

Navigating the treatment system

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Outline

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- Co-ordinating treatment
- Continuing care

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You have to be active with the health care system when you're trying to get help for your family member . . . the dynamic is not that the system is serving you. The dynamic is that you're getting what you need out of the system—and that takes effort. Trying to deal with the mental health system or the addiction system for that matter . . . can be just as frustrating as dealing with the problems your sick family member has all by yourself—and by that I mean just as soul-devouring and just as hope-destroying . . . because the health care system—well, you think of it as something that's going to help you, and when it doesn't, it's doubly devastating. It feels like you've been let down by your grandma or something . . . the door has been shut in your face by someone you thought was kind and benevolent. So, we have to be strong and knowledgeable . . . people have to become “system navigators”—like a new profession that requires education and training. We have to be proactive and learn what to do, who to call, what kind of program is best and how to find the right spot in the system . . . and we have to develop negotiation skills and talk like we have knowledge.

IS THERE A SYSTEM?

While there are many substance use and mental health resources and services available, what are missing are the threads that would join these resources and services together. If those threads were in place, roles and tasks would be clearly understood, client-centred planning started, and services across programs easily accessed. Connecting services is even more of a concern when clients have complex problems, which is usually the case with concurrent substance use and mental health problems. Though providers will acknowledge that a client has many needs, too often, they aren't willing or able to say, “You've come to the right place, and we are the right people to work with you. If we can't meet all of your needs, we have access to other resources that can.”

WHAT SHOULD HAPPEN: INTEGRATED TREATMENT

Treatment for concurrent disorders works best if the client has a stable, trusting, long-term relationship with one health care professional—for example, a case manager or therapist.

Integrated treatment means that treatment for substance use and mental health problems are combined and ideally provided in the same treatment setting by the same clinicians and support workers, or same team of clinicians and support workers. This ensures that a client receives a consistent explanation of substance use and mental health problems and a coherent treatment plan. Integrated treatment means that the client gets co-ordinated and comprehensive treatment, as well as help in other life areas, such as housing

and employment. Ongoing support in these life areas helps clients to maintain treatment successes, prevent relapses and meet their basic life needs.

Most integrated programs have been developed for clients who have severe mental health problems. They have common features including:

- staged interventions (see “States of change” and “Stages of treatment” on p. 121–122)
- assertive outreach (see “Assertive community treatment,” p. 133–134)
- motivational interventions (see “Motivational approaches to treatment,” p. 119–121)
- social support interventions (e.g., housing and employment support).

If integrated care always required that clients be served in a single program, current service systems would have to be completely rebuilt. Fortunately, substance use and mental health service providers are discovering that many people with concurrent disorders can receive well-integrated care from different programs, if:

- links are established among programs
- one person or team takes overall responsibility for ensuring that services are co-ordinated.

Many substance use and mental health service providers have developed collaborative relationships that allow them to offer integrated approaches to treating concurrent disorders.

People with severe mental illness and substance use problems usually respond better when both problems are treated at the same time. However, people with other types of mental health problems may respond better when substance use and mental health problems are treated in sequence (e.g., anxiety problems often improve when substance use is reduced or stopped). In this example, substance use problems are usually addressed first, but within the context of a treatment plan that considers both mental health and substance use problems (Health Canada, 2002).

WHAT MAY HAPPEN: SEQUENTIAL OR PARALLEL TREATMENT

In many communities, treatments for substance use and mental health problems are still offered in isolation from one another. This may occur in one of two ways:

- treatment for one problem is only available after the other problem has stabilized (sequential treatment)
- both problems are treated at the same time, but there is little, if any, communication between the mental health and substance use service providers (parallel treatment).

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Sequential treatment

In sequential treatment, a client with concurrent disorders is not eligible for treatment in one part of the system (e.g., in the mental health care system) until the other problem (e.g., alcohol or other drug use) is resolved or stabilized.

Drawbacks of sequential treatment include the following:

- The untreated problem continues to affect the problem that is being treated.
- Substance use and mental health providers may not agree about which problem (mental health or substance use) should be treated first.
- It is unclear when one problem has been “successfully treated” so that treatment of the other problem can begin.
- Often the client is not referred for treatment of the other problem.

Parallel treatment

In parallel treatment, mental health and substance use disorders are treated at the same time, but by different professionals or teams (often working for different agencies, but sometimes within the same agency).

Drawbacks of parallel treatment include the following:

- Mental health and substance use treatments are often not integrated into a cohesive treatment package. For example:
 - Many addiction services agree that *reducing* or even *monitoring* substance use is a realistic goal for clients at the beginning of treatment. However, some mental health programs ask clients to stop *all* use of alcohol or other drugs before they can begin treatment.
 - Many mental health problems benefit from treatment with medications. However, some substance use programs may want the client to stop taking all drugs, including those used to treat mental health problems.
- Treatment providers may not talk with each other.
- The job of pulling the substance use treatment plan and the mental health treatment plan together may fall on the client and his or her family.
- Clients may not meet eligibility criteria when trying to access one system or the other. This could mean the client receive no services at all.

ACCESS POINTS

Finding a program that is a good fit for your relative can be a challenge for several reasons:

- Many communities have no specialized, integrated concurrent disorders services to assess and treat complex cases.
- In some communities, the waiting lists for specialized services are too long.

- Substance use and mental health programs and services may have admission criteria that exclude clients with concurrent disorders.
- Finding psychiatrists or clinical psychologists who can provide psychiatric diagnoses can be a challenge in many communities.
- Treatment resources may be lacking, even though you, your relative or your doctor understand what would be most helpful.

But you have to start somewhere, so we begin by talking about the most common entry points into the system.

Family doctors and psychiatrists

Family doctors, or general practitioners (GPs), are often the first professionals that people talk to about a mental health problem. Doctors can examine your relative's physical health and rule out problems that could be adding to or affecting changes in his or her mood, thinking or behaviour. Sometimes doctors can do a full psychiatric assessment, particularly for the more common conditions, such as depression or anxiety. Sometimes, doctors will suggest that a person see a psychiatrist.

Psychiatrists almost always need a referral from a doctor before they can see a client. Family doctors often have a list of psychiatrists they can refer a person to. After booking an appointment, a person often has to wait at least two to three months to see a psychiatrist. **If you and/or your relative don't agree with the diagnosis, your relative should ask the family doctor for a referral to another psychiatrist for a second opinion.** Most doctors are open to clients seeking another perspective and may even suggest it.

Community mental health agencies

Community agencies can also offer assessments. The type of assessment will depend on the health care provider available. Sometimes this may be a doctor, psychologist, social worker or nurse. In smaller cities and rural areas, you are more likely to be seen by a community mental health worker. This person will try to match your needs with the services available.

Substance use agencies

Most substance use agencies accept self-referrals. After an initial assessment, the person will be referred to the level of care (e.g., community-based treatment, residential treatment, withdrawal management) that meets his or her needs at that time. Screening for mental health problems should be part of the assessment process, and referral to a mental health treatment program or a specialized concurrent disorders program is a possibility.

Hospital emergency departments

In a crisis, you and your relative can go to the emergency department of a hospital. If the situation does not require immediate medical care, the next step may be a more in-depth assessment from a crisis worker. This person is often a nurse or social worker. (For more information about emergency treatment, see Chapter 10.)

Access Points is adapted from *Challenges & Choices: Finding Mental Health Services in Ontario*. You can find *Challenges & Choices* at www.camh.net/Publications/CAMH_Publications/challenges_choices.html.

ConnexOntario

ConnexOntario is a bilingual information and referral service in Ontario for the public and professionals wanting to access addiction and mental health treatment for themselves, family, friends or clients. Information and referral specialists offer education and guidance based on each caller's situation.

Toll-free telephone numbers:

Drug and Alcohol Registry of Treatment: 1 800 565-8603

Mental Health Service Information: 1 866 531-2600

Ontario Problem Gambling Helpline: 1 888 230-3505

These information lines are available 24 hours a day, seven days a week. You can find more information about ConnexOntario at www.connexontario.ca.

Questions to ask a treatment agency

- What is your treatment philosophy and method?
- Do you refer clients to other agencies for some substance use and/or mental health services? If so, who is responsible for overall co-ordination of services?
- What percentage of your clients has co-occurring substance use and mental health problems?
- What is your policy about using medication as a treatment option?
- Does the program support a full range of needs (e.g., social and medical)?
- What role do family members play in their relatives' treatment?
- Do you offer services and referrals for family members?

SCREENING, ASSESSMENT AND DIAGNOSIS

Screening

Screening procedures are designed to identify whether someone *might* have a mental health and/or a substance use problem, and whether he or she should have a comprehensive assessment.

People who work in the substance use and mental health fields are encouraged to expect to see concurrent disorders rather than see them as an exception. However, some mental health agencies still don't screen clients for substance use problems, and some substance use agencies don't screen clients for mental health problems. When your family member begins treatment, ask if both problems have been considered.

Assessment

Assessments usually start with a conversation with the health care provider. Questionnaires are often part of the assessment interview. The treatment provider investigates how the substance use and mental health problems interact. During an assessment, people are often asked to discuss things such as:

- why they have come for help, what kind of help they are looking for and what has helped in the past
- their physical condition
- general life problems, troubling thoughts or feelings, substance use problems, as well as how long problems have lasted
- whether they have experienced or seen violence (e.g., physical or sexual assault, war), even if it occurred years before
- whether there is a history of substance use or mental health problems in their family
- what their life is like (e.g., how they feel, what they think, how they sleep, if they exercise and socialize, how they do at school or work, how their relationships with friends and family are)
- whether they've come to Canada in the last few years and/or whether they've come from a war-torn country
- what, if any, medications they take.

The client and the treatment provider use the information from the assessment to develop a treatment plan.

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Diagnosis

It is not always necessary to have a diagnosis before starting treatment. However, a diagnosis may help to direct treatment. For example, a diagnosis may determine if a particular kind of therapy would be most helpful and whether there are medications that could help treat the problem.

Even if your relative does receive a preliminary diagnosis, it may change or be interpreted differently by other health care providers over the course of treatment. It is often hard to determine whether symptoms are related to substance use or a mental health problem. The only way to figure out what you are dealing with is to see how the symptoms develop over time.

It's very difficult to identify the issues when it comes to mental illness and substance abuse. You know, cancer is much more clear-cut. And I don't think even the psychiatrists are really sure a lot of the time. They may be sure of the diagnosis, but they often don't help very much with the prognosis—and that doesn't help the cause of families, who know this is an illness that can respond to medication. We all need to view mental illness as something that can be treated, so at least there's hope out there! Having hope can make all the difference in the world.

TREATMENT PLANNING

There is no single, correct intervention or program for people who have concurrent disorders. The treatment plan needs to be customized to address each client's particular needs. Treatment plans should:

- identify issues and problems
- outline short-term and long-term goals
- establish approaches and interventions to meet the goals.

In many cases, treatment includes helping a person with employment, housing, finances, leisure activities and basic daily self-care. The person giving the assessment may recommend your family member see a therapist or that he or she start taking medication. Joining a self-help group is also an important part of treatment for many people. A person may decide he or she simply needs more support during stressful times. The ultimate goal of treatment is for people to decide what a healthy future means for them and to find ways to live a healthy life.

Family involvement

Families often provide the ongoing, day-to-day care, so they should be involved in treatment planning if possible. Families will often have information that should be considered by the treatment team as part of the planning process. Their perspective may be different than that of the client or the treatment team.

The amount of family participation will depend on the client. One barrier to family involvement cited by providers and families is unclear confidentiality policies. **A treatment provider cannot share case-specific information with you without your family member's agreement.** Treatment providers should ask clients if they agree to family members participating in planning and treatment. However, many providers don't ask, so it's best if you talk to your family member and let the treatment team know what you have agreed to. Have this agreement added to your family member's treatment record. If more than one agency is involved in care, make sure each agency is aware of whether your relative has agreed to share information with you and whether the agency has a copy of that agreement in its files. You may need to start the conversation because each agency may assume that the other has talked to your relative.

Learning about substance use and mental health problems will help you recognize what type of information will be useful to the treatment team. It often helps to organize your questions and concerns into a document. Keep the document short and to the point, and keep the tone neutral. If possible, you and your relative should work together to decide what information to include.

IF YOUR RELATIVE DOES NOT WANT YOU INVOLVED

Even if your relative hasn't agreed to share treatment information with you, the treatment team can still talk to you about:

- the nature of substance use and mental health problems
- how to respond to disturbing behaviours
- how to get help in an emergency
- how to get help for yourself.

The treatment provider can also listen to your observations. Avoid making treatment recommendations—remember, you are not the attending physician or psychiatrist!—but allow the treatment team to draw conclusions from the information you present.

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Figure 7-1: Sample family information document

Information provided to:

Client's name:

Form completed by:

Relationship to client:

Date:

Issues that I am concerned about:

- 1.
- 2.
- 3.
- 4.
- 5.

Recent family or life events that may have contributed to mental health and/or substance use problems.

- 1.
- 2.
- 3.
- 4.
- 5.

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If your family member doesn't want you to be involved, check periodically to see if he or she has reconsidered or to express your interest in being involved.

Questions to ask about the treatment plan

If your relative has agreed to having you involved, here are some questions to ask about his or her treatment plan:

- What is the provisional diagnosis?
- What are the possible causes of my relative's problems?
- What is the proposed treatment?
- What are the benefits and risks of the treatment?
- Are other treatments available?
- What are the options if this treatment doesn't work?

TREATMENT

In the past, treatment for people with severe mental illness and substance use problems tended to concentrate on the limits and impairments associated with mental health problems, while overlooking the strengths that people can often harness to achieve their personal goals. We have found that treatment is more effective when it focuses on identifying people's personal goals and abilities, and the personal and community resources and opportunities available to help them achieve their goals.

Motivational approaches to treatment

Motivational approaches can be more effective than conventional methods of working with people with concurrent disorders. Motivational approaches are also useful in encouraging people to identify their goals, and in building hope and commitment to change and recovery.

Some people enter therapy determined to change and are ready to talk about their reasons for wanting to change. However, many people are not motivated to change. There are many justifiable reasons for this:

- Some people may not even acknowledge that they have problems.
- People with concurrent disorders are more likely than others to have had previous unsuccessful attempts to change.
- The interaction of their substance use and mental health problems may have made it harder to follow treatment plans.
- They are more likely than other clients to feel discouraged about the prospects of improving their situation.
- They may also feel that substance use gives them relief from other symptoms and from their distress.

Being ambivalent (being of two minds) about a particular behaviour is normal. How people balance the costs and benefits of a behaviour affects whether they'll continue or change the behaviour.

Motivational approaches use the client's perspective on his or her mental health and substance use problems as the starting point for treatment. It requires that therapists get in touch with how the client sees things. This approach often opens a pathway to working on practical issues of concern to the client. This can include issues of health and safety—for example, finding housing—even when the client isn't ready to change behaviours that may actually contribute to the problem. Acknowledging the client's perception and lifestyle doesn't necessarily mean that the therapist agrees with that perception. **The long-term objective is to help the client set goals and recognize that his or her current lifestyle interferes with achieving these goals.** However, in the short-term, the family—or others, such as an employer—may not understand why the client and the therapist are not working directly on the substance use and mental health problems.

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Activity 7-1: Exploring ambivalence about change

One of the fundamental techniques of the motivational approach is to look at the benefits and costs of not changing and the benefits and costs of changing. Therapists call this *decisional balance*.

Think about what your relative might see as the benefits and costs of using substances. It may help you understand why your family member uses substances or is reluctant to seek treatment.

The benefits of continuing to use alcohol and/or other drugs for my family member may include:	The costs of continuing to use alcohol and/or other drugs for my family member may include:
The benefits of changing this use of alcohol and/or other drugs for my family member may include:	The costs of changing this use of alcohol and/or other drugs) for my family member may include:

Motivation and substance use goals

When people have concurrent disorders, abstinence is often the best long-term substance use goal. Continued use of alcohol and/or other drugs may worsen emotional and mental health problems and threaten a person's overall physical and psychological well-being. However, many people may, at least at first, lack the confidence and skills to decrease or stop their substance use. So, when clinicians work with someone who is struggling with both major substance use and mental health problems, the short-term goal is often to reduce the most harmful effects of substance use while developing a strong working alliance with the client. This trusting relationship can help clients understand the negative effects of their substance use and develop the motivation to address it. This approach—not requiring the person to commit to abstinence as a condition for help—is called *harm reduction*.

STAGES OF CHANGE

Changes in behaviour occur over a series of stages (Pruchaska et al., 1992). Recognizing what stage a particular client is at can help clinicians decide which interventions are more likely to be successful at a particular point in treatment and recovery.

The stages of change model outlines five basic stages:

- precontemplation
- contemplation
- preparation
- action
- maintenance.

Some people move steadily through the stages toward recovery. Others move rapidly and then slow down or stop for a while. People often relapse (return to problematic behaviours), move backward through the stages and then move forward again.

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Table 7-1: Stages of change

STAGE	EXAMPLE
Precontemplation	“I don’t think I have a problem.”
Contemplation	“I’m not sure, but I might have a problem.”
Preparation	“I think I have a problem, but I am not sure what to do about it.”
Action	“I have a problem, and I want to change it. I know where to get help with this change if I need it.”
Maintenance	“I have already made changes and I want help to maintain them.”

STAGES OF TREATMENT

The stages of change model describes the process of behavioural change. Treatment strategies should be adapted to a person’s motivation to change. Researchers have developed a complementary step-wise model of stages of treatment. The model describes four major stages:

- engagement
- persuasion
- active treatment
- relapse prevention.

Table 7-2: Stages of treatment

ENGAGEMENT			
Stage of change	Current situation	Treatment goal	Clinical interventions (examples)
Precontemplation	Person does not have regular contact with a clinician	To establish a trusting therapeutic relationship with the person	<ul style="list-style-type: none"> • Practical assistance (e.g., food, clothing, financial benefits) • Crisis intervention • Stabilization of psychiatric symptoms (e.g., medication management)

PERSUASION			
Stage of change	Current situation	Treatment goal	Clinical interventions (examples)
Contemplation Preparation	Person has regular contact with a clinician, but does not want to work on reducing substance use	To develop the person's awareness that his or her substance use is a problem and to increase the person's motivation to change	<ul style="list-style-type: none"> • Individual and/or family education • Motivational interviewing

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ACTIVE TREATMENT			
Stage of change	Current situation	Treatment goal	Clinical interventions (examples)
Action	Person is motivated to reduce substance use	To help the client further reduce his or her substance use and, if possible, attain abstinence	<ul style="list-style-type: none"> • Individual counselling (e.g., cognitive-behavioural therapy) • Peer groups (e.g., group therapy) • Social skills training

RELAPSE PREVENTION			
Stage of change	Current situation	Treatment goal	Clinical interventions (examples)
Maintenance	Person has not experienced problems related to substance use for at least six months (or the person is abstinent)	To maintain awareness that relapse can happen; to extend recovery to other areas of the person's life (e.g., family and other relationships, social activities, work and school)	<ul style="list-style-type: none"> • Peer groups (group therapy or relapse prevention groups) • Self-help groups (e.g., Alcoholics Anonymous, Mood Disorders Association of Ontario) • Family problem solving

Table 7-3: Stages of treatment and family collaboration

ENGAGEMENT		
Current situation	Family collaboration goal	What family members should expect
Family members are in contact with a case manager or counsellor and are beginning to develop a working relationship	To establish regular contacts and develop an alliance between the clinician and the family	<ul style="list-style-type: none"> • Education about substance use and mental health disorders • Encouragement that change is possible • To be heard and supported

PERSUASION		
Current situation	Family collaboration goal	What family members should expect
<p>Families are engaged in a relationship with a case manager or counsellor, and are discussing their relative's substance use and mental health problems</p> <p>Families may also be participating in monitoring and helping their relative to begin to reduce his or her substance use</p>	<ul style="list-style-type: none"> • To help family members see that their relative's use of alcohol and/or other drugs is a problem • To help family members see how substance use is interacting with his or her mental health problem • To help families understand that both issues need to be addressed 	<ul style="list-style-type: none"> • More specific education about the effects of substance use on mental illness and how the two illnesses interact • Encouragement and help to develop external social supports • Help with problem-solving on family issues related to substance use and mental health problems

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ACTIVE TREATMENT		
Current situation	Family collaboration goal	What family members should expect
Families are engaged in treatment, help their relative reduce or stop substance use, follow aspects of their relative's treatment plan, help their relative avoid high-risk situations and reduce stressors	To help family members develop strategies to reduce substance use and follow aspects of their relative's treatment plan	<ul style="list-style-type: none"> • Help in modifying stressful communication styles that may contribute to relative's substance use • Education about different types of therapy for concurrent substance use and mental health problems and how to access these services

RELAPSE PREVENTION		
Current situation	Family collaboration goal	What family members should expect
Family members continue to offer their relative support and practical assistance in their efforts to avoid substances of abuse and follow their treatment plan	<ul style="list-style-type: none"> • To help family members maintain an awareness of their relative's vulnerability to relapses • To help family members build on their relative's successes by facilitating improvements in other areas 	<ul style="list-style-type: none"> • Periodic review of progress made by the family and risk factors associated with relapse of substance use or mental health problems • Education about how to enhance other areas of their relative's functioning—for example, relationship skills, work, school, self-care, independent living skills and healthy leisure activities

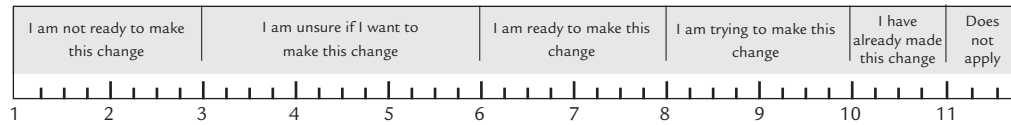
Activity 7-2: The family concurrent disorders

Readiness to change ruler

Completing this tool may help you to think about how ready you are to change certain beliefs and actions associated with having a loved one with concurrent disorders.

Using the ruler shown below, indicate how ready you are to make a change in each of the following areas. If you are not at all ready to make a change, you would circle the 1. If you are already trying hard to make a change, you would circle the 11. If you are unsure whether you want to make a change, you would circle 3, 4 or 5. If a particular item does not apply to you, circle “Does Not Apply” in the box to the right.

How **ready** am I to ... ?



. . . admit that my family member has both a mental health and a substance use problem?

1 2 3 4 5 6 7 8 9 10 11

. . . accept that my family member has both a mental health and a substance use problem?

1 2 3 4 5 6 7 8 9 10 11

. . . accept that I am not to blame for my family member’s concurrent disorders?

1 2 3 4 5 6 7 8 9 10 11

. . . think about ways I can best help my family member?

1 2 3 4 5 6 7 8 9 10 11

. . . seek help for my family member from mental health and/or addiction professionals?

1 2 3 4 5 6 7 8 9 10 11

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I am not ready to make this change	I am unsure if I want to make this change	I am ready to make this change	I am trying to make this change	I have already made this change	Does not apply					
1	2	3	4	5	6	7	8	9	10	11
. . . seek help for myself from mental health and/or addiction professionals?										
1	2	3	4	5	6	7	8	9	10	11
. . . seek help for my family member from a self-help group (e.g., AA, Dual Recovery)?										
1	2	3	4	5	6	7	8	9	10	11
. . . seek help for myself from a family peer support group (e.g. Al-Anon, Mood Disorders Association of Ontario)?										
1	2	3	4	5	6	7	8	9	10	11
. . . seek help for my family member or for myself in spite of the stigma associated with concurrent disorders?										
1	2	3	4	5	6	7	8	9	10	11
. . . work on overcoming any other barriers preventing me from attending a professional or self-help family intervention?										
1	2	3	4	5	6	7	8	9	10	11
. . . commit to taking care of myself as a top priority?										
1	2	3	4	5	6	7	8	9	10	11
. . . admit to and accept my own personal strengths and limitations?										
1	2	3	4	5	6	7	8	9	10	11
. . . accept that relapses are common in recovery from concurrent disorders?										
1	2	3	4	5	6	7	8	9	10	11

TREATMENT APPROACHES

Treatment for concurrent disorders includes psychosocial treatments (discussed in this chapter) and medication (discussed in Chapter 8). Clients may receive one or the other, or both.

Types of therapy

Individual therapy allows the therapist to focus his or her attention solely on the client, with no distraction from others. Individual therapy is especially helpful in developing a close working relationship, exploring personal motivation and goals, and identifying individualized targets for intervention.

Group therapy (groups led by professionals) approaches offer the advantage of promoting social support among clients and providing positive role models for clients at earlier stages of treatment. Groups usually consist of up to 10 people. Often two therapists run them. A group setting can be a comfortable place to discuss issues such as family relationships, medication side-effects and relapses.

PSYCHOEDUCATION

Psychoeducation is education about mental health and substance use issues. People who know about their problems are better prepared to make informed choices. Knowledge can help clients and their families deal with their problems, make plans to prevent future problems and build a plan to support recovery.

Everyone should receive psychoeducation when they begin treatment for concurrent disorders. Some people may have trouble processing or remembering information that they receive at this early stage. As they move through recovery, they may benefit more from psychoeducation. For people who have milder problems, psychoeducation alone may be the only treatment they need.

Psychoeducation sessions include discussions about:

- what causes substance use and mental health problems
- how the problems might be treated
- how to self-manage the problems (if possible)
- how to prevent future episodes.

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PSYCHOTHERAPY

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

Certain types of psychotherapy are better for certain problems. Psychotherapy can be either short-term or long-term.

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

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

Successful therapy depends on a supportive, comfortable relationship with a trusted therapist. The therapist can be a doctor, social worker, psychologist or other professional. Therapists may work in hospitals, clinics and/or private practice. There are many different types of psychotherapy.

Cognitive-Behavioural Therapy

Cognitive-behavioural therapy (CBT) is based on the theory that thoughts have an important influence on how people behave. Therapists help people to identify unhelpful thoughts and behaviours and learn healthier skills and habits. The client and therapist identify goals and strategies. There is an emphasis on practising the skills between sessions (homework).

Social Skills Training

Social skills training uses techniques such as role-playing, modelling, coaching, homework and feedback to help people learn (or relearn) interpersonal skills and competencies.

Dialectical Behaviour Therapy (DBT)

Dialectical behaviour therapy (DBT) is a type of cognitive-behavioural therapy. It is used to treat a range of behaviour problems. In DBT, people look at how their background and their life experience affect how they control their emotions. DBT draws on western cognitive-behavioural techniques and eastern Zen philosophies. It teaches clients how to:

- become more aware of their thoughts and actions (“mindfulness”)
- tolerate distress
- manage their emotions
- get better at communicating with others
- improve their relationships with other people.

Structured Relapse Prevention

Structured Relapse Prevention (SRP) uses a cognitive-behavioural approach to help people with moderate to severe problems gain more control over their use of alcohol and other drugs.

Psychodynamic (or Insight-Oriented) Therapy

Psychodynamic psychotherapy, also referred to as insight-oriented therapy, is based on the theory that unconscious processes (issues that a person may not be aware of) influence behaviour. This approach helps people examine unresolved issues that have resulted from relationship problems in their past.

Interpersonal Therapy

Interpersonal therapies help clients get better at communicating and interacting with others. These therapies help people:

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

Interpersonal group therapy focuses on the interactions among group members.

Motivational Interviewing

Motivational Interviewing (MI) is a method of enhancing a client's own motivation to change. MI was originally developed as a way of working with people with alcohol and other substance use problems. The approach is now used with people who have problems such as bulimia, hypertension, diabetes and concurrent disorders.

Peer support groups

A peer support group is made up of people who all have similar problems. Group members can share their struggles in a safe, supportive environment. People who have recently been diagnosed with concurrent disorders can benefit from hearing about the experiences of others. Group members usually develop strong bonds.

There are peer support groups for clients and for families. Double Trouble groups and Dual Recovery Anonymous are examples of groups for clients. The Family Association for Mental Health Everywhere (FAME) has groups for families. Although these groups are often called *self-help*, peer support actually offers a type of help called *mutual aid*.

Navigating the treatment system

Tips for evaluating peer support groups

Most family self-help / mutual aid organizations are geared toward either mental health issues (e.g., Mood Disorders Association of Ontario or the Schizophrenia Society of Ontario) or substance use issues (e.g., Al-Anon). However, many family members of people with concurrent disorders have found either or both of these types of organizations and groups to be extremely helpful.

If you decide to attend one of these groups, it is a good idea to evaluate them to decide if the particular group suits you and your situation.

Questions to ask about a self-help group

- Does this group welcome new members?
- Do group members respect each other?
- Is the group relevant to my situation, concerns and needs?
- Are there any requirements for attending this group (e.g., a membership fee)?
- Is the group respectful and inclusive of family members from diverse backgrounds (e.g., from a range of cultural, racial, religious and economic backgrounds)?
- Does the group offer both support and education?
- Is the group ongoing or is it time-limited?
- Does the group have a positive attitude toward professional help for families?
- Who facilitates the group and how is the group process managed?

If this group is for family members of persons with mental health problems:

- Is it OK to discuss my relative's substance use problems?

Is the group willing to consider harm reduction as an option in substance use treatment? If this group is for family members of persons with substance use problems:

- Is it OK to discuss my relative's mental health problems?
- Does the group support using medication to treat mental health problems?

Therapy for family members

Family members can also enter care as clients themselves.

Family therapy can offer advice and support to family members and teach them:

- about concurrent disorders
- how to help the client and support treatment efforts
- how to care for themselves.

Usually, therapists work with one family at a time. However, sometimes, family therapy is offered in a group setting with other families in similar situations. Group members can share feelings and experiences with other families who understand and support them.

Family interventions take advantage of clients' natural support systems and can lead to the creation of a home/family environment that is supportive of decreased substance use and adherence to an overall treatment program for the mental health problem.

CO-ORDINATING TREATMENT

Assertive community treatment

The assertive community treatment (ACT) model was developed to meet the needs of clients with severe mental illness who often experienced relapse and rehospitalization, frequently due to their inability or unwillingness to go to local mental health centres. The ACT team provides around-the-clock support and services such as case management, assessment, psychiatric care, employment and housing assistance, family support and education, substance use treatment and other services that help a person to live in the community.

ACT teams may include a psychiatrist, psychologist, psychiatric nurse, social worker, peer support worker (someone with a similar problem or issue who offers support), caseworker, recreation therapist, addiction specialist, vocational (job) specialist and/or occupational therapist who help with tasks of day-to-day living. Some team members are linked to a hospital; others are based in the community.

ACT team members usually meet with the client every day in the community (e.g., in the person's home or in a coffee shop). They make sure that people receive consistent care and strong, ongoing support from the team members.

ACT team services are usually accessed through a mental health agency. Like many other services, you are more likely to find ACT teams in cities and larger communities.

Navigating the treatment system

In Ontario, the criteria used to decide which clients get priority for ACT services are:

- a diagnosis of schizophrenia, bipolar disorder or another psychotic disorder
- significant problems with basic activities of daily living
- long-term problems (such as a co-occurring substance use disorder) that require eight or more hours of service per month.

More details about the criteria are available in the *Ontario Program Standards for ACT Teams* (www.health.gov.on.ca/english/public/pub/ministry_reports/psychosis/psychosis.html).

Case management

Clinical case management has been the dominant model for co-ordinating and delivering mental health treatment. The overall goals of this model are:

- to assess clients' needs
- to identify and provide necessary services to meet those needs
- to monitor client outcomes to determine the success of treatment interventions or the need for other services.

In the ACT model, the responsibility for delivering services is shared by the team. In the case management model, services are provided by the case manager. However, case management is most effective when the case manager is part of a multidisciplinary treatment team that also includes a psychiatrist and various other mental health care professionals (e.g., nurses and vocational specialists).

CONTINUING CARE

People with concurrent disorders should be entitled to a team of resource workers that take an ongoing, respectful and proactive interest in supporting them and their families. **Continuing care does not necessarily mean that the client and counsellor must continue to meet regularly, but that, from the counsellor's perspective, the door is always open and the client is welcome, even if the last contact was some time ago.**

The long-term goal is a stable recovery and transition out of treatment. Because concurrent disorders are often complex, recovery may include several transitions between levels of care (e.g., between inpatient and outpatient care; between outpatient and community care). Treatment providers should take responsibility for managing the transition and for following up to ensure that the new arrangement works. However, we know that this co-ordination is sometimes left to the family and the client.

Transition or discharge planning should begin when the client enters care. You and your relative need to be involved. You should make sure that the treatment team

understands how much care you can provide for your relative, and that services are put in place to fill any gaps. A transition plan should include a full array of services:

- case management
- child care
- financial support
- housing
- physical health needs
- a support network.

When your relative leaves treatment, you need to be clear about how to reconnect with the service, if necessary.

Questions to ask about a transition or discharge plan

- Has a follow-up session been scheduled? (If so, make sure you know the date and time, location, contact name and telephone number.)
- What medications have been prescribed? What are they for? What is the dosage of each prescription? When should they be taken?
- Have relapse risk factors/triggers been identified?

If your relative isn't living with you:

- What arrangements have been made for housing?
- Have resources been identified to help the person reconnect to employment, school or vocational training?

It takes a lot of effort and commitment to make the mental health and substance use systems work for your relative. **You should be recognized as a partner in organizing and delivering the care your relative needs, so educate yourself about concurrent disorders and treatment options, be persistent, ask questions—and keep asking them until you get the information you need**

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