as other community support services.

A comprehensive assessment considers the following issues:

- Type of substance used
- Effect of the substance on the individual (both positive and detrimental)
- Where individual is on continuum of use: experimentation to addiction
- Whether individual is currently intoxicated or at the end of the physical detoxification syndrome
- Presence of cognitive impairment (due to substances and/or FASD and/or head injury)
- Personality of user
- Symptoms of mental illness
- Depression (usually magnified during the physical detoxification stage of use)
- Anxiety (cause of use or a symptom of use)
- Personality disorder
- Antisocial personality
- Schizophrenia
- Relationship between substance abuse and mental pathology (summarized from Kandel, 2007)

Assessment, both at intake and throughout treatment, provides the foundation for decisions about the most appropriate treatment interventions at all stages of the recovery process. It is vital that the treatment “approaches [chosen]... be aligned to readiness on the basis of assessment findings. Specific evidence-based practices are indicated at each of these stages...the therapeutic task varies according to the stage of treatment readiness” (McGovern, Wrisley, & Drake, 2005, p. 1271). Matching the correct approach at each stage of treatment contributes to overall treatment success.

Assessing for the presence of concurrent disorders can be challenging. “In the initial interviewing process it is difficult to identify active mental symptoms, since the clinical expression of drug addiction symptoms is very similar to those present in the active stage of mental disorder” (Kandel, 2007, p. 65).
It may be necessary to see a client several times, as well as to gather information from family members and/or other professionals who have had been involved in the past to make an accurate assessment. This is why the continuity of caregiver discussed earlier is so important.

An often overlooked issue related to assessment is the impact neurocognitive impairment. A lack of insight into reasons to change substance use patterns may be caused by “lower levels of general intellectual functioning and memory, less cognitive flexibility, poor problem solving and abstraction abilities” that lead to difficulty with reflection on and contemplation of alternative behaviours (Crawford, Crome, & Clancy, 2003, p. S11). These types of impairment, sometimes perceived as defensiveness or denial, severely limit the ability of the person affected to develop insight into behaviour and the patterns that sustain dysfunction. “Difficulties with verbal skills and verbal and visual memory may interfere with change of substance use behaviour,” causing someone to really not understand what is a problem or recognize how to make changes (Crawford, Crome, & Clancy, 2003, p. S11). Helpful communication with a client who has cognitive impairment is clear, concise and regularly repeated, with opportunities for rehearsal to ensure it is understood. Successful concurrent disorder treatment programs include neuron-cognitive assessment as one component of a holistic process.

Within Addiction and Mental Health Services there is no concurrent disorder screening tool is currently in use. It is vital that a tool be acquired and developed soon, and that policies and procedures are developed to support this change in practice. Obviously a broad-reaching training program to ensure clinical staff understands the tool, and uses it consistently and correctly is needed. The new systems being developed have the potential to create this vital program component.

Clinical Case Management

People who have both addiction and mental health issues, for a variety of reasons, experience difficulty when trying to engage in outpatient services. Intensive clinical case management that incorporates individual substance abuse counselling, assertive outreach services, and community based
supports, tailored to individual needs including regular appointments with a nurse practitioner, general physician and/or psychiatrist provides the structure required to ensure holistic treatment is provided by the team. “Treatment success is enhanced by maintaining integrated treatment relationships providing ...interventions for both disorders continuously across multiple treatment episodes, balancing case management support with detachment and expectation at each point in time” (Drake, et al 1993; 2001 Minkoff, 1998 as cited in Minkoff, 2001, pp. 2-3). Because progress towards recovery is non-linear and there is no single brief intervention that provides the perfect treatment for persistent, co-existing conditions, it is essential that case management support and structure are provided in proportion to the client’s level of ability, with an expectation, at times, of some level of impairment in functioning.

When developing treatment plans for clients with concurrent disorders, individual needs and strengths as well as personal and community resources must be considered to maximize the potential for success. “When mental pathology is combined with substance abuse, the individual displays a very low level of functioning, with an inability to organize mental and functional faculties as well as behavioural instability in mental situations” support to maintain ready access to a variety of services is needed (Kandel, 2007, p. 65). A different, lower of expectation required. Drug-seeking behaviour, when it occurs may be quite intensive with less capacity for reasoning, thereby requiring social or medical detoxification before further treatment planning can occur successfully. A case manager familiar with multiple resources is invaluable in assisting a client to link the required services as needs arise.

Within Addiction and Mental Health Services there is increased potential to develop information sharing processes that enable service providers to collaborate more effectively. On a broader scale, the use of a case manager, who has access to other professionals and their expertise, creates an ability to be responsive to wide variety of client needs. Primary care networks are one example of an internal Alberta Health Services system that uses a case manager to effectively bring together several service
providers to meet multiple client needs. Expansion of these networks supports client needs effectively while using existing resources differently.

**Individual Substance Abuse Counselling**

Many clients value the support and insights they gain through individual counselling that focuses on addressing issues arising due to substance abuse. This service is a cornerstone in effective concurrent disorder treatment programs. The way this service is offered contributes to success (or not) in supporting clients to make changes in their patterns of use, while developing a healthier lifestyle.

Not surprisingly, many clients, particularly those with concurrent disorders, are not helped by confrontation techniques, the concept of a higher power, and a model of addiction as an illness that is used in many substance abuse treatment programs. Rather, programs that provide clients with motivational support, through motivational counselling are more effective. Motivational counselling is a way of interacting with a client that helps a practitioner to develop a relationship in which a client receives support through the challenging process of reducing or quitting substance use. Within this therapeutic relationship the counsellor encourages a client to set goals, develop hopes for the future, understand the incongruity between the stated goals and behaviour when using substances, helps the client to develop new skills and leisure interests and supports the client's growing self-efficacy.

When negotiating treatment goals it is important that a therapeutic contract be developed between the care provider and the client to outline expectations. Items to include are: instructions about compliance with the psychiatrist's directions, including the use of medication use, taken at the prescribed dosage and interval; behaving in accordance with the therapeutic environment (personally and in group therapy); abstinence from alcohol and/or drug abuse; honesty and reliability in the therapeutic relationship; avoiding the use of verbal and physical violence; maintaining confidentiality of others in the group; and cooperating in order to achieve the social and rehabilitative goals determined in the patient's individual program (summarized from Kandel, 2007, p. 65). Many of these strategies to
achieving improved health are regularly included in treatment plans; however, there is room for improvement in several areas, including communication between psychiatrists and addiction counsellors and in increasing the knowledge of many addiction counsellors regarding medications and their effects. Once again integration provides opportunity for these linkages to be strengthened and for knowledge sharing between professions to occur, with motivation and leadership to support these process changes.

Cognitive behavioural therapy (CBT)

CBT is a widely use therapeutic technique that combines cognitive therapy with behavioural techniques and is used in the treatment of both addiction and mental health. Its goal is to address distorted or dysfunctional thinking which influences mood and behaviour; that is, the maladaptive patterns of thought and belief that perpetuate substance abuse, as well as those that impact mood (adapted from Osilla, Hepner, Muñoz, Woo, & Watkins, 2009, p. 413). “These similarities [mean], CBT may be an ideal approach to identify and modify harmful thinking and behaviours that trigger depressed mood and substance use in a single treatment” (Osilla, Hepner, Muñoz, Woo, & Watkins, 2009, p. 413). One originally unanticipated positive benefit of CBT is its transferability, which allows a client to use CBT techniques to address more than one issue so that inter-related issues in his/her life all benefit from its use. “CBT encourages individuals to learn and practice concrete skills in an iterative fashion and seem[s] to benefit these clients' self-efficacy beyond the target problems” (Osilla, Hepner, Muñoz, Woo, & Watkins, 2009, p. 417).

“CBT's strong conceptual underpinnings, track record of efficacy across substance use problems, and acceptance among practitioners make it a promising candidate for dissemination to community-based organizations” (Morgenstern, Blanchard, Morgan, Labouvie, & Hayaki, 2001, p. 1007). It is a credible and accessible treatment modality that can be adapted to any size of organization to assist in managing a wide variety of mental health and addiction problems.

A commonly used and effective form of CBT is relapse prevention therapy. It
consists of a number of key ingredients: reducing exposure to substances, fostering motivation for abstinence (decisional balancing of pros & cons of use and abstinence and processing ambivalence), self-monitoring (situations, settings, and states), recognizing and coping with cravings and negative affect; identifying thought processes with relapse potential, and deploying, if necessary, a crisis plan (McGovern, Wrisley, & Drake, 2005, p. 1270).

Many of these skills are also important in managing a mental illness. For example, self-monitoring, coping with negative moods, identifying unhealthy thought patterns and the need to deploy a crisis plan are all essential in recognizing and managing mental de-compensation and represent facets of a healthy lifestyle.

Whether CBT is delivered in individual or group formats did not impact effectiveness of treatment in a recent study, although there was benefit in shorter duration interventions, especially in early stages of treatment (Magill & Ray, 2009). Adding CBT to another form of treatment did not appear to increase effectiveness, although a small benefit is noted when it is used with a method of contingent reinforcement such as providing vouchers as a reward for compliance (Magill & Ray, 2009, p. 524).

In spite of its potential, there are several cautions that must be raised. First, CBT “approaches may be best suited for persons in the action or maintenance stages of treatment or recovery” since motivation is also an important factor in sustaining change and this is enhanced as a client progresses through the stages of change (McGovern, Wrisley, & Drake, 2005, p. 1271). Second, “current CBT approaches to [substance abuse] treatment do not focus on the necessary content in treatment in order to effectively address specific forms of psychiatric co-morbidity, and thus only provide clients with generic coping strategies for managing psychiatric illness” (Conrod, Stewart, Pihl, et al., 2000 as cited in Conrod & Stewart, 2005, p. 264). Therefore, it is important that clinicians use CBT strategies or other psychotherapeutic interventions tailored to the needs of those with concurrent disorders. Ongoing assessment to monitor results of interventions informs decisions about its effectiveness, and the need to continue or try other approaches. Third, matching the treatment modality to the assessed needs enhances outcomes. When assessment reveals clients have “difficulty recognizing and articulating their
feelings... have a social network that condones or reinforces their alcohol use and/or are diagnosed with an antisocial personality disorder... a standard CBT approach” is recommended (Rosenblum, Cleland, Magura, Mahmood, & Kosanke, 2005, p. 53). The same study suggests clients who can recognize and articulate feelings “may benefit more from a motivationally enhanced CBT approach” while those with “low... network support... either CBT or GMI [Group Motivational Interviewing] seems appropriate” (Rosenblum, Cleland, Magura, Mahmood, & Kosanke, 2005, p. 53).

CBT is widely used by both addiction counsellors and mental health therapists in Alberta Health Services, Addiction and Mental Health. Ensuring new staff have these skills, or are provided with the training and clinical supervision needed to ensure competence, is essential to ensuring effective treatment methods are being used. As well, based on current research, it is essential that staff have the knowledge and skills that enable them to use CBT at times when it is most likely to be effective and to draw on other modalities when it is not.

Substance abuse group interventions

The use of groups to support recovery from substance abuse has a long history and continues to provide an effective, relatively inexpensive treatment modality. Groups serve a variety of purposes, such as a “focus on substance use and their specific sensitivity to the person with a severe mental illness, provide psycho-education and support, social skills training, stage-wise treatment (to engage and persuade clients for reducing or eliminating substance use), or a combination of these features” (Mercer, Mueser, & Drake, 1998, p. 155). An example of an essential social skill to address in a recovery is the ability to manage social relationships of all kinds including “managing drug purveyors, as well as making friends” (Drake, Mueser, & Brunette, 2007, p. 133). Participating in treatment focused groups creates opportunity to develop and practice these and other skills.

A review of recently completed research found that “peer-oriented group interventions directed by a professional leader, despite heterogeneity of clinical models, are consistently effective in helping clients
to reduce substance use and to improve other outcomes” (Drake, Mueser, & Brunette, 2007, p. 132). These authors indicate there is no conclusive evidence regarding the type of group clients experience most success in. “The key is steady attendance for several months, probably at least a year... offering several options so that clients can find a group in which they feel comfortable” so that commitment and consistency are enhanced (Drake, Mueser, & Brunette, 2007, p. 134).

Integration provides opportunity for concurrent disorder groups, drawn from clients in both the addiction and mental health programs, to be run in smaller communities, where either program may have inadequate numbers to run a program. This approach is successfully used in one community I manage and has the potential to be replicated in many others.

Access to a twelve step recovery group such Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) is another option that provides benefit to many in recovery since these groups exist in most communities, regardless of size. Key benefits of this type of group are reduced social isolation, peer teaching, role modeling a substance free lifestyle and the opportunity to develop and practice leadership at meetings or through sponsorship of newer members. In some centers a group called Double Trouble in Recovery applies these same principles to concurrent disorder recovery. For those who prefer a peer-led group that uses CBT principles, Smart Recovery is another credible alternative, that uses in-person or online meetings to provide support.

*Family support and family psycho-education*

Another component of a broad continuum of services is the needs of family members of those with concurrent disorders. Currently this group represents an underserved population that also require services for several reasons. First, family members require support to cope with an un-well person, especially when there are long and/or intensive periods of active substance use or severe symptoms of mental illness. Reaching family members may require assertive outreach since they often advocate for services for their loved one without recognizing their own needs. “Engaging family members early in the
[concurrent] disorder treatment process appears to correlate with a more rapid engagement of the client in... treatment,” creating the potential for results to become evident more quickly for both client and his/her family (Mercer, Mueser, & Drake, 1998, p. 155). Second, providing opportunity for family members to receive information about addiction and mental health in a non-judgemental way is important. At a minimum they require “education about substances, substance use, and... treatment” options available to address all of the addiction and mental health concerns experienced by their loved one (Mercer, Mueser, & Drake, 1998, p. 155). Recognizing and naming what a family member experiences can provide family members with a richer understanding of what is helpful and harmful, as well as how to enhance the potential for change or improvement. Understanding that grief is normal when a concurrent disorder diagnosis is received can reduce isolation and facilitate the development of reasonable expectations. Third, “training for family members can prepare them with the skills to recognize signs of substance relapse, to manage crises, to prevent and manage violent behaviour, and to avoid enabling substance use” (Mercer, Mueser, & Drake, 1998, p. 155). Developing confidence in family members to support their loved ones builds a natural support that can be helpful in preventing relapse and enhancing the client’s overall ability to function in the community.

Within the client’s assessment process, examining the family dynamics, when possible, can be very useful. The intention of the family assessment process is to create a treatment plan that supports all family members, recognizing the client is always responsible for any substance use he/she engages in, as well as for the behaviours that may result. A thorough family assessment considers how the family interacts, including the role of alcohol and other drugs in these relationships. It is also important to consider what family needs are being met by use and to explore “the family’s need to maintain the [client’s] behaviour in order to, for example, create excitement, triangulate conflicts [or] avoid intimacy” and any “active substance abuse in other family members as well as their enabling behaviours and the extent of their own suffering as a result of the [client’s] problems” (Kaufman, 1989, p. 11). Any changes
agreed to in this treatment plan “involve every family member in the effort to achieve new behaviours that help not only the substance abuser but [each family member] as well” (Kaufman, 1989, p. 11).

Family members provide important supports in concurrent disorder recovery in many ways. For example, often family members are a primary source of social and financial support, in the restricted networks of people who struggle with addiction and mental health issues. “Relatives are often the most important people in their lives. This special relationship puts relatives in the unique position of being able to encourage clients to take steps toward recovery and greater self-sufficiency” since they may have a greater understanding of what is working (or not) than professionals who have only snapshots of behaviour and functioning on which to base decisions (Meuser & Fox, 2002, p. 254). Second, this relationship can also be the source of considerable stress and support for family member is a way to, in a small way, diminish the burden. Clients with concurrent disorders are often at the centre of conflict and quarrels within their families. The long-term effect of this ongoing stress may be weakened support and patience from family members. "Family intervention...can prevent overwhelming the coping efforts of relatives, thereby averting the loss of their support” for their loved ones (Meuser & Fox, 2002, p. 254). Third, family education can assist family members in providing support without enabling dysfunctional behaviors by creating a better understanding of the interaction between addiction and mental health issues.

Research about the educational needs of families, collected through focus groups, reveals the following needs:

- Information about addiction, mental health issues, their interaction and treatment options.
- Strategies to help to decrease family relationship stress.
- Help with solving problems so that the goals of family members are not thwarted.
- Collaboration with the treatment team, including opportunity for family input into planning and intervention when a client is on his/her way to relapse.
- Increased social support, potentially through a self-help group for family members.

(adapted from Meuser & Fox, 2002, pp. 255-256).
Because Addiction and Mental Health Services currently has no program in use that addresses these needs, a potential resource for use in community settings is the *Family Intervention for Dual Disorders Program*. It uses treatment stages as a way to educate and engage family members while enhancing their motivation to change. Over the course of nine months to two years, family members participate in a five stage treatment process: connecting, assessment, psycho-education, communication and problem solving skills training and termination. Preliminary results are positive, suggesting that family members can be engaged and that their support is associated with improved client outcomes. Clearly there is potential for Addiction and Mental Health Services to use its resources to develop and deliver programs for this underserved population, with a vicarious side effect of creating additional supports for this client group.

*Supported employment*

Often those with concurrent disorders have difficulty finding and maintaining employment and so are excluded from an important part of life and from achieving financial stability. Providing an effective vocational rehabilitation program that recognizes and supports individual and employer needs while encouraging skill development “can facilitate positive outcomes in substance abuse treatment and can also decrease use of the relatively expensive day treatment programs” by meeting social, belonging and financial needs (Mercer, Mueser, & Drake, 1998, p. 156). When clients live with concurrent disorders, a more intensive model of supported employment may be required, using the services of an employment specialist who assists in finding employment for clients. An advantage of this program is that it “does not require the client to be abstinent from substance use before she receives help finding a job,” although moving towards abstinence is part of the longer term goals a client is encouraged to pursue (Mercer, Mueser, & Drake, 1998, p. 156). An obvious, but important consideration is that any employment must support abstinence. Work in a bar, bottle depot or drive thru all pose risks a client with concurrent disorders would be wise to avoid.
Although this type of program is beyond the mandate of Addiction and Mental Health Services, there is an important role for staff in making referrals, advocating for clients and educating service providers. At present these programs are available in some but not all communities. Enhancing this support service through partnerships with local agencies in more communities is important in creating a more holistic approach to concurrent disorder treatment and in improving the quality of life for people who live with this reality.

*Medical management*

Integrated treatment service includes the diagnosis and treatment of medical needs. The concurrent presence of mental health needs and addiction create a need for both general health-care to manage these issues, as well as specific care for unique needs and ongoing monitoring and evaluation by a doctor or nurse practitioner. “Medical supervision must be available for ordering and supervising laboratory tests for the detection of drug and alcohol use.... [and to ensure] pharmacological treatment of both psychiatric and substance-related symptoms [is consistently available], mental health agencies must arrange for ongoing pharmacological evaluation and support” (Mercer, Mueser, & Drake, 1998, p. 156).

A glaring gap in services in Alberta is the presence of strong liaison between service providers from various disciplines. Laboratory tests are not currently used to monitor substance use, except in methadone maintenance programs. To date, no reliable system to monitor prescription medications for those who have addiction issues and mental health issues is available to facilitate communication between doctors, pharmacists, therapists and addictions counsellors. With dedicated human and financial resources and political will to change, this is an area where Alberta Health Services could leverage its resources to fill a gap.

For some clients the detoxification process may require medical supervision. For example, those with poly-drug use and/or underlying medical conditions and/or physical dependence on depressant drugs
and/or overdose may benefit from medical support to reduce withdrawal symptoms and to monitor for potential seizures. Some medications may be useful in managing withdrawal. For example, “antidepressants have been used to block cocaine highs and relieve rebound depression, so they may be helpful in interrupting cocaine abuse” (Kaufman, 1989, p. 11).

Detoxification services are available in some rural hospitals, as well as through recovery centres in larger communities throughout the province. Many community members suggest there should be a detoxification facility in each community; however, this is not a fiscally realistic option. Rather, training about managing social needs (sleep, nutrition, hydration, a safe environment and some education about refusal skills and managing cravings) through the detoxification process is likely a more cost effective alternative.

Developing training for staff in the many disciplines that treat concurrent disorders could increase understanding about each professional’s role in enhancing the health of this population of clients.

Encouraging a multi-disciplinary approach to integrated treatment has many benefits, not the least of which is improvement in clients’ quality of life and reduced demand for expensive interventions. There are multiple motivations for moving this agenda forward.

Crisis response services

Responding to a crisis is a necessary but expensive and intrusive way to deliver services. Research identifies three times when it is essential to provide crisis response services for those with concurrent disorders including:

- For clients not yet engaged in substance abuse treatment;
- For clients who experience difficulties with relapses;
- For clients who experience difficulties with violent behaviour (Mercer, Mueser, & Drake, 1998, p. 156).

When crisis response services are required, making some modifications to the way services are delivered can enhance the experience for first responders, as well as clients with concurrent disorders they treat. Adaptations can include: “assigning specialized substance abuse treatment staff, providing
[concurrent] disorders training for crisis responders, and developing referral arrangements with facilities that can provide appropriate treatments, such as detoxification” (Mercer, Mueser, & Drake, 1998, pp. 156-157). Enhanced team-based services are available in larger centres and early results show a decrease in repeat calls and increased satisfaction of those who receive and provide services.

Again, integration of all health services into one system provides the opportunity for Alberta Health Services to enhance linkages between service providers in different disciplines. Having conversations to negotiate treatment referral protocols that offer accurate, realistic information and developing professional development opportunities for first responders are two obvious examples of activities that to enhance the continuum of programs to better meet the needs of clients with concurrent disorders.

**Housing**

People with concurrent disorders, like every other human being, need safe, stable living arrangements. “The people in the places where clients live need to support clients' substance abuse treatment goals” in order for the client to be successful in reaching and maintaining these goals (Mercer, Mueser, & Drake, 1998, p. 157). When others in the home use, success is compromised. Where there are emotional, physical, financial or other forms of abuse, success is also compromised.

Some current research suggests that adopting a ‘housing first’ approach is helpful. When clients have assistance to escape homelessness, their energy and effort can be directed towards other goals. This same study recommends a continuum approach to housing, in which clients have access to a variety of options with varying levels of independence and care, matched to needs that are expected to change over time. Because suitable housing is essential to achieving and sustaining successful recovery, and the evidence for specific housing approaches for clients with concurrent disorders is not strong “providing multiple options makes sense” to enhance opportunities for safety and the potential for change (Drake, Mueser, & Brunette, 2007, p. 134). Unfortunately, most communities do have supported living options
for people with addiction and mental health issues. This is another area for improvement, using a multi-sectoral approach to developing and delivering these services.

Inpatient psychiatric hospital services

Present practices to manage admissions and discharges from inpatient psychiatric treatment programs do not provide the kind of care required to adequately meet the needs of clients with concurrent disorders. Policies used dictate stays be very brief in length, focused on the stabilization of acute symptoms. However, to provide the best possible service to clients with concurrent disorders, for whom treatment is a long-term process, stays in inpatient psychiatric hospitals could provide an opportunity to screen, assess and do treatment planning for substance abuse, while also encouraging the individual to make linkages with outpatient services for concurrent disorders upon discharge. This short-term investment in more intensive services, when required, could help clients to achieve better stability in the longer term by providing better problem solving regarding some risk factors that can trigger relapse of substance abuse, circumstances that exacerbate mental health symptoms. For example, ensuring a client has safe accommodations and connections to healthy social supports, including self help groups or an outreach worker, along with outpatient appointments with a physician and/or addiction counsellor and/or mental health therapist, provides structure a client may not be able to arrange independently. The focus of all of these supports must always be on engagement and enhancing motivation to change, using a case managed approach. When these services link consistently and well, the repeated use of “intensive inpatient [concurrent disorder] diagnosis treatment may not be indicated” as a client’s needs are managed effectively in the community (Mercer, Mueser, & Drake, 1998, p. 157).

Intensive concurrent disorder inpatient services are newly available at two sites in Alberta. Currently demand seems to exceed bed availability, creating wait lists that are between six and eight weeks in length. Rather than adding more beds, I argue it is essential to build the capacity of community agencies
and support services through the availability of stable, long-term funding to provide programs and resources that are responsive to the needs of people with concurrent disorders.

Summary of Best Practice Recommendations

Analysis of the components that comprise best practices reveals there is no single correct [concurrent] diagnosis intervention, no single correct program. For each individual, at any point in time, the correct intervention must be individualized, according to subgroup, diagnosis, stage of treatment or stage of change, phase of recovery, need for continuity, extent of disability, availability of external contingencies (e.g., legal), and level of care assessment (Minkoff, 2001, p. 3).

This reality creates both challenge and opportunity for Addiction and Mental Health Services. It is essential to develop a variety of programs to support the multiplicity of needs within this heterogeneous population. Success must be measured by more than abstinence from substances or hospitalizations. Instead, “outcome variables include ...abstinence, [and the] amount and frequency of use, reduction in psychiatric symptoms, stage of change, level of functioning, utilization of acute care services, and reduction of harm” (Drake et al, 2001; Minkoff, 1998 as cited in Minkoff, 2001, p. 3). Recognizing the need for a continuum of services and then ensuring adequate resources are available consistently to provide these supports is necessary to enhance the quality of life for people living with concurrent disorders and to ultimately reduce the cost of treatment services. The current challenge for Alberta Health Services is to develop an organization that has the capacity and resources to create and sustain the required continuum of concurrent disorder treatment services.

Organizational structures to support best practices

Articulating a complete organizational structure is too large a task for this project. For this reason, I focus on highlighting areas where there is potential to enhance services for clients in rural, outpatient settings.
First, development and implementation of effective community-based programs that are adequately funded enhances services to clients who require consistent monitoring and support in their homes and community, rather than inpatient settings. Alberta Health Services inherited a wide variety of contracts with community agencies from the former Regional Health Authorities, the Alberta Alcohol and Drug Abuse Commission and the Alberta Mental Health Board. It is essential that these be evaluated for their ability to provide the kind of services at the level of intensity required by residents of the communities served by the contract. Where necessary, adjustments must be made and professional development offered to meet minimum standards. As well, funding levels must be increased to ensure these agencies have the ability to provide services effectively. Within the area I manage contract amounts have not increased since 2004, forcing staff to spend time fundraising rather than delivering direct services.

Second “cumulative evidence...show[s] that severe mental illness is associated with an increased risk for violent behaviour [and] among people who have severe mental illnesses, substance abuse is the most important risk factor” (Mercer, Mueser, & Drake, 1998, p. 157). There is little information currently available to inform service providers and family members about how to predict, prevent or provide effective treatments for people with concurrent disorders and a tendency towards violence. It is, however, useful to create “effective community-based programs with accurate assessment, treatment planning, and close monitoring, and also by engaging in... collaboration with criminal justice agencies” (Mercer, Mueser, & Drake, 1998, pp. 157-158). Presently this degree of collaboration is rare, although the potential benefits are enormous for all: the client, family members, community members and service providers. This is an area where Alberta Health Services, at corporate level can provide leadership through the development and distribution of resources and curriculum to be distributed and used by front-line staff in delivering information and education sessions in local communities, as needs arise.
Third, at times, when all other options have proved ineffective, involuntary interventions may be required to engage a client in treatment. “Mandates for substance abuse treatment can be appropriate and effective when they come through the criminal justice system, but should not be ordered by the mental health system” (Mercer, Mueser, & Drake, 1998, p. 158). Where an involuntary intervention is used, it is important to make the best possible use of the client’s time in treatment by attempting to “simultaneously address several treatment objectives: the development of the client’s self-motivation, the development of the client’s self-control, the delivery of effective treatment, and the assurance of safety” for the client and for others (Mercer, Mueser, & Drake, 1998, p. 158).

At this time there is no legislation in Alberta that allows a judge to order an adult client to attend outpatient substance abuse treatment or mental health therapy. Presently, all adult outpatient treatment programs are voluntary, creating tension between the needs of the courts and the services available to them. A potential area for expansion for substance abuse treatment programs, as well as mental health therapy programs within Addictions and Mental Health Services is the development of specific programs for those are ordered by the courts to seek outpatient treatment to address substance use and/or mental health issues.

When a client who has a history of violent behaviour is willing and able to engage in treatment, “voluntary options include treatment plan contracts, informal agreements, and behavioural contracts” between the client and his/her service provider(s) (Mercer, Mueser, & Drake, 1998, p. 158). Focussing on engagement and relationship building, while meeting the client where he/she is at, through a stage-based approach to treatment is encouraged and more likely to be effective. Voluntary treatment services that also address issues of violence are an emerging area of service in Alberta through Safe Communities funding and are available in some communities. An obvious recommendation is deliver training and make the tools to implement contracts or agreements available consistently, in easy to use formats.
Fourth, research suggests that laboratory testing for drugs and alcohol may be a useful tool in the treatment of concurrent disorders. Because the harmful use of alcohol and other drugs involves secrecy and deception, self-reporting may not provide accurate information on which to base treatment decisions. “Testing does pose ethical dilemmas; yet these dilemmas are ameliorated as the technologies for testing become less invasive and more accurate and as clients learn to use the test results for feedback on their own goals” (Mercer, Mueser, & Drake, 1998, p. 158). Current practice in Alberta does not include testing, except with methadone maintenance services and by outside agencies (i.e.: Child and Family Services or Probation Services).

Considering and/or moving to this kind of treatment model requires debate with staff, clients and stakeholders, as well as a privacy impact assessment that considers whether the benefits of this information outweighs the issues the process creates. Part of the debate involves questions about the kind of testing to be done. “Hair analysis carries a major advantage over urine testing in that it covers much longer periods than a single urine test” (McPhillips et al., 1997 as cited in Crawford, Crome, & Clancy, 2003, p. S11). Hair test results are useful as they provide more accurate information about type, frequency and intensity of use, rather than snapshot of a very short period of time, in which behaviour may have been abnormal. Integration of services to implement this best practice recommendation requires that the services of a physician and laboratory services be added to the multi-disciplinary team providing care.

Fifth, an emerging area of research deals with the use of medications for the mental health issues, even when the individual continues to use substances, challenging the belief one must be sober before the medications to treat mental health issues are prescribed (Mercer, Mueser, & Drake, 1998, p. 158). “Pharmacological management of both the psychiatric and the substance use disorder is an important foundation of the treatment of clients with co-occurring severe mental illness and substance use disorder” (Drake, Mueser, & Brunette, 2007, p. 132). Although research in this area is in early stages,
there are some clear indications of the benefits of combining pharmacological and psychosocial interventions. For example, “medications shown to be effective for the treatment of alcohol disorders in the general population, such as disulfuram and naltrexone, are probably effective also in clients with serious mental illness” (Drake, Mueser, & Brunette, 2007, p. 132). As well, common medications used to treat mental illness may also reduce the severity of the substance use disorder as long as care to avoid harmful interactions and potentially addictive medications are taken. Examples of potentially beneficial medications to more effectively address the needs of some clients include:

- Antidepressants appear to reduce symptoms of depression, as well as alcohol use in clients with major depression and alcohol disorder
- Mood stabilizers are active not only on mania but also alcohol use in clients with bipolar disorder and co-morbid alcohol dependence
- Typical antipsychotics improve the symptoms of schizophrenia but have little effect on co-occurring substance use
- Most of the newer (atypical) antipsychotics are equally effective as the typical antipsychotics in improving schizophrenia symptoms and may offer some benefit in reducing craving or substance use, but research is preliminary
- Clozapine is clearly the most powerful drug in treating schizophrenia symptoms and, at least in quasi-experimental studies, appears to be at the same time the most effective antipsychotic medication in relation to substance use (paraphrased from Drake, Mueser, & Brunette, 2007, p. 132).

These findings suggest more collaboration between family doctors, psychiatrists, pharmacists, mental health therapists and addiction counsellors is required to manage and enhance the success of those who live with the challenges of concurrent disorders. There is opportunity for this to occur more readily since all of these providers are now Alberta Health Services employees, covered by the same information sharing legislation, the Health Information Act. An essential step in moving this agenda forward is education of doctors and psychiatrists about the benefits of these medications and the circumstances in which they are indicated to ensure those who need this intervention receive it.

Sixth, the expectation of abstinence from substances as a condition of receiving services needs to be reconsidered in the context of concurrent disorders, in the policies and procedures of government and non profit agencies that provide housing and income support, as well as by those who offer treatment
programs. “Clients need safe and stable housing that supports their substance abuse treatment goals long before they become abstinent. Yet traditionally most housing options sponsored by mental health or substance abuse treatment programs have been “dry”: alcohol and drug use are prohibited” (Mercer, Mueser, & Drake, 1998, p. 159). A more realistic approach may be to encourage the reduction of substance use by individuals living in supported community housing that offers flexible house rules. Individual goals and needs can then be supported in a staged approach to housing that offers “wet” or “damp” housing options, in addition to “dry” options (Mercer, Mueser, & Drake, 1998, p. 159). Safe housing options are scarce in many parts of Alberta, particularly in rural communities. Filling this gap requires a shift in government priorities that would place value on providing shelter for vulnerable citizens who lack the resources to address this need for on their own. This shift must also address the need for leadership, know-how and financial resources.

As well, many clients with concurrent disorders have difficulty in accessing financial assistance unless they receive benefits from the Assured Income for the Severely Handicapped program. Regular income support programs often require a medical note and/or a job search on a monthly basis. Unless a formal diagnosis is made by the physician, many clients struggle to provide the documentation that ensures their cheques are received each month.

Treatment program policy often insists on abstinence from all mood-altering substances, including prescription medications. This is not always realistic and excludes some clients from the very treatment programs needed to begin the process of making change. Also, if/when a client relapses and uses substances (s) he is asked to leave the residential program and is ineligible to return for three to six months, depending on the agency’s policy. Based on what is known about the treatment of concurrent disorders, it is more helpful to approach this as behaviour for which there is consequences that hold one accountable for actions, rather than barring the offender from continuing in a treatment program. Making this shift within Addiction and Mental Health treatment programs requires that administrators
be educated and develop a willingness to acknowledge and accept the limitations some clients bring to their recovery program. When these services are offered by contracted agencies, education about the need for revised policies and an expectation these be implemented would ensure a client has access to the services needed to being the process of recovery that ensures he/she functions at the highest possible level most of the time.

Seventh, research also suggests that “involving consumers in shared decision-making demands new concepts about professional and client roles in mental health services... that promises to improve treatment” (Mercer, Mueser, & Drake, 1998). Those with concurrent disorders need accurate information about their condition, as well the treatment options available, so they, perhaps with support from a partner or family member(s) can make an informed choice about treatment interventions. Doing this “engenders respect and trust with the clients, and the clients are more likely to become motivated for change” since the goals are their own. (Mercer, Mueser, & Drake, 1998, p. 159).

This shift in underlying assumptions and beliefs about people and their capacity to recover requires that an expectation of recovery become part of the treatment services system’s values, replacing the idea that when one is diagnosed with addiction or mental illness this is a lifelong impairment that requires the ongoing involvement of professionals to manage. “All interactions and treatments need to be based on the expectation that the person will recover and resume or become engaged in a productive life” rather than require life-long supportive interventions (Cherry, 2008, p. 412). An example of how this shift in service delivery could be applied is evident when a client is reluctant to take psychotropic medications as one component of treatment, in spite of the recommendations of the doctor, psychiatrist or therapist. The treatment team may agree to support the client in this choice, with the proviso that if a relapse occurs, the client tries the medication(s). This removes the service provider(s)
from the role of expert and enables a client to learn what are his/her most effective treatment alternatives, with the support of the team.

Many people, including service providers believe those who abuse substances are at unremitting risk to relapse. Those who abuse substance and have a mental health diagnosis are believed to have an even more hopeless long-term prognosis. In spite of the knowledge that relapse is common, those who develop and deliver treatment programming continue to provide episodic interventions at the time of crises, rather shifting to a recovery based format of programming that supports a conceptualization of the user in recovery.

Next steps in the complex process of changing the treatment services delivery system involve the creation and assessment of ways to monitor and support clients who may be at risk to relapse to substance (ab) use and/or mental health issues. The focus shifts from curing someone through episodes of acute care to encouraging recovery through long-term monitoring and support services. Implementing this kind of “transition is both consistent with the changed conception of the drug abuse client and would seem critical to the increased effectiveness of treatment efforts with clients evidencing [concurrent disorders]” (Flynn & Brown, 2008, p. 44). Clearly there is significant work to do in developing programs that shift the focus from primary care to community based care, from (perceived) experts to the person receiving care making treatment decisions. An important component of this shift is re-educating people who receive services and empowering them to take back some of the control of their treatment, while ensuring health professionals communicate alternatives in language by lay people. This kind of paradigm shift requires education and discussion, both for professionals and those who receive services. Additionally, organizational policies must evolve to reflect this shift in how client needs are understood.

Eighth, an area with great potential for growth is adopting policies to encourage clients to be hired as paid staff when they reach a stage in their recovery where this is possible. The message to both the staff member and other clients is that those with mental health and addiction problems are valuable
resources for the system that provides treatment services. It is possible for these staff members “to engage other clients in treatment and ... provide peer support and [act as] positive role models. They... enlighten their clinical co-workers about clients' perspectives and experiences with medication, mental illness, and homelessness” creating greater empathy and understanding of an otherwise inaccessible reality (Mercer, Mueser, & Drake, 1998, p. 159).

Within Alberta Health Services, currently, there are not processes or policies that encourage this type of engagement with clients or former clients. It is important for those in provincial, executive roles to recognize this as an area for development of new policies and practices, and for those in managerial roles to acknowledge and encourage the development of this potential of clients who receive services. Ninth, creating and supporting a culture of life-long learning for staff is essential in the emerging field of concurrent disorder treatment. At minimum all clinicians require basic training that includes:

- information about the interactions between substance use and psychiatric illness,
- instruments for recognizing and assessing substance use problems,
- an understanding of the concepts of stages of change and stages of treatment
- treatment planning skills
- strategies for engaging clients in treatment and enhancing their motivation for sobriety
- the principles of collaborating with family members and other significant persons in treatment (Drake, Mueser, & Brunette, 2007, p. 134).

Because this is an emerging field organizational support for learning is needed on at least two levels. Program administrators must remain current regarding the research and best practice information and develop treatment programs that evolve with new learning. Individual clinicians must be flexible in his/her practice and supported to take the initiative to seek out and integrate new knowledge into concurrent disorder treatment programming.

A related issue is the need for clinicians who specialize in concurrent disorder treatment to develop and maintain the expertise required in therapeutic modalities shown to be effective in this field. These include: “individual cognitive-behavioural therapy, group-based motivational and skills training approaches, family therapy, as well as skills for addressing common problem areas such as housing
instability, legal problems, health problems, and trauma/victimization” (Drake, Mueser, & Brunette, 2007, p. 134). Some of the responsibility for this falls to the hiring supervisor or manager to ensure that those considered for front-line treatment services positions have the required skills. At times, in rural communities that have difficulty attracting qualified applicants, positions may be filled with candidates who bring less than the minimum education and/or experience to their role. In these situations, organizational support for learning opportunities that bring the individual to the required level is essential.

Unfortunately, my experience in the Addiction and Mental Health Services professional development system echoes the research which states the “two primary concerns [of clinical staff] were lack of resources [to provide appropriate services] and lack of funding to provide adequate training and supervision (Osilla, Hepner, Muñoz, Woo, & Watkins, 2009, p. 418). A potential solution to some of these dilemmas is found in a system developed by Minkoff in 1998. The Comprehensive Continuous Integrated System of Care (CCISC), “provide[s] a framework for developing clinical practice guidelines for treatment matching...and...to design a welcoming, accessible, integrated, continuous, and comprehensive system of care, initially within the context of existing resources... in systems of any size and complexity” (Minkoff & Cline, 2004). The entire system of care is involved in providing dual diagnosis capable (or enhanced) services to a particular segment of clients. Because “individuals with [concurrent disorders] have a wide range of disorders and needs in combination...best practice treatment involves integrating the provision of best practice treatment for each disorder at the level of the client” (Minkoff & Cline, 2004). The result is an “extensive range of best practices for mental health and substance disorders...organize[d]...so that any best practice for either type of disorder is provided in a dual diagnosis capable fashion” (Minkoff & Cline, 2004). A key to successfully implementing this type of system is an integrated treatment philosophy “that utilizes a common language that makes sense from the perspective of both mental health and substance disorder providers” (Minkoff & Cline, 2004).
Obviously implementing a different system of providing care on a provincial level is a challenging endeavor. A 12 step model to accomplish this outlined:

1. Integrated system planning process
2. Formal consensus on CCISC model
3. Formal consensus on funding the CCISC model
4. Identification of priority populations, and locus of responsibility for each
5. Development and implementation of program standards
6. Structures for intersystem and inter-program care coordination
7. Development and implementation of practice guidelines
8. Facilitation of identification, welcoming, and accessibility
9. Implementation of continuous integrated treatment: Integrated treatment relationships are a vital component of the CCISC
10. Development of basic dual diagnosis capable competencies for all clinicians
11. Implementation of a system wide training plan
12. Development of a plan for a comprehensive program array
   - Evidence based best practice
   - Peer dual recovery supports
   - Residential supports and services
   - Continuum of levels of care (Summarized from Minkoff & Cline, 2004).

An important advantage of this system is that it provides an “ongoing quality improvement process that encourages the development of a plan that includes attention to each of these areas in a comprehensive service array” (Minkoff & Cline, 2004).

Moving to a model of service delivery, Minkoff’s or another, resolves several outstanding issues in the provincial addiction and mental health care system. A vision of the type of treatment service delivery model and values that programs and projects use to develop, maintain and enhance their work is provided, along with direction, both at a program and philosophical level.

Tenth, the importance of prevention and early intervention efforts are highlighted as practitioners and researchers develop an enhanced understanding of the aetiology of concurrent disorders. Their observations point clearly to the fact “many mental health disorders have a strong developmental trajectory with an onset often linked to the adolescent period” (Canadian Centre on Substance Abuse, 2009, p. 62). Because of the developmental nature of concurrent disorders, “not only is integration necessary with respect to research, education and care, but a particular developmental focus on youth
and early detection is also called for as we tackle the challenges of concurrent disorders” (Canadian Centre on Substance Abuse, 2009, p. 62). To lessen the severity and frequency of the development of concurrent disorders, it is essential that children, youth and their families are supported and have ready access to services they need. A challenge currently being addressed by Addiction and Mental Health is creation of an internal system that facilitates the development and distribution of resources for this population, as well as co-ordination of services that may be required.

Additionally, “[t]here is a need to ensure that we have practices in place to identify individual and group risk factors early, and to intervene with integrated care programs aimed at preventing concurrent disorders” (Canadian Centre on Substance Abuse, 2009, p. 62). This is an emerging area of practice that requires both resources and focus. It is also one which a government struggling to bring spending under control finds easy to cut. Unfortunately, the long term costs are not recognized, at a societal, community, family or individual level. Both AHS employees and members of the public must advocate for the development and implementation of local programs that work with youth, their family members and other social supports to ensure appropriate interventions are provided at the time they are needed.

Within the research and in my experience a “significant barrier to disseminating empirically supported practices is the lack of time, money, and incentives available to adapt these new approaches” (Osilla, Hepner, Muñoz, Woo, & Watkins, 2009, p. 418). One of the key challenges is ensuring information and training opportunities are available. Making better use of technology and the opportunities to deliver web-based training provides a lower cost alternative, in travel time and expenses, as well as clinician availability in the community. The integration of several organizations into Alberta Health Services provides an opportunity to develop an IT system that supports these emerging technologies and connects professionals in faraway communities with one another.

Research also identifies the need for “implementation tools... to support ongoing monitoring of treatment fidelity” (Osilla, Hepner, Muñoz, Woo, & Watkins, 2009, p. 418). It is not enough to provide
treatment an agency or organization hopes is helpful. Completing the process with evaluation is necessary. Opportunity to gather provincial data is now possible, should the organizational will to develop appropriate systems be present.

Underlying all of these recommendations and suggestions is the need for a different approach to research, as well as a sustained commitment to applying the findings of research to current practices in a timely manner. “The addictions and mental health communities must come together to effectively seize the resources and momentum necessary to address the current gap in research and research funding within the concurrent disorders field” (Canadian Centre on Substance Abuse, 2009, p. 61).

Addressing the significant clinical and human needs of this population is essential to contain costs, address the needs of people who are currently unable to advocate for themselves and to prevent our children and youth from developing these challenges. Success in raising other issues, such as AIDS research, to the forefront, demonstrates the effectiveness of an approach that raises public awareness of the needs and challenges that exist. To successfully move this agenda forward, “it will be important to establish a common national [and provincial] framework for understanding the interplay between substance use disorders and mental health disorders and to establish a unified approach to the care and treatment of those affected by concurrent disorders” (Canadian Centre on Substance Abuse, 2009, p. 63).

Resistance from current staff in addiction or mental health services to a new way of doing their work, can at times, create a barrier to successfully implementing program changes. Therefore, “an optimal solution may involve adding new staff with a commitment to treatment of [concurrent] disorders rather than more training for existing staff, many of whom are not interested in this area (Carey, Purnine, Maisto, Carey, & Simons, 2000, p. 196). It is also essential that the system provide resources for “more case managers, especially those trained to work with [concurrent disorders]” (Carey, Purnine, Maisto, Carey, & Simons, 2000, p. 196).
Conclusion

Clearly there is an enormous amount of research, history and practice to consider in making changes to the system of services that address addiction and mental health. Unfortunately, Alberta Health Services missed the opportunity to do some of the upfront work that could guide this transition. However, there are still many opportunities to use this organizational transition process to move an integrated treatment agenda forward. Some important actions that support this include:

- Staff cross-trained in both substance abuse and mental health models of treatment, and qualified supervision;
- Attention to cultivating therapeutic alliances and engaging [concurrent] patients on their own terms;
- Recognition of the cognitive, social, and environmental limitations of [concurrent] disordered individuals;
- Treatment models that include psycho-education, flexible treatment goals, and multiple indices of improvement;
- Systematic study of the viability of abstinent and non-abstinent goals;
- Development of therapeutic techniques for reducing ambivalence and enhancing motivation to change;
- Increased availability of external incentives for change; and
- Institutional support for integrated treatment programs (Carey, Purnine, Maisto, Carey, & Simons, 2000).

It is incumbent upon all members of the Addiction and Mental Health team, as well as stakeholders and clients to assist in the developing and implementing multiple processes required to break down barriers to concurrent disorder treatment. Policy barriers, including “conflicting statutory regulations at the federal [and provincial] level, inconsistent professional licensure requirements, zoning ordinances that prohibit the establishment of substance abuse[and mental health] treatment facilities, and the lack of shared assessment tools to determine the exact nature and extent of co-occurring disorders” require the leadership of federal, provincial and municipal governments and administrators of various addiction and mental health treatment programs (Power & DeMartino, 2004, p. 721).

Funding barriers, “exemplified by the current patchwork of... funding sources” is likely to be addressed through the transition to one board, overseeing all Alberta Health Services programs. This can prevent
the development of significant disparities in the ability to access service in various parts of the province.

A recent decision by the board to continue to provide funds for long vacant positions in parts of Northern Alberta and to develop and implement a recruiting strategy to address long-time needs in these areas, speaks to positive changes that were not possible in the legacy systems.

Program and clinical barriers “marked by a lack of service models, administrative guidelines, quality-assurance procedures, and outcome measures; the absence of education and cross-training for co-occurring disorders for clinicians; and the underlying and often competing philosophical differences in treatment approaches” require the commitment of senior leadership, as well as directors and managers who set the agenda for priorities to addressed within the organization (Power & DeMartino, 2004, p. 721). Staff must be willing to engage in dialogue that may challenge long held beliefs and demonstrate courage and openness that adapts to an evolving way of practicing. Effective, integrated concurrent disorder treatment and prevention services cannot be delivered without the support of all front-line staff.

Client and family barriers, including “discrimination and stigma, lack of cultural competence among providers, and restrictive eligibility requirements that, too often, result in a decreased desire to receive care” need the engagement of those who receive services to provide feedback, as well as the commitment of all levels of the organization to develop and implement processes that gather information about the experience of receiving service(s) (Power & DeMartino, 2004, p. 721). Using feedback to adjust attitudes and processes to create a welcoming and supportive treatment environment is a required next step.

Clearly there is an enormous amount of work required to undertake and complete the systemic overhaul that is needed to address the challenges of integration, as well as to develop a concurrent disorder treatment system that is responsive the emerging best practices.

The hope is that a new model will emerge as a synthesis of the best practices from the field of mental health, substance abuse treatment, and the traditions from the self-help consumer movement. As
best practices are identified from each field, the exercise in and of itself will help professionals in both fields discard attitudes and interventions that have been harmful to people with a mental disorder or with an addiction, their families, and to us—the clinicians. Like the three legged stool, all three groups (mental health practitioners, addiction practitioners, and peer counsellors) are essential for developing and maintaining a platform that can support the inevitable paradigm shift to hopefully a more effective and moral treatment model for people with a co-occurring disorder of mental illness and addiction (Cherry, 2008, p. 418).

Although the transition to date is less smooth than one would hope, it essential to view this process as the opportunity it is since it is unlikely that most staff, stakeholders and service users can expect to have this potential for influencing services again. Seizing upon the opportunities that exist is essential to evolving a more responsive, effective treatment service system for the clients it is intended to support.

Bibliography


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