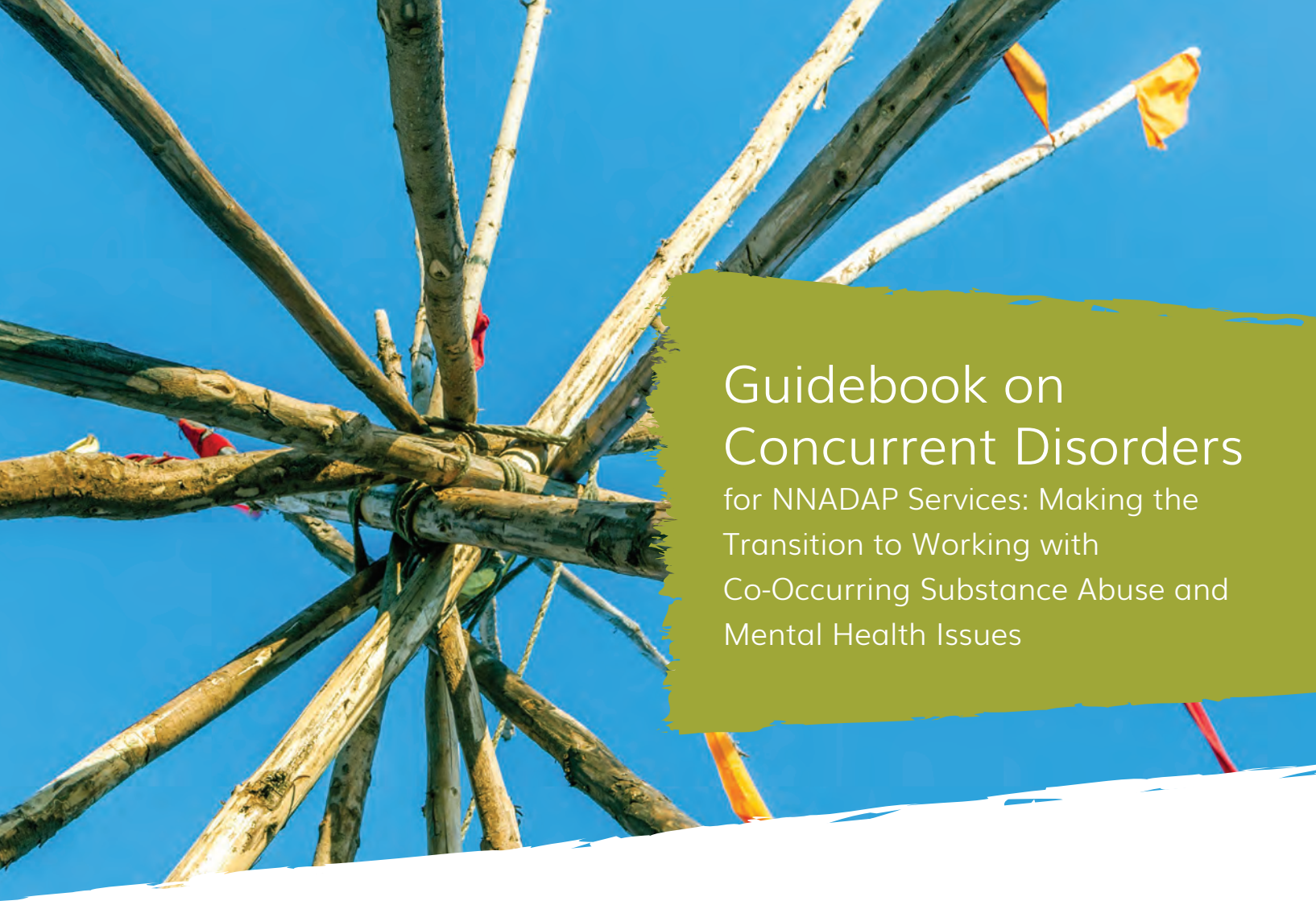


Guidebook on Concurrent Disorders

for NNADAP Services: Making the Transition to Working with Co-Occurring Substance Abuse and Mental Health Issues

Thunderbird Partnership Foundation

TABLE OF CONTENTS

Introduction

This guidebook has been developed to provide information that will support First Nations Treatment Centres and Community Programs in adapting their programs to address co-occurring mental health and substance abuse treatment issues within a cultural framework. This guidebook also gives direction for additional information / training to develop programming for more specialized or complex Concurrent Disorders. This guidebook is designed to provide information on how to become Concurrent Disorders Capable and is not meant to be a training document on the treatment of Concurrent Disorders. A brief annotated bibliography lists resources with more intensive information on treatment.

Why Work with Co-Occurring Addictions and Mental Health Issues?

The fields of mental health and addictions have become increasingly aware over the past thirty years of the complex nature of working with people who have both mental health and addictions issues. Historically, it was common practice for substance abuse treatment programs to ask potential participants to deal with their mental health issues first and not come into treatment while taking physician-prescribed psychiatric medications; people wishing to access mental health treatment programs were asked to be free of substance abuse prior to accessing the service. This meant that a large group of people who had both an addiction and a mental health issue were not able to access any treatment. This sequential treatment[1] of each disorder ignored the interactive nature of co-occurring issues.[2] Mental health and addictions workers determined during the late 1980's and 1990's that the co-occurring presence of both addictions and mental health issues in clients was so prevalent that the development of best practices was needed to extend to the general treatment populations in both fields.[3]

It is important to address the mental health issues caused by trauma when supporting people through substance abuse treatment.[4] Western-based research is not the only source from which this guidebook draws its best practices as Indigenous individuals and communities often have shared multi-generational experiences. While some forms of intergenerational trauma affect many Indigenous people – including colonization, separation from the land, dissolution of communities, oppression, residential schools, the Sixties Scoop, marginalization, and aboriginalism[5] – it is important to recognize that individuals and communities may have experienced their own unique traumas as well. In addition, First Nations individuals accessing mainstream health services treatment have reported experiences of discrimination and disrespect which can worsen the effects of trauma.

1 Sequential treatment: treating one disorder first and then the other disorder second.

2 K. Mueser et al., *Integrated Treatment for Dual Disorders:A Guide to Effective Practice*, New York: The Guilford Press, 2003.

3 K. Minkoff, *Developing Standards opf Care for Individuals with Co-occurring Psychiatric and Substance Use Disorders*, Psychiatric Services, May 2001.

4 Klinic Community Health Centre, *The trauma-informed toolkit,* Winnipeg: Klinic Community Health Centre, 2008.

5 "'Aboriginalism,' or the social and cultural reimagining of genocide, is based on the idea that what is integral to Indigenous peoples is an irrelevant relic, and that if First Nations are to have a viable future, it will be defined by and express itself only at the discretion of the dominant society. Aboriginalism assumes that in renewing relationships between First Nations and the colonial regime, the important and valuable aspects of indigenous culture will be abandoned or compromised in the interests of honouring Euroamerican values and cultures and preserving the central premises of the colonial regime and the preferences of settler society. In reality, aboriginalism is a false consciousness, a permanent embedding of colonialism's assumptions and attitudes into First Nations culture and society." Gerald Taiaiake Alfred, "Colonialism and State Dependency," Journal of Aboriginal Health 5.2 (November 2009): 51.

Honouring Our Strengths

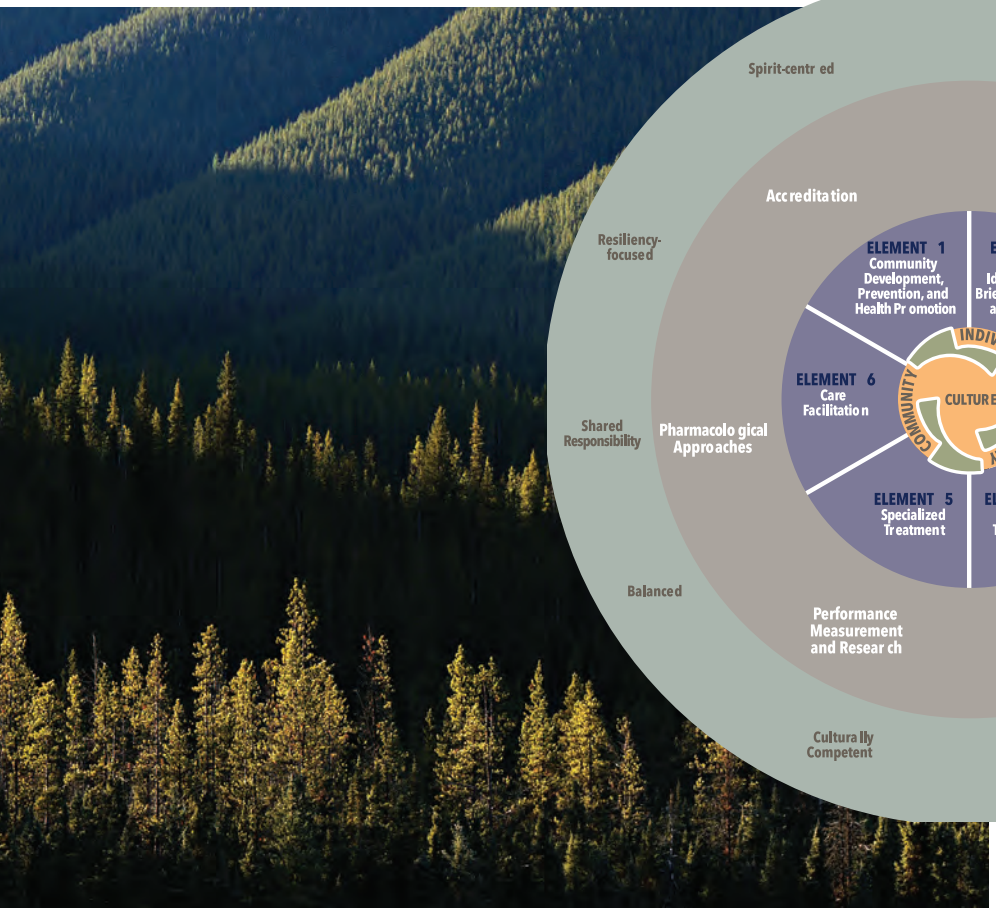
Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (HOS)[6] was published by the Assembly of First Nations (AFN), the National Native Addictions Partnership Foundation (NNAPF),[7] and Health Canada in 2011 after a five year long extensive consultation process. HOS was informed by input from First Nations communities across Canada, researchers in the field of substance abuse, and Indigenous cultural knowledge holders. This document identifies that there is a need for both intensive substance abuse treatment programs and community-based mental wellness and substance abuse programs in order to develop an integrated approach to those with co-occurring treatment needs. It also maps out what this may mean in terms of resources, programming, and staffing requirements. Regarding co-occurring mental health and addictions services, the HOS Framework states:

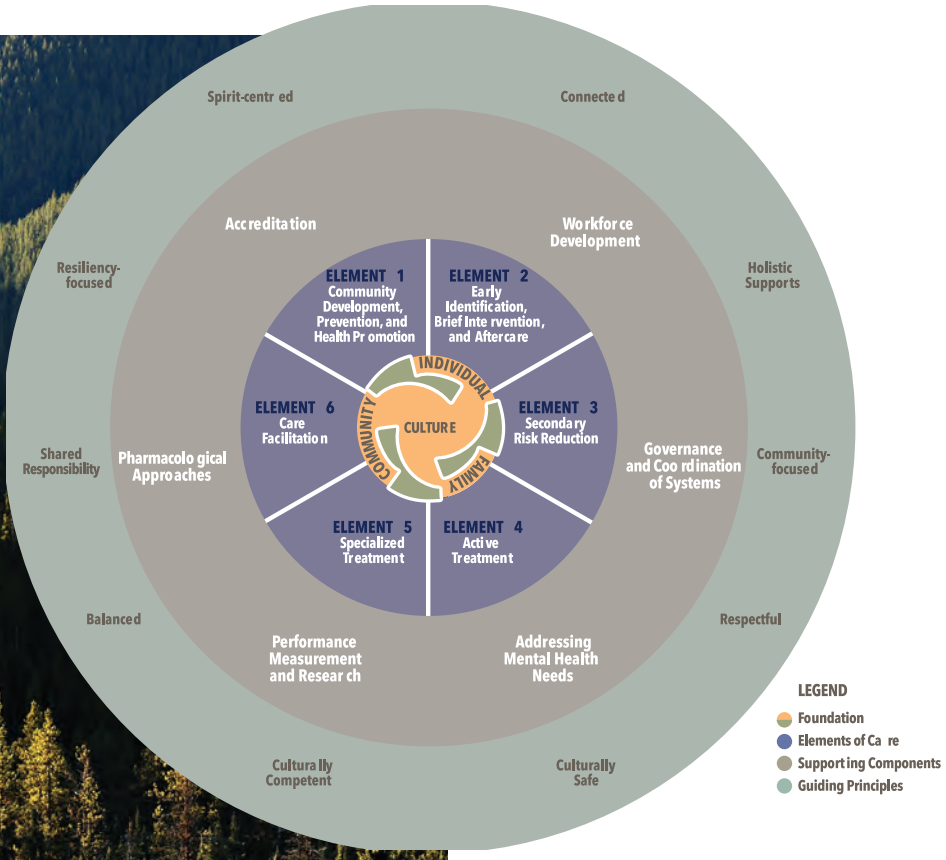
> "Existing addictions services can safely and effectively meet the needs of some clients with Concurrent Disorders, particularly those that are less severe. This may be the case if the addiction service has well-trained staff with access to clinical supervision and specialized cultural supports [...] It may not be necessary or feasible for all centres to have a capacity to manage specialized Concurrent Disorders. What is more practical is for every centre to have some level of competency with respect to mental health issues, and to have specific centres within the regional and national continuum of services that can provide specialized Concurrent Disorders service, based on need." [8]

6 http://thunderbirdpf.org/honouring-our-strengths-full-version-2/

7 As of June 2015, the National Native Addictions Partnership Foundation (NNAPF) changed its name to the Thunderbird Partnership Foundation, a division of NNAPF Inc. For more information, visit www.thunderbirdpf.org.

8 Assembly of First Nations, National Native Addictions Partnership Foundation, and Health Canada, 76-77.





NNADAP / NYSAP and Concurrent Disorders

There are several National Native Alcohol and Drug Abuse Program (NNADAP) and National Youth Solvent Abuse Program (NYSAP) treatment centres that accept clients with substance abuse issues and complex mental health needs. The experiences and practice wisdom of the centres, both the ones that have made the transition from an addictions-only perspective to integrated treatment and the treatment centres that originally began with an integrated approach, were documented in 2012-2013. Findings of the research will be provided in this handbook to assist those programs wishing to become Concurrent Disorders Capable.

NNADAP and NYSAP are making tremendous strides in concurrent capable programming design. Several regions offer mental health certified training at annual NNADAP gatherings. The Youth Solvent Addiction Committee (YSAC)has also developed a full training program on culturally responsive concurrent capable programming. Further information on this training can be found at: http://ysac.info/?page_id=337.

For the full listing of NNADAP/NYSAP treatment centres, including those that offer Concurrent Disorders capable services, see the Treatment Centre Directory at the following link:
http://healthycanadians.gc.ca/healthy-living-vie-saine/substance-abuse-toxicomanie/help-aide/treatment-centres-traitement-eng.php

Using a Cultural Framework

HOS presents a set of ten principles that are used to guide work leading from the document. These principles were developed through input from cultural practitioners and Elders and are listed below:

Spirit-Centred
Connected
Resiliency-Focused
Holistic Supports
Community-Focused
Respectful
Balanced
Shared Responsibility
Culturally Competent
Culturally Safe

A complete description of each principle can be found in the HOS Framework. [9]

9 Assembly of First Nations and Health Canada, First Nations Mental Wellness Continuum Framework, Ottawa: Health Canada, January 2015.

Since the completion of the HOS Framework and its original background papers, a great deal more work has been done to acknowledge the importance of culture as a basis for healing. The *First Nation Mental Wellness Continuum Framework (FNMWC Framework)*[10] began its work in 2012 and asserts that First Nations cultural knowledge and evidence must be given equal value to western evidence-based approaches. The *Guidebook Supporting the Use of Natural Medicines in Cultural-Based Healing Practices for NNADAP/NYSAP Counsellors* discusses the use of culture-based healing in First Nations across Canada; fifty per cent of NNADAP and NYSAP programs are using culture-based practices and treatment and have demonstrated successful outcomes.[11] *A Cultural Safety Toolkit for Mental Health and Addiction Workers In-Service with First Nations People* provides further guidance for workers.[12] (See Appendix A for the 5 Ws of Cultural Safety).

The cultural values, sacred knowledge, language and practices of First Nations are essential determinants of individual, family and community health and wellness.[13]

The information in this guidebook is presented with the assumption that the diverse cultures in First Nations communities across Canada are foundational to any approach for healing of First Nation individuals and communities. Although some of the information and references for accepted approaches to the treatment of Concurrent Disorders is based on a western perspective, this guidebook recognizes the equal value of First Nations cultural values, knowledge, and diverse practices. It presents mainstream information and aligns the world view of First Nations where possible and highlights the critical differences.

"[A] person's inner spirit and community cannot be disentangled from one another as is commonly done within a Western world view. A person's inner spirit is intertwined with their family, community, and the land, and cannot be understood apart from them." [14]

10 Assembly of First Nations and Health Canada, First Nations Mental Wellness Continuum Framework, Ottawa: Health Canada, January 2015.

11 National Native Addictions Partnership Foundation, Guidebook Supporting the Use of Natural Medicines in Cultural-Based Healing Practices for NNADAP/NYSAP Counsellors, NNAPF, 2013.

12 National Native Addictions Partnership Foundation, A Cultural Safety Toolkit for Mental Health and Addiction Workers In-Service with First Nations People, NNAPF, 2013.

13 Assembly of First Nations and Health Canada, 9.

14 Colleen Anne Dell, Raymond Tempier, and Debra Dell, "From Benzos to Berries: Treatment offered at an Aboriginal Youth Solvent Abuse Treatment Centre Relays the Importance of Culture," The Canadian Journal of Psychiatry 2011, 76.

Co-Occurring Disorders Definitions and Concepts

Concurrent Disorders

In Canada, Concurrent Disorders is a term meaning the presence of both a mental health disorder and a substance use disorder. Health Canada's *Best Practices Guidelines* define the Concurrent Disorders population as:

> "those people who are experiencing a combination of mental health/emotional/psychiatric problems with the abuse of alcohol and /or other psychoactive drugs."[15]

Although the term Concurrent Disorders has become a term used within the mental health and substance abuse field, it is useful to remember that a *disorder* is technically diagnosed by a medical doctor, a psychiatrist, or a registered psychologist using the classifications outlined in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.[16] Diagnosis of Concurrent Disorders, at this time, are often too limited in its scope for many First Nations people as there are many mental health, emotional and psychiatric issues within First Nations communities that do not meet the medical requirements of a clinical diagnosis as currently recognized. Examples of these are the lack of clinical diagnosis of intergenerational or collective trauma, post-traumatic stress disorder, etc. Other cultural differences not reflected in the DSM can result in misdiagnosis of clients, as it does not reach the dimension of cultural difference.[17]

With the emphasis of the HOS Renewal Framework on strength-based treatment and culture-centred practice, the use of the DSM and its representation of the medical model of care present some issues for discussion (see the *Issues of Diagnosis* section on page 12).

Concurrent Disorders will be defined in this guidebook as a range of co-occurring mental health and addictions issues which may or may not be accompanied by a psychiatric diagnosis.

Dual Diagnosis

The term Concurrent Disorders was formerly known as Dual Diagnosis. However, as the term Concurrent Disorders became more widely accepted in Canada, Dual Diagnosis has come to refer to a person with an intellectual disability and a mental health problem. The term Concurrent Disorders in the United States can be found in the literature.[18]

15 Health Canada, Best Practices: Concurrent Mental Health and Substance Use Disordes, Ottawa: Minister of Public Works and Government of Canada, 2002.

16 American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th ed.), Washington, D.C.: American Psychiatric Association, 2013.

17 Phillips, J (2010). The Cultural Dimension in DSM-5: PTSD. Psychiatric Times. On DSM-5. August 15, 2010. http://www.psychiatrictimes.com/blog/dsm-5/content/article/10168/1635720

18 S. Currie, Knowledge notes: What exactly are Concurrent Disorders? Alberta Mental Health Research Partnership, 2005.

Co-Occurring Mental Health and Substance Use Issues

This term refers to the population that has co-occurring issues, either of which may be mild to severe and who do not necessarily have a formal diagnosis.[19] This phrase may more technically or accurately describe First Nations clients coming in to residential treatment for the first time from rural and remote areas where they may not have access to clinical diagnosis or do not wish to go through the process of being assessed prior to treatment.

Program Integration

Best practices suggest that the best outcomes of treatment for Concurrent Disorders occur when the treatment team has an integrated approach. This does not necessarily mean that specific interventions are delivered simultaneously; it means that they are offered in a planned and unified way. Health Canada defines program integration as when:

> "mental health treatment and substance abuse treatment 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"[20]

There are many benefits to providing integrated service through an integrated treatment team:

- Administrative and organizational gaps in service are reduced because coordination comes from within the organization's own treatment team and not between organizations.
- Each of the disorders are treated as primary and are targeted for primary treatment.
- Differing treatment philosophies between mental health and substance abuse professionals are more likely to get worked out when they are on the same team.[21]

Program integration has a number of implications for NNADAP and First Nations Mental Health programming:

- There will be a need to cross-train staff in both mental health and addiction services, particularly in remote or underserviced areas where a multi-disciplinary team is not always available.
- It will be important to help staff make changes in their attitudes and approach to their work to support the new model.[22,23]
- With the acknowledgement that cultural practices are foundational to healing, the integrated team will include cultural practitioners and specific cultural programming.
- In respect of providing a culturally safe environment, there will be an expectation that clinicians on the team, regardless of their cultural background, "acknowledge, respect, and honour the cultural values and norms of the people requiring care."[24] This expectation may also require some cross-training.

19 Skinner et al., Concurrent Substance Use and Mental Health Disorders: An information guide. Toronto: Centre for Addiction and Mental Health, 2004.

20 Health Canada, vii.

21 K.T. Mueser, Integrated Treatment for Dual Disorders. New York: Guilford Press , 2003.

22 Nancy Black, Personal interview, 4 January 2013.

23 Paul Mulzer, Personal interview, 4 January 2013

24 National Native Addictions Partnership Foundation, Cultural Safety Toolkit.

Prevalence Rates

Prevalence rates for Concurrent Disorders differ substantially depending on demographics, types of mental health diagnosis, substance use (whether it be alcohol related, drug related, or poly-substance use), and whether the study has sampled the general population or just the treatment community.[28,29,30,31] The data from the NNADAP outcome review shows the percent of people in treatment with a diagnosed mental health issue and the percentt of people with a suspected mental health issue. It is still generally accepted that up to 40% of those receiving treatment for mental health problems may have substance use issues and that up to 60% of those receiving substance use services will have mental health issues.[32]

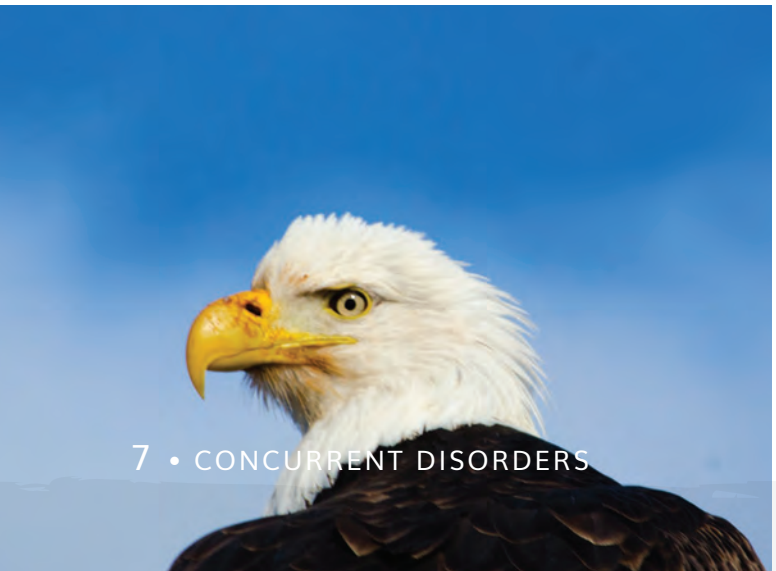
The method of data collection for prevalence rates has implications for First Nations communities. For instance, data from First Nations communities were not included in a study on prevalence rates in the Canadian population.[33] There is a very real gap in prevalence data for First Nations given that research indicates a strong link between trauma, the stress response, and substance use problems and given the experience of First Nations in terms of intergenerational trauma.[34,35]

Screening for Concurrent Disorders

Screening is the process by which it is identified that a person may have a substance use issue or a mental health problem. Screening tools are most useful when they are brief, valid and reliable, and have specificity and sensitivity.[36]

Screening and assessing people with a concurrent disorder can be a complex process, particularly as there are few tools that screen for both addictions and mental health issues.[37] This means that most agencies have added tools to their protocols that are particular to the area they are missing. For instance, a mental health program may add substance use scales and an addictions treatment program may add mental health scales.[38]

Health Canada's *Best Practice Guidelines* identifies two levels of screening. The first level of screening can use an index of suspicion which is "a checklist of behavioural, clinical and/or social indicators." For example, the ABC Checklist provides the counsellor with an observational framework to appraise the client's mental health. As discussed later regarding any assessment tools used for First Nations clients, the following checklist should be used within a cultural context.



28 Currie.
29 Health Canada.
30 Concurrent Disorders Ontario Network, Concurrent Disorders Policy Framework, Toronto: CAMH, 2005.
31 Rush et al., "Prevalence of co-occuring substance use and other mental disorders in the Canadian population," Canadian Journal of Psychiatry, 800-809.
32 Wayne Skinner, Personal interview, 17 January 2013.
33 Rush et al.
34 Rush et al.
35 Canadian Centre on Substance Abuse, Substance Abuse in Canada - Concurrent Disorders, Ottawa: 2009
36 CAMH Knowledge Exchange, Screening and Assessment, 2009.
37 The Gain, Addiction Severity Index [ASI], Substance Abuse Subtle Screening Inventory [SASSI], and DUSI [Drug Use Screening Inventory] have mental health scales imbedded in them.
38 CAMH Knowledge Exchange.

ABC CHECK LIST[39]

Appearance, Alertness, Affect, and Anxiety

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

Behaviour

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

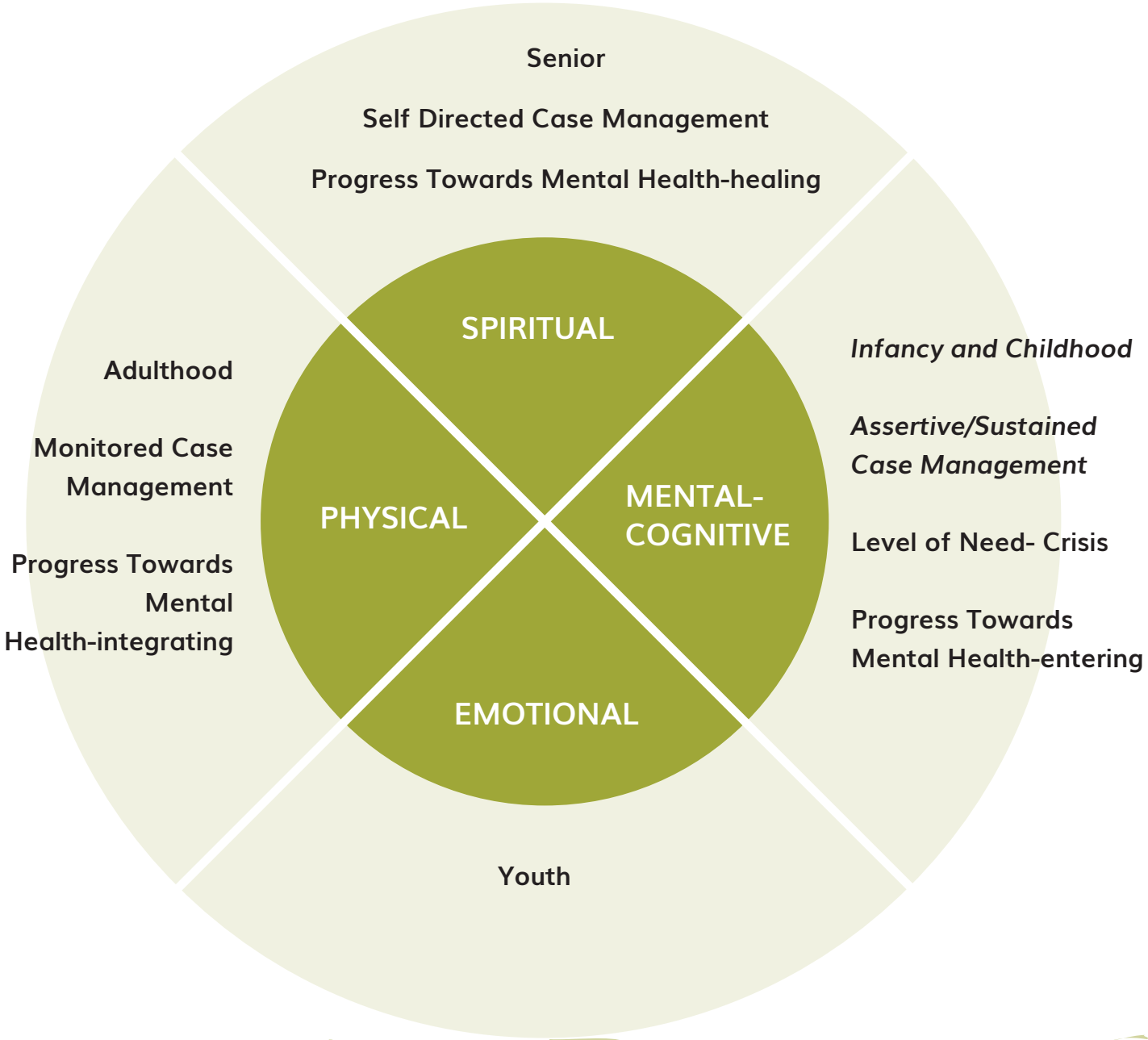
Cognition

- ☐ Orientation: Person, place, time, and condition.
- ☐ Calculation: Person, place, time, and condition.
- ☐ Reasoning: Insight, judgment, and problem solving.

Another Level One screening approach can be "asking a few questions."[40] As the reliability of current screening tools has not been tested for rural and remote populations or for First Nation populations, developing a list of a few questions that are appropriate for the group may be the best practice for Indigenous services.[41,42] However, a consistent screening tool gives a consistent baseline. Samples of questions and checklists are given in the Health Canada document (see : *Questions About Mental Health*) but many clinicians and mental health intake workers have developed their own lists that work for their client group.[43]

39 Health Canada.
40 Health Canada, 36-37.
41 Black.
42 Mulzer.
43 Black.

Perhaps a more relevant use of "asking a few questions" can be found at Anishinawbe Health Toronto (AHT) which uses the Medicine Wheel and narrative interviews for their screening and assessment.



"Representing a circle of care, the Medicine Wheel reflects the fours aspects of self – emotional, physical, mental-cognitive and spiritual. AHT states that this approach to the intake process considers the whole person and expands the identification of mental health determinants." [44]

44 National Native Addictions Partnership Foundation, Discussion Paper: Mental Health & Addictions Screening and Assessment Tools, Draft, NNAPF, 2012, 32-33.

QUESTIONS ABOUT MENTAL HEALTH[45]

A positive response by a client to one or more of the following questions indicates a need for further exploration of the client's mental health status:

a. "Have you ever been given a mental health diagnosis by a qualified mental health professional?"
b. "Have you ever been hospitalized for a mental health related illness?"
c. "Have you ever harmed yourself or thought about harming yourself, but not as a direct result of alcohol or other drug use?" [46]

The second level of screening discusses the use of validated and reliable screening tools.[47] The National Native Alcohol and Drug Abuse program and the National Youth Solvent Abuse program use the Drug Use Screening Inventory (DUSI) for screening and assessing mental health and addictions. The screening tool is available to these service providers through the Thunderbird Partnership Foundation and through the national Addictions Management Information System (AMIS). Completing the online screening will also provide the service provider with a report that indicates the best level of care for the client and will advise if residential treatment is the best option. A referral to a NNADAP or YSAP treatment center can be made through AMIS and continuing care for the client can also be managed through AMIS.

Below is a table adapted from the Centre for Addiction and Mental Health's (CAMH) "Navigating Screening Options for Concurrent Disorders" found on their Knowledge Exchange website which gives options for screening for **substance abuse**. [48]

Tool	Purpose	Target Population	Administration Time	Substances
CAGE	Screens for alcohol and other drug problems	Adults	1 min. (4 items)	Alcohol, other drugs
GAIN Short Screener (**GAIN-SS**) Note: there is a charge for use of the GAIN-SS	Identifies people who are likely to have a substance abuse or dependence disorder NOTE: also screens for mental health disorders	Adolescents, Adults	3-5 min. (20 items)	Alcohol, other drugs
GAIN Substance Use Disorder Scale (**GAIN-SUDS**) Note: there is a charge for use of the GAIN-SUDS	Initial screening for substance use severity using DSM-IV substance abuse disorder and substance dependence disorder criteria	Adolescents, Adults	5-10 min. (16 items)	Alcohol, other drugs
Psychiatric Diagnostic Screening Questionnaire (**PDSQ**) Alcohol and Drug Subscales Note: there is a charge for use of the PDSQ	Subscales screen for substance abuse and substance dependence disorders	Adults	2-3 min. (12 items)	Alcohol, other drugs
Alcohol Use Disorders Identification Test (**AUDIT**)	Screens for harmful or hazardous alcohol consumption	Adults	2-5 min. (10 items)	Alcohol

45 Health Canada.
46 Health Canada, 24.
47 Health Canada, 38.
48 CAMH Knowledge Exchange.

Below is a table adapted from CAMH's "Navigating Screening Options for Concurrent Disorders" found on their Knowledge Exchange website which gives options for screening for **mental health issues.**[49]

Tool	Purpose	Target Population	Administration Time
GAIN-Short Screener (GAIN-SS) Note: there is a charge for use of the GAIN-SS	Quickly and accurately identifies mental health problems (internal - e.g., mood disorder; external - e.g., attention deficit disorder)	Adolescents, Adults	3–5 min. (20 items)
Modified Mini Screen	Brief screening tool based on psychiatric interview	Adults	15 min. (22 items)
K6	A measure of mental health problems to discriminate cases of serious mental illness from cases of less serious mental illness	Adults	2-5 min (6 items)
Addiction Severity Index (ASI) Psychiatric subscale	Overview of psychiatric status	Adults	15 min. (13 items completed by client; 9 items completed by interviewer)
Psychiatric Diagnostic Screening Questionnaire (PDSQ) Note: there is a charge for use of the PDSQ	Designed to screen for DSM-IV Axis I disorders most commonly encountered in medical and outpatient mental health settings (including substance use disorders)	Adults	20 min. (125 items)

Assessment

There are a variety of assessments available for either addictions or for mental health, but concerns exist regarding the reliability of these for concurrent disorder clients. For instance, there may be some reluctance on the part of a client participating in addictions treatment to report any mental health issues.[50] This reluctance may be lessening where integrated programming has become more widely accepted but, for the purposes of diagnosis and case management, it is advisable that a mental health interview be done by a qualified mental health professional.[51,52] Many assessment tools can only be legally used by licensed practitioners (i.e., psychologists, non-specialist physicians, or psychiatrists); some assessment tools can be legally used by those other than licensed practitioners. However, care should be taken to never pronounce a *diagnosis* if one is not licensed. It is, in fact, illegal to do so.

Health Canada's *Best Practices* document recommends that, to be reliable, an assessment should:[53]

- Be conducted over more than one interview and use multiple sources of information
- Utilize mental health evaluation with a full structured or semi-structured interview by a qualified mental health professional
- Employ evaluation or identification of client motivation for treatment
- Include assessment of psychosocial functioning

There are a number of implications for First Nations programs in the use of screening and assessment tools. Some of these are listed below:

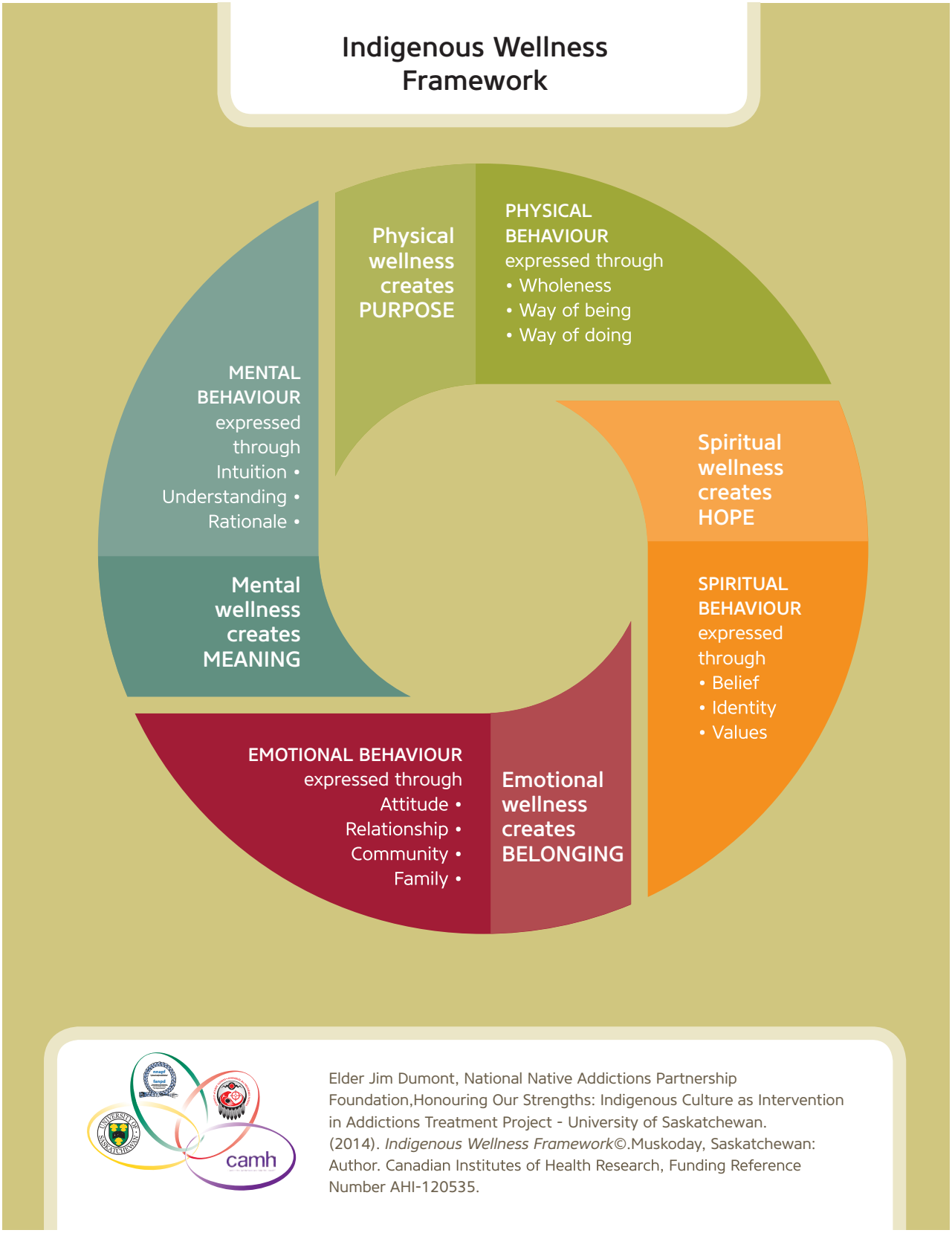
- The validity[54] and reliability[55] of the screening and assessment tools in most cases have not been tested for First Nations, particularly given the diverse cultural characteristics and languages of First Nations across Canada.
- Assessments need to be done within the cultural context of the client to guard against misdiagnosis, under-diagnosis, and over-diagnosis.[56]
- That which is being measured must be agreed upon by both the interviewer and the client. [57]
- Any clinical assessment or treatment work done with a client should be done with an understanding of not only cultural competence but also cultural humility and cultural safety.[58,59]

The National Native Alcohol and Drug Abuse Program (NNADAP) and the National Youth Solvent Abuse Program (NYSAP) use the Drug Use Screening Inventory (DUSI) for assessing mental health and addictions. The DUSI is available in both an adult and youth version. Service providers can use the long or short form DUSI for either population depending on whether the focus is Concurrent Disorders or addictions, or mental health. The Thunderbird Partnership Foundation and the National Youth Solvent Abuse Program have reviewed and modified the DUSI to ensure that it is culturally relevant. Adjustments were made to the DUSI as a result and now the DUSI has a trauma specific scale that reflects the experience of First Nations people that the DSM diagnostics and most standard mental health assessments do not attend to; such as impacts of: intergenerational trauma, community crisis, racism, and natural disasters.

This version of the DUSI is also used in the Thunderbird Partnership Foundation's Buffalo Rider program, a school based early intervention program. Access to the DUSI is currently through the Buffalo Riders program and the NNADAP or NYSAP programs. Outside of these programs the DUSI can be accessed through eCenter Research. The DUSI is also valid in measuring changes in mental health and addictions over time and automated reports can be generated from each administration to monitor client change.

50 Health Canada.
51 Mulzer.
52 Health Canada
53 Health Canada, 43.
54 ***Validity*** refers to whether an assessment tool actually answers the question it is intended to answer.
55 ***Reliability*** refers to whether an assessment tool produces similar results.
56 National Native Addictions Partnership Foundation, *Discussion Paper*.
57 National Native Addictions Partnership Foundation, *Discussion Paper.*
58 L.J. Kirmayer, "Cultural competene and evidence-based practice in mental health: Epistemic communities and the politics of pluralism," *Social Science and Medicine* 2012, 249-256.
59 National Native Addictions Partnership Foundation, *Cultural Safety Toolkit*.

The Native Wellness Assessment™ is also a tool that is based on Indigenous knowledge and developed based on a definition of wellness. It measures wellness rather than deficits. The Indigenous Wellness Framework below provides the structure for the Native Wellness Assessment™.



Elder Jim Dumont, National Native Addictions Partnership Foundation,Honouring Our Strengths: Indigenous Culture as Intervention in Addictions Treatment Project - University of Saskatchewan. (2014). *Indigenous Wellness Framework*©.Muskoday, Saskatchewan: Author. Canadian Institutes of Health Research, Funding Reference Number AHI-120535.

The Native Wellness Assessment™ (NWA) is also standardized to measure change in client wellness over time. An automated report is generated so that service providers who use culture to promote wellness in addressing substance use and/or mental health issues can gain valuable feedback to support client care.

A more in-depth discussion on this subject is presented in the Thunderbird Partnership Foundation's[60] *Developing a Basket of Mental Health and Addiction Screening and Assessment Tools for Use with First Nations Clients*.[61] In addition, the "Screening Tools for Consideration" chapter of this guidebook presents a number of tools that have been found to be culturally appropriate in a variety of Indigenous cultures and may be useful in meeting the needs of First Nations clients.

60 Thunderbird Partnership Foundation is a division of the National Native Addiction Partnership Foundation, Inc. (NNAPF).

61 Native Addictions Partnership Foundation, Developing a Basket of Mental Health and Addiction Screening and Assessment Tools for Use with First Nations Clients, 2015.

Issues of Diagnosis

Questions about Diagnostic and Statistical Manual of Mental Disorders (DSM)

When viewing Concurrent Disorders from a mainstream perspective, a psychiatric diagnosis using the DSM can become central to a client's assessment and treatment. Although a psychiatric diagnosis can assist the client's access to additional funds and more specialized services (e.g., access to a psychiatrist, access to appropriate psychiatric medication), there are a number of implications to making diagnosis an integral part of assessment and treatment for the general population and, particularly, for First Nations clients.

In the spring of 2013, the director of the National Institute of Mental Health (NIHM) announced that the institute would be "re-orienting its research away from DSM categories."

> *While DSM has been described as a "Bible" for the field, it is, at best, a dictionary, creating a set of labels and defining each. The strength of each of the editions of DSM has been "reliability" – each edition has ensured that clinicians use the same terms in the same ways. The weakness is its lack of validity.*[62]

In general, most psychiatric scientists would agree that the validity of the DSM is extremely weak.[63] In addition, there are those mental health professionals that feel that labelling is dehumanizing and demoralizing, and feel that focusing on DSM criteria and symptoms loses sight of the client as a unique individual.[64]

Cultural Bias

Diagnostic criteria for various disorders have a cultural bias toward western culture and do not always relate well to First Nations culture and understandings. For instance, traits associated with a diagnosis may not be considered problematic in diverse cultures (e.g., Dependent Personality Disorder may not be considered problematic within a collectivist culture that places a greater emphasis on family cohesion over the individual's desires).[65] In the area of treatment, it is probably more important to address symptoms using the best of what we know from both mainstream and culture-based approaches rather than require a mainstream diagnosis, which may or may not meaningfully improve the clients' outcomes.[66] In addition, measuring outcomes of a particular treatment approach without first considering cultural and social norms may give an inaccurate picture of its effectiveness (Kirmayer, 2012).[67]

62 Quote from Thomas Insel, Director of the National Institute of Mental Health. M. Herper, "Why Psychiatry's Seismic Shift Will Happen Slowly," Forbes, 8 May 2013.

63 J. Gone and L. Kirmayer, "The Wisdom of Considering Culture and Context in Psychopathology," Contemporary Directions in Psychopathology, New York: Guilford Press, 2010.

64 A. Schaeffer, The Advantages and Disadvantages of DSM IV, eNow Health, 2013.

65 Schaeffer.

66 Mushquash.

67 L.J. Kirmayer, " Cultural competene and evidence-based practice in mental health: Epistemic communities and the politics of pluralism," Social Science and Medicine 2012, 249-256.

Pre-Treatment

The goal of pre-treatment is to give the client an orientation to the treatment program in which they are about to participate. The orientation assists in: helping them to develop realistic expectations about the program; decreasing anxiety by allaying fears about the program; understanding the program's expectations in terms of behaviour and role; helping the client to prepare their personal belongings for the program; assisting the client to prepare their home situation for their absence; and assisting the treatment program in assessing the client's readiness and commitment to attend the program. Research has demonstrated that preparing clients for treatment results in better outcomes, a more collaborative atmosphere, and lower dropout rates.[68]

In the case of First Nations clients who may be coming from more isolated communities, one NNADAP program provides a pre-treatment checklist for clients to review with a supportive person in their community as well as a readiness checklist and a copy of the Treatment Centre's information video for viewing. These are included in *Appendix B: Example of Pre-Treatment Checklist* and *Appendix C: Admission Checklist*.

68 J.F. Guajardo, *The Effects of Pretreatment Preparation with Clients in a Substance Abuse Treatment Program,* Dissertation - Ohio University, 2008.

Treatment

Clients may have best success when both problems are addressed at the same time and in a coordinated, holistic way. The treatment approach usually depends on the type and severity of the person's problems. The treatment plan should consider both mental health and substance use problems as some clients may need a wraparound treatment. Wraparound treatment is a way of making sure that treatment is culturally appropriate, coordinated, and comprehensive for the client. It ensures that the client receives help not only with the Concurrent Disorders but also in other life areas such as spirituality, socialization, education, housing, and employment. Ongoing support in these life areas helps clients to ensure their basic life needs are being met.

Core Components for a Concurrent Disorders Program

The following are some core components that are common to programs providing integrated treatment services for Concurrent Disorders:

1. ***A multi-disciplinary team approach***
2. ***Shared decision-making*** among treatment team, client, and family
3. ***Integrated service*** through a worker or team of workers that provides treatment for mental health and substance use issues at the same time
4. ***Comprehensiveness*** involving consideration of a wide range of client needs such as housing, family and social relationships, work or meaningful activity, life skills, and supports
5. ***Assertiveness*** on the part of the treatment team to engage the client
6. ***Reduction of negative consequences*** as a primary initial goal because of the damaging impacts that Concurrent Disorders has had on the client's life
7. ***Long-term perspective*** addresses the need for a lengthy or time-unlimited treatment service that is flexible enough to manage client relapses
8. ***Motivation-based treatment*** addresses the client's motivation for change
9. ***Multiple treatment modalities*** for individuals, families, and groups provide the client with choices to achieve the best outcomes[69]
10. ***Case management and individualized treatment planning***[70]

69 K. Mueser et al., *Integrated Treatment for Dual Disorders:A Guide to Effective Practice,* New York: The Guilford Press, 2003.

70 K.T. Mueser, *Integrated Treatment for Dual Disorders,* New York: Guilford Press, 2003.

Treatment Approaches

As stated previously, this guidebook is not meant to be a training document on the treatment of Concurrent Disorders. Developing a Concurrent Disorders capable model of care is complex and requires knowledgeable frontline staff and trained clinical professionals who can work together as a team to improve outcomes and minimize risk.

There are a number of excellent documents on the basics of the treatment of Concurrent Disorders in Canada and North America.[71,72,73,74,75,76,77] Some of the most common treatment approaches are listed below:

1. A strength-based client-centred approach
2. Motivational interviewing techniques
3. Cognitive Behavioural Therapy (CBT)
4. Dialectical Behaviour Therapy (DBT)
5. Social Learning Theory and social skills development
6. A harm-reduction approach
7. Relapse prevention programming using CBT
8. Use of modified community based self-help/12-step groups that accept those with co-occurring issues and see abstinence as a goal instead of an absolute.

Concurrent Approaches and Sequencing

In a Concurrent Disorders program both the mental health diagnosis and the substance abuse diagnosis are regarded as primary and should be treated as part of an integrated system of care. However, within this integrated approach the disorders may be treated either at the same time or in sequence. It should be noted that, in a NNADAP residential treatment centre, the needs of the client are addressed as they surface and in reality it may be necessary to be flexible about sequencing.[79] However, Health Canada's *Best Practice* document divides mental health disorders into sub groups to discuss specific treatment approaches and sequencing:

Substance Use and Mood and Anxiety Disorders: Treating the substance use first within the integrated program is advised because depression and anxiety syndromes can be the consequences of chronic alcohol use and will improve significantly with treatment of the alcohol use. The evidence also indicates overwhelmingly that cognitive behavioural therapy (CBT) is the most effective approach for alcohol and mood and anxiety disorders.

Substance Use and Persistent Mental Disorders: Research indicates that treating this combination concurrently is most effective. There is evidence that effective interventions for this sub-group are behavioural skills management and intensive assertiveness case management, as opposed to a 12-step program.

Substance Use and Personality Disorders: Although the research is not conclusive in the approach to this sub-group, it is believed that sequencing is probably the most effective approach. Components of a 12-step program may have a helpful effect on personality structure. The use of DBT for addictions is also gaining an evidence base.[80]

Substance Use and Eating Disorders: There is little research and no conclusive evidence that gives direction on whether to treat at the same time or in sequence. Practice wisdom indicates that the best approach is to treat concurrently except in the case of one of the disorders being life threatening.[81]

In its Concurrent Disorders document, the Canadian Centre on Substance Abuse divides Concurrent Disorders groupings into Stress, Trauma, and Substance Use Disorders; Anxiety Disorders and Substance Use Disorders; Impulsivity and Substance Use Disorders; Mood Disorders and Substance Use Disorders; and Psychosis and Substance Use Disorders. The document also discusses prevalence, sequencing, and treatment approaches.[82]

---

71 Health Canada.
72 Skinner et al.
73 Concurrent Disorders Ontario Network.
74 Canadian Centre on Substance Abuse.
75 Mueser et al.
76 J. Smith, *Co-Occurring Substance Abuse and Mental Disorders: A Practitioner's Guide*, USA: Rowman and Littlefield Publishers Inc., 2007.
77 Mushquash.
78 G.A. Marlatt and D.M. Donovan, *Relapse Prevention: Maintenance Strategies in the Treatment of Addicitve Behaviours*, New York: Guilford Press, 2005.
79 Bagnall.
80 Mushquash.
81 Health Canada.
82 Canadian Centre on Substance Abuse.

Trauma

There is a prevalence of trauma in people with substance use and mental health problems; between 25% to 66% of people in addiction treatment will have histories of trauma (though all will not necessarily be diagnosed as PTSD).[83] Therefore, understanding the client's history of trauma is advisable prior to screening and assessment. Questioning should avoid re-traumatizing the client.

Due to the multi-generational impact of colonization, residential schools, and socio-economic conditions, First Nations individuals have experienced a great deal of psychological trauma. In addition, experiences of discrimination and disrespect have been reported by First Nations individuals accessing mainstream health services. It will be necessary for workers providing screening, and for specialists who are providing services for First Nations, to maintain a trauma informed practice so that clients do not become re-traumatized by the intervention.[84] A review may be needed to discover if services are experienced as respectful, trauma informed, and based on harm minimization.

> Further, where post-traumatic stress symptoms occur, the evidence is clear that, for adults, prolonged exposure therapy (PET) (developed by Edna B. Foa) is the most effective treatment. Among children, cognitive processing therapy, which includes narrative-based trauma story development and family focused intervention approaches, is the most effective. (Mushquash, 2013)

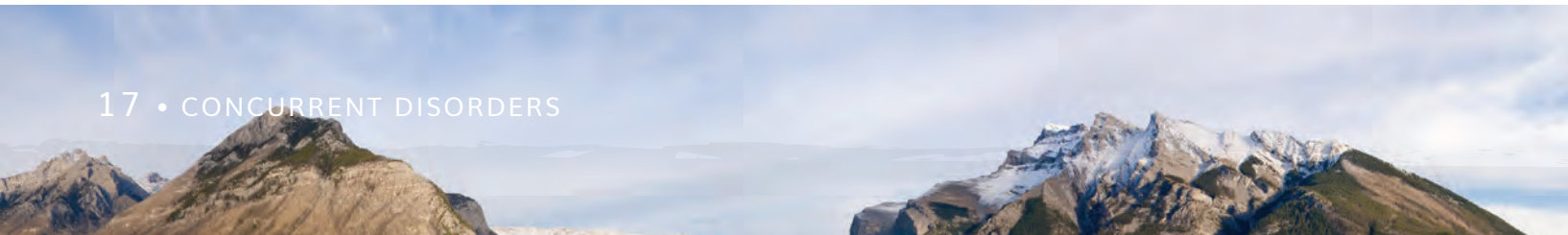
Requirements for a Concurrent Disorders Capable Program

A definition of a Concurrent Disorders capable program is presented by Skinner as a program that:

> "...welcomes people with co-occurring disorders whose conditions are sufficiently stable so that neither symptoms nor disabilities significantly interfere with standard treatment. The program makes provision for Concurrent Disorders in the program mission, screening assessment, treatment planning, psychopharmacology policies, program content, discharge planning and staff competency and training."[85]

A review of the mainstream literature (Concurrent Disorders Ontario Network, 2005; Westra, Aviram, & Doell, 2011; Christie A. Cline, 2002; Minkoff, 2001; CARMHA, 2007; Health Canada, 2002; Henny a. Westra, Adi Aviram, Doell, & PhD, 2011; el-Guebaly, 2004; Black, 2013; Mulzer, 2013; Mueser, Noordsy, Drake, & Fox, 2003) clearly indicates a list of common principles, resources, and processes that need to be in place to offer a clinically effective, safe, Concurrent Disorder capable program. These are:

85 Klinic Community Health Centre, The trauma-informed toolkit, Winnipeg: Klinic Community Health Centre, 2008.



1) Systems Level Planning and Support

Adapting to an integrated model can be a challenging process and will require additional resources; it is important that the approach is understood and supported at the systems and administration level. A coordinated and integrated approach from both the mental health system and the addictions system is critical to success.

From a First Nations perspective, this may mean getting buy-in from the leadership in a community or from the board of directors in a service organization. It will also mean engaging the community in the process. Some of the means to get support from the leadership and the community for your new program are the following:

- **Find a Champion in Your Community**

Find a respected community leader/member who is interested in what you are doing and give them a preview. Ask them to help champion your work in the community.

- **Information Is Important**

Develop a presentation for delivery to the leadership and then to others in the community. Offer factual information and provide time for questions and discussion. Some of the ideas may be new ways of thinking for your leadership. Be prepared to answer challenging questions.

- **Use a Guest Speaker**

Invite a speaker from a NNADAP or NYSAP program that is currently delivering a successful Concurrent Disorders Program.

2) Use Principles of Change Management[86]

Changes may be more significant for programs that have been strictly addictions treatment or mental health oriented. Thought will have to be given to the changes that will be necessary and the various processes needed to accomplish the changes as smoothly as possible. Attention will have to be given to **staff** who may have expanded roles and be required to develop new skills and change their philosophy of treatment (e.g., change from a deficit-based approach to a strength-based approach to client care and treatment).

Although **organizational culture** is typically fairly stable in any organization and therefore may be resistant to change, it may need to be changed to accommodate different approaches (e.g., change from an abstinence-based policy to an integrated model supporting psychoactive medications). As services are expanded or changed, the **structure of the program** (e.g., additional individualized programming or using additional culture-based healing within the program) may need to be changed. Attention to **processes** which will accomplish some of the changes will be important. There is a great deal of literature on change management. Some examples of components of change management that may be needed in your program are listed below:[87]

- **People**
  - Staff engagement
  - Communication
  - Feedback
  - Information and Training
- **Organizational Culture**
  - Communications and team building
  - Reinforce new values
  - Positive role models
- **Structure of Program**
  - Development of new positions
  - New lines of communication
- **Processes**
  - Policy development
  - Procedures
  - Protocols

86 Presented here are basic Change Management principles. An information package and online training has been prepared by the Thunderbird Partnership Foundation that presents a change model that can be applied to the First Nations environment within a cultural framework. This information will be available at www.thunderbirdpf.org.

87 S. Robbins, M. Coulter, and N. Langton, Fundamentals of Management, Toronto: Pearson Prentice Hall, 2008.

3) Development of Partnerships

It is important to develop partnerships to provide mutual support and share expertise because the nature of Concurrent Disorders requires intensive resources. From a First Nations perspective, partnerships may mean ensuring that mainstream services can support programming within a cultural framework. Partnerships are discussed further in the *Key Themes from Concurrent Disorders Capable NNADAP Programs* section.

4) Development of a Common Language and Framework

An integrated approach to a Concurrent Disorders capable program requires gaining an understanding of the philosophy of the self-harm continuum (including abstinence), an understanding of the recovery philosophy in mental health, and an understanding of treatment issues from both the addictions and mental health fields. This may be a long-term process which also requires an understanding of your employees' personal perspectives.

5) Cross-Training of Treatment Staff

When transitioning into the area of mental health treatment, addictions staff may need to develop skills that may not have been required in a strictly 12-step program or structured addictions program. Although many staff already support clients with mental health needs, the Concurrent Disorders capable approach does provide a challenge for some staff in terms of philosophy and professional skills. Knowledge of mental illness, serious mental illness, and such effective approaches such as motivational interviewing, cognitive behavioural and dialectic behaviour approaches, narrative therapy, prolonged exposure therapy (PET), and other psycho-social practices will be required.

6) Case Management

Treatment for Concurrent Disorders requires a team approach with a complex array of options and interventions, comprehensiveness, ongoing support, and a long term perspective. A case manager is therefore required to ensure advocacy, coordinated interventions, ongoing assessment, and evaluation of the treatment plan. In Concurrent Disorders treatment, the case manager develops a relationship with the client, will provide some of the clinical work, and ensures that the team interventions come from a strength-based perspective. The case manager for each client can be anyone on the team with appropriate training, is ultimately responsible for the total treatment package, and is the "glue" that holds the various components of treatment together to create an integrated response.

"Case Management is pivotal to streamlining the service for the complex client."

(Cheryl Bagnall, NNADAP Adult Residential Treatment Program Manager, 2013)

7) Use of Technology

The complex nature of Concurrent Disorders requires that staff be supported by other professionals through a team approach. The use of tele-psychiatry and video conferencing is an important part of programming both for clinical support and knowledge transfer. This will be particularly important for rural and remote First Nations programs. Various online courses are available for training purposes.

8) Medical Support and Psychopharmacology

The introduction of medication as an accepted part of treatment for a specific mental health diagnosis, coupled with medical supervision is required.

9) Qualified Mental Health Professional

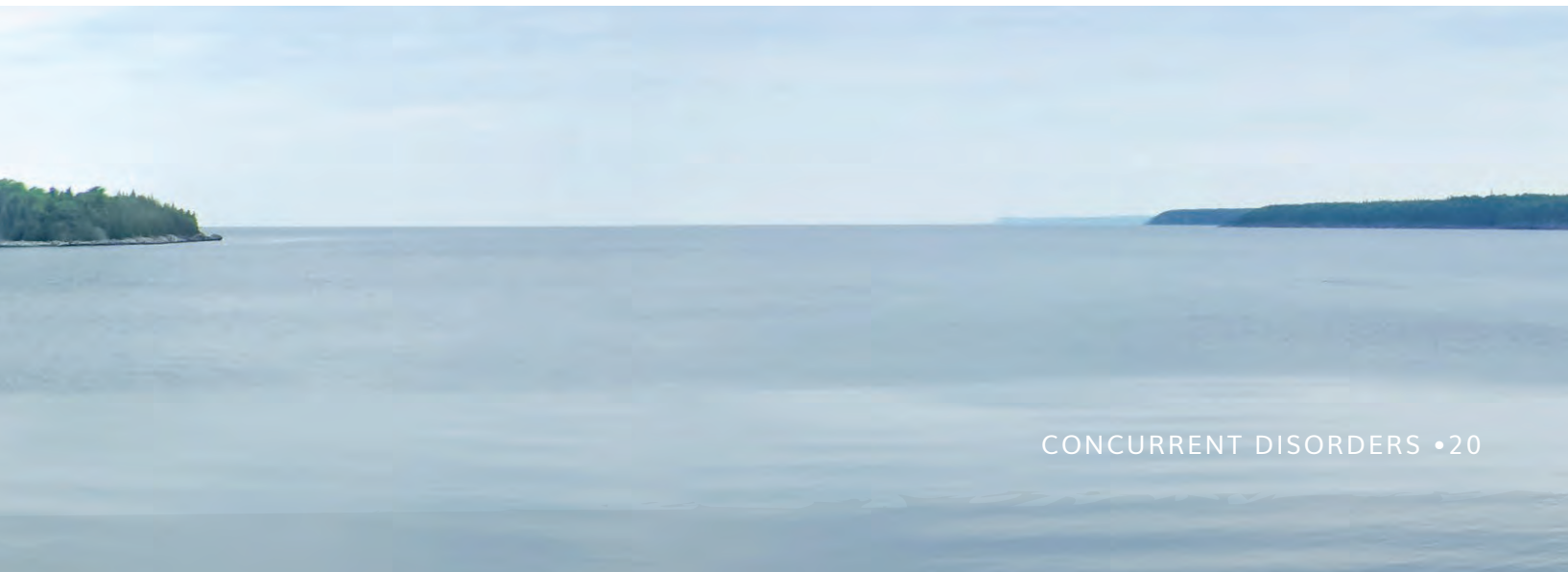
In the case of complex mental health issues, a consultation with a qualified mental health professional or qualified staff member is necessary.

10) Strength-Based Approach, Empowerment, and Engagement

As people with Concurrent Disorders are sensitive to the double stigma of their circumstance, it is particularly important to use an approach that is respectful.

11) Creativity and Flexibility

As the treatment of Concurrent Disorders is still developing, there is latitude for creativity and flexibility at a program level. Frequent meetings and discussion with staff about their ideas for improving the program will be important. Staff members' confidence and creativity about program adaptations will grow when they take mental health-specific training modules.



Requirements for a Concurrent Disorders Capable Program

Ten interviews were completed in March of 2013, representing the practice wisdom and experience of a cross-section of NNADAP Treatment Centres, Youth Solvent Abuse Centres, First Nations Mental Health Programs, and Health Canada administrators who have experience in developing programs that are Concurrent Disorders capable. Although responses to the interviews were varied, depending on programs being delivered and the unique experiences of the individuals, key themes emerged to assist new programs in becoming Concurrent Disorders capable. Some of these are similar to the previously mentioned mainstream literature review but are presented here from a First Nations program perspective.

Governance and Administration

Respondents said that it was important to get the commitment of the leadership and the board. If the program is a community-based program this also may mean finding a champion from Chief and Council. Lay the groundwork by providing them with information on the essentials of a Concurrent Disorders Program and why it would be beneficial to the community. Once an administrator or manager has support from the leadership and has made the decision, as one manager said, "Go for it!"

First Nations Community Information and Awareness

Depending on the connections to the community, it will be important to provide community information and awareness sessions. Engage the community by asking for input on how this program could be adapted to suit the unique characteristics of the First Nations community or communities that you serve.

Program Planning and Preparation

Many people advised that managers and program developers should look at the capacity of their program and the population that could be served before developing the model. The following questions were suggested:

- Do you have trained staff? Have you assessed training needs and costs?
- Is your facility suitable? Will it accommodate your programming needs?
- Do you have services close to those who can help in a crisis? (e.g., physician, police, ER)
- What services can you realistically provide?
- Is your staff complement suitable?
- How often can you realistically access specialized services? (e.g., psychologist, psychiatrist, mental health therapist)

The use of a generally recognized program change model would be useful.[88,89]

88 K.L. Barry, *TIP 34: Brief Interventions and Brief Therapies for Substance Abuse: Treatment Improvement Protocol (TIP) Series 34*, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1999.

89 T.F. Babor and J.C. Higgins-Biddle, *Brief Intervention for Hazardous and Harmful Drinking - A Manual for Use in Primary Care*, Geneva: World Health Organization, 2001.

Getting Staff Engaged

Internal change can be difficult for any staff. This change is difficult for two central reasons: change of philosophy and change of job responsibilities.

Change of Philosophy:

If an addictions program has traditionally run on a 12-step model, staff will be asked to broaden their approach and accept that individual counselling, a harm reduction approach, and psychiatric medication may become part of the treatment program. They will also be expected to operate from a strength-based perspective.

Community mental health staff will be asked to move past the stereotypes they may hold and look at addictions as both a biological and a mental health issue.

Change of Job Responsibilities:

If your staff has been using a structured 12-step approach in treatment, they may be asked to expand their practice skills and provide mental health counselling with a less structured client-based approach. Community Mental Health workers will also have to learn how to work within an addictions framework.

> I think the emphasis on mental health in addictions is really an example of research catching up to practice in NNADAP. The clients in NNADAP have not significantly changed in all these years; they have always presented with complicated grief, trauma, and the anxiety and depression that often stems from those. I think NNADAP workers are some of the best equipped to provide concurrent capable programming, simply because they always have. Our task is just to recognize that, honour it, and move forward without creating a two tiered system of intervention.
> *(Debra Dell, National Coordinator at YSAC, 2013)*

Staff Engagement Pointers

- Help staff to believe in their own abilities
- Notice and comment positively on things like language change (e.g., strength-based versus negative)
- Regularly ask for input regarding program changes
- Review the successes of other programs
- Use change management principles
- Establish a team culture of strength-based language and open feedback

At some point it may be necessary to provide an ultimatum for staff members who are unwilling or unable to make the changes necessary to provide an effective Concurrent Disorders Program.

Canoe Speech

"We are all about to go on a difficult journey together. There will be rough waters that we need to portage around. There will be work we need to do and lessons to learn to complete the journey safely.

There will be times when it seems we are stuck in an eddy or times when we have to paddle up river against the current, but if we all work together as a team we will reach our goal.

It is important that we are all moving forward together, and I need your commitment to the journey and to the team. If you don't feel you can be on this journey, or do not agree with the course we have plotted, or if you do not want to work as a part of the team, then you need to get out of the canoe, because this is the journey we are embarking on together and we will continue."

(John Dixon, Director of Mental Health and Addictions at Dilico Anishinabek Family Care, 2013)

Change Takes Time

Almost everyone who has been involved with programs that experienced the transition from mental health or addictions services to concurrent disorders services said that it took time to make the changes. Developing resources, getting buy-in from staff, staff training, and finding additional funding all take time. Programs that introduced the change four or five years ago were still working on some of the core elements. All seemed pleased with their progress and were positive about the course taken. It is suggested that programs embarking on the transition link with programs that are further along for support, advice, and encouragement.

Staff Training

Almost all respondents said that staff training was key to a successful transition to a Concurrent Disorders capable program. Both knowledge transfer (e.g., pharmacology) and practice skills (e.g., counselling, motivational interviewing) are necessary to engage staff and give them the tools they need. Some programs used extensive online training packages. Cross-training was indicated in programs that were not truly integrated. Training topics mentioned by key informants were the following:

- Stages of Change Model [90]
- Motivational Interviewing
- Trauma, grief, and loss
- Harm reduction
- Cross-Training
- Psychopharmacology
- CBT-based Relapse Prevention
- Drugs and the Brain
- Dispelling the myths (regarding addictions and/or mental illness)
- Case Management

Partnerships and Linkages with Other Services

As mentioned in the Requirements of a *Concurrent Disorders Program* section, the complex nature of Concurrent Disorders requires intensive resources. It is therefore important to develop partnerships to provide mutual support and share expertise. From a First Nations perspective, this may mean developing stronger, more positive linkages with other services provided in First Nations communities and services through Health Canada (e.g., the Drug Exception Centre). It will also mean expanding your horizons by developing stronger partnerships with allied agencies outside of the First Nations Community.

> When developing partnerships, I have found it helpful to consider the social determinants of health or the medicine wheel to give me direction: Going out into the community and developing partnerships with government social services, housing, women's shelters, homeless shelters, and programs which will provide one-time financial support for individuals - hospital programs, community mental health programs all assist in providing holistic care for our clients.
>
> *(Cheryl Bagnall, NNADAP Adult Residential Treatment Program Manager, 2013)*

90 The Stages of Change Model has been challenged in mainstream addictions literature (e.g., West, 2005) and may not be considered a useful model in treatment for First Nations clients (Mushquash, 2013).

Additional partnerships that may be helpful are other NNADAP treatment programs, mainstream treatment programs, corrections, probation and parole, pre and post treatment homes, withdrawal management programs, community health and nutrition programs (e.g., diabetes health clinics), local contacts for provincial mental health and addictions funding bodies, hospital mental health unit, and hospital emergency departments. Part of the development of external partnerships will entail setting the expectation that these services will support programming within a cultural framework.

Mental Health Specialists

All felt that it was important to have access to mental health specialists, particularly psychologists and a psychiatrist. Some also felt that it was important to have access to clinical social workers and therapists; others felt that this was not as necessary and that it was more important to develop practice skills of the regular staff complement through training and practice.

People said "be selective" when using external consultants. Ensure they are trauma-informed and provide a culturally safe environment. They should have a multidisciplinary team approach (i.e., work with regular members of staff and other specialists as a team). It was noted that the list of mental health providers accepted by Health Canada for NIHB do not necessarily guarantee that their practices were culturally sensitive or trauma-informed.

Trauma-Informed Work

The staff of all programs had either training in trauma, including intergenerational trauma and PTSD, or training for them was planned for the future. The importance of trauma-informed work was recognized and emphasized by all.

Continuum of Care VS. Integrated Care

It was observed that funding silos within First Nations communities prevented community-based mental health programs and addictions programs from being fully integrated. Working together with shared clients and cross-training was happening in some communities but the process had to be collaborative and, depending on the openness of the leadership in both services, could take time.

Residential treatment programs tended to be moving more quickly towards integrated care because of the structure of the programs and services.

Contribution of Cultural Coordinators and Elders

Elders or cultural leaders were an important part of all programs and were involved in the programming to varying degrees. Some programs asked Elders what they were most interested in helping with (e.g., working in the grief and loss group, sweat lodge, cultural teachings, grandmother's group, land-based activities, etc.). Some programs had cultural coordinators on staff. Some programs asked staff who were also culturally involved in their community to provide cultural teachings as part of their position.

Mention was made about the need to ask Elders to give their insights into traditional approaches and healing practices for mental illness.

Screening and Assessment

Depending on the service provided, various screening and assessment tools were used. The following is a partial list of those screening and assessment tools used by the programs given by key informants:

- Asking a Few Questions
- Functional Assessment Interview
- Wellness Interview
- CAGE and CAGE-Aid Questions
- SASSI, MAST, DAST
- Assessment tools
- Suicide Risk Assessment
- Beck Depression and Anxiety Inventory
- Beck Suicidality Survey
- BASIS 32
- PTSD Screening
- Life Event Checklist

Single Point of Entry/Access

> "It doesn't matter who they see or what they need; someone can help them."

Community-based programs in particular discussed the need for a single point of entry, or "no door is the wrong door." This meant that it doesn't matter who they see or what they need; someone can help them. Staff should be cross-trained in the appropriate screening tools for both addictions and mental health, there should be some common forms and releases, and initial assistance could be given by any service.

Medical Support

Key informants for residential treatment programs felt that it was extremely important to have the support of the client's physician for the initial medical and for medication reviews during the program, as well as access to a medical practitioner linked to the treatment program itself. Some treatment programs situated in First Nations enjoy an excellent relationship with a Community Nurse. At least one program not located in a First Nations community has a contract with a Nurse Practitioner experienced in the treatment of addictions and mental health as well as knowledgeable in related pharmacology.

Medication and Pharmacological Support

Particularly for residential treatment programs, key informants advised that training in psychopharmacology, strict policies and procedures for medication dispensing, and a good relationship with a pharmacy are important. Working with a single pharmacy may be preferable as they will become familiar with your program. Several programs mentioned the use of the "blister pack" as a standardized method of managing mediation.

Residential programs may want to provide a pre-stabilization phase of treatment with the capacity for assessed short term pharmacological management of withdrawal symptoms under medical supervision. An example of some of the pharmacological features of a one week stabilization program within a Concurrent Disorders capable NNADAP residential treatment program is the following:

Stabilization period and pharmacological management of withdrawal symptoms:

- Prescription withdrawal medications may be used through the recommendation of a medical professional.
- A Nurse Practitioner has been contracted to assist with the medical management of withdrawal from opiates.

- After an assessment, a client may be provided a one-week regimen of medication to help with symptom management including Clonidine (to assist with anxiousness and agitation), Trazadone (to assist with sleep and relaxation), Gravol (to assist with inevitable stomach issues), and Ibuprofen.
- Clients are assessed daily by the treatment team in consultation with the nurse practitioner with a plan of being withdrawn by the end of the second week.[91]

It should be noted here that pharmacological management of withdrawal symptoms is only used when recommended. Many other choices can be used during the withdrawal phase. The use of traditional medicines and cultural activities can contribute to the support and comfort of clients.[92] One NNADAP Treatment Centre has developed a Withdrawal Management comfort kit to assist clients with their acute withdrawal symptoms. This is shared in *Appendix D: Withdrawal Management Kits*. Further to this list, the Centre is gradually introducing additional traditional medicines for the comfort of their clients.

Challenges and Strategies

Overall, those interviewed were very positive about their transition to a Concurrent Disorders capable program. Challenges that were given and respective strategies to overcome them are summarized below:

Challenges	Strategies
1. Siloed funding and staffing at federal level	Have regular meetings with all services Develop common intake/assessment forms Use common release of information Develop protocols with allied services
2. Jurisdictional funding	Advocate for integrated funding
3. Staffing attitudes and skills – getting staff to accept change	Staff training, competence, change management Team building, cross-training Online training, get credentials
4. Community attitude/ perspective	Community engagement and information sessions
5. Specialized resources – finding someone who is culturally knowledgeable and trauma informed	Develop protocols and cultural training with allied mainstream agencies Use non-insured benefits mental health resource list
6. Hospitals and external specialists are not trauma informed in relation to the First Nations experience	Outreach Caution when contracting with mental health specialists
7. Program models do not reflect culture (i.e., four directions)	Wrote our own!

Characteristics of an Ideal Program

Practitioners were asked to describe the components of an ideal Concurrent Disorders capable program. Some of these components have appeared in the previous sections but the following serves to emphasize the importance placed on them from the practice wisdom of those interviewed:

- Access to a psychiatrist who understands the importance of the cultural component and who has a trauma-informed practice in relation to the First Nations experience;
- Screening tools that are adapted to First Nations in Canada and are reliable and valid for First Nations;
- A connected medical withdrawal management facility and stabilization unit;
- Regular access to a medical practitioner and being directly connected with a clinic;
- Bio-psychosocial services and the facilities to accommodate them: massage, integrating cultural elements such as picking herbs and traditional medicines, biofeedback equipment, yoga and martial arts, land-based activities, mindfulness, physical activity program, CBT, DBT, and group work;
- Cross-trained program staff: knowledge in mental health counselling and addictions work;
- Culture-based programming; and
- Outcome measurement.

> "We need to be systematically measuring how our clients are doing. This is central to appropriate treatment."
>
> *(Dr. Christopher Mushquash, Assistant Professor at Lakehead University Department of Psychology and Northern School of Medicine, 2013)*

Concluding Observations

Changing to an integrated program may seem like an insurmountable task, especially when reviewing the requirements of a Concurrent Disorders capable program presented in this guide book. It is important to remember that most of the NNADAP programs just moved forward initially by doing what they could with what they had and felt that it was worth it for the benefit of those with co-occurring needs.

There is a great deal of information on the treatment of Concurrent Disorders in the mainstream. The field is developing and changing as research and practice wisdom is recorded. Online searches can provide a program with a quick way of learning about new developments.

Work done through the Thunderbird Partnership Foundation, its partners, and information on the First Nation Mental Wellness Continuum Framework and the Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada, is available to the public at www.thunderbirdpf.org. Research on the topic of Culture as Intervention in Addictions Treatment has led to the development of the Native Wellness Assessment™ which was launched in 2015.

93 A division of the National Native Addictions Partnership Foundation, (NNAPF) Inc.

Annotated Bibliography

Information on Program Components of a Western approach to Concurrent Disorders

Best Practices: Concurrent Mental Health and Substance Use Disorders

Health Canada | 2002 | 139 pages

This document provides a synthesis of research information combined with the advice and input of experts and other key stakeholders in the field including consumers. It is easy to read and offers clear recommendations for the screening, assessment, and treatment/support of the Concurrent Disorders population. It is offered as a complementary document to the work already done by various other authors including Minkoff and Mueser.

This report is not only intended as a resource for managers and practitioners, it is also targeted at planners, community developers, and other decision makers who work at a systems level. It may be useful for advocating for change in both system integration and program integration arenas.

The First Nations population is identified as a sub-population along with youth, the elderly, women, etc. and specific recommendations are not included in this document.

Integrated Treatment for Dual Disorders: A Guide to Effective Practice

Kim T. Mueser, Douglas l. Noordsy, Robert E. Drake, and Lindy Fox.

The Guildford Press, New York | 2003 | 462 pages

This detailed handbook provides extensive information on planning, delivering, and evaluating an effective treatment program for people with co-occurring mental health and substance use issues. Clear guidelines are presented for developing integrated treatment programs which include assessments, a wide range of interventions in various treatment modalities, and allied interventions which address the client's broader needs. A variety of useful hand-outs and forms are included with a limited permission to reproduce for the purchaser of the handbook.

Notably, the handbook does not address how to work with the unique cultural needs of any group. It represents a mainstream view of Assessment and Treatment.

Information on Culture-Based Healing

The Thunderbird Partnership Foundation has a variety of guidebooks and toolkits to assist NNADAP programs. The Thunderbird Partnership Foundation is a partner in ongoing research on the healing power of First Nations culture, language, and traditions. Documents are posted on the Thunderbird Partnership Foundation website at http://www.thunderbirdpf.org as they are compiled.

Appendix A: The 5 Ws of Cultural Safety

Who is Cultural Safety for?

Anyone who is not from the dominant culture (i.e., First Nations, Métis, and Inuit) needs to have a culturally safe environment where the individual feels respected and valued. The dominant culture in Canada is Western and non-Indigenous. Therefore, to respect and improve the wellness of all people, cultural safety is necessary.

What is Cultural Safety?

Cultural safety is the effect of strengthening, encouraging, and empowering the cultural identity of Indigenous Peoples. According to the 2011 *Honouring Our Strengths Report*,

> *"Services, both in Indigenous or non-Indigenous environments, recognize the cultural diversity within First Nations and aim to competently relate to individuals, families and communities in consideration of, and in relation to, their social, political, linguistic, economic and spiritual realities. This extends beyond cultural awareness and sensitivity within services and includes reflecting upon cultural, historical, and structural differences and power relationships within the care that is provided. It involves a process of ongoing self-reflection and organizational growth for service providers and the system as a whole to respond effectively to First Nations people."*

When should Cultural Safety be relevant?

Colonization has been the main factor in the breakdown of Indigenous people's family and social structures throughout the world. In addition, understanding the historical trauma of the oppressive policies enforced upon Indigenous people needs to be acknowledged and understood to witness the detrimental impact these oppressive policies have had on Indigenous people.

Where is Cultural Safety needed?

Cultural safety is needed in every institution, community, and organization that serves and employs Indigenous people. Cultural safety will assist breaking the cycle of colonization within the very institutions that have disrupted Indigenous family and social systems.

Why is Cultural Safety needed?

Cultural safety is needed to be able to provide excellent care by acknowledging, respecting, and honouring the cultural values and norms of the people requiring care. We all have culture, whether we are First Nations, Métis, Inuit, or of European descent – we all have a history with our own traditions and cultures.

How is the Thunderbird Partnership Foundation's Renewal Leadership Team addressing Cultural Safety?

The development of *A Cultural Safety Toolkit* is one of the renewal projects from the *Honouring Our Strengths* recommendations by the cultural practitioners and Elders at the NNADAP Renewal Indigenous Knowledge Forum. The purpose of this toolkit is to assist mental health and addiction workers to effectively and safely communicate, verbally and non-verbally, with First Nations clients. This toolkit is built upon humility, a common value found within many cultures.

Thunderbird Partnership Foundation
22361 Austin Line, Bothwell, Ontario, N0P 1C0
http://www.thunderbirdpf.org

Appendix B: Example of Pre-Treatment Checklist

Pre-Treatment Checklist

(Referent review with client)

Legal

- ☐ Probation / Parole is aware I am going to treatment
- ☐ Arrangements have been made for any outstanding charges
- ☐ Court dates have been rescheduled for after treatment
- ☐ I have a copy of my probation order and conditions
- ☐ Legal identification, i.e. health card and status card

Financial

- ☐ I have arranged for my bills to be paid
- ☐ I have made arrangements with my employer, Ontario Works, or Ontario Disability Support Program
- ☐ I have enough money for cigarettes and snacks
- ☐ My rent is paid and someone will check on my house for me
- ☐ Someone will deposit my cheques for me

Dependents

- ☐ Arrangements made for child care and child welfare access visit information
- ☐ Arrangements made for elder / parent care
- ☐ Arrangements made for pets feed / water / walk
- ☐ Arrangements made for partner
- ☐ Arrangements made for visits while in treatment

Personal Needs

- ☐ Prescription medication arrangements made with intake worker / Janzen's Pharmacy
- ☐ Diabetes management glucometer and test strips
- ☐ Personal supply of required toiletries including toothpaste, toothbrush, hair brush/comb, shampoo & conditioner, deodorant and hair styling products (not alcohol based), creams
- ☐ Clothing appropriate to weather / season: Outdoor wear for either cool or warm temperatures, pajamas /night wear, bathing suit
- ☐ Personal Items: slippers and/or indoor shoes, reading or journaling material, cigarettes (or money to buy), iPod or MP3 players (to be kept in lock-up and signed out for daytime usage)
- ☐ Traditional or Spiritual items: bundles or sacred items, shorts and t-shirts or long skirts to wear during ceremonies including sweat lodge
- ☐ Extra clothing and/or financial needs if planning to attend aftercare / recovery home
- ☐ Environmental Clean-up plan should be made between referent and client, i.e. remove all drug paraphernalia, empty alcohol bottle, etc.
- ☐ I am thinking about where I will live post treatment, i.e. home community or recovery home
- ☐ My medical needs have been addressed prior to treatment
- ☐ My dental needs have been addressed prior to treatment
- ☐ I have completed this checklist
- ☐ I watched the Dilico ARTC Video and answered the questions
- ☐ My ADAT assessment has been completed

Do Not Bring

- ☐ Any personal items containing alcohol including mouthwash and cologne
- ☐ Medications not in package or prescribed
- ☐ Cellular phones, if brought will be locked-up and returned upon completion of program
- ☐ Any items or materials which may be considered dangerous

(Bagnall, 2013)

Appendix C: Admission Checklist

Adult Residential Treatment Centre

Admission Check List

1. Review the Adult Residential Treatment Centre's **Maajii Maadaa-dizion: Beginning a Journey Video:** complete the **readiness checklist** with the person being referred to our Centre.

2. Our Centre requires a copy of the completed **Admission and Discharge Referral and Decision Tracking Summary (ADAT)**. This assessment will be accepted up to six months prior to applying for admission to our Centre.

3. Forward the completed **Application for Admission** to our Intake Worker where it will be reviewed by our Intake Team based on the client admission criteria.

4. With the client, complete a **Consent to Obtain and/ or Release of Information Form**. This will allow for our Centre to communicate with your agency to facilitate information sharing and treatment planning.

5. We require a **clinical assessment** from referent to determine client stabilization and readiness for treatment. This includes psychiatric or medical assessment and/or consultation, counselling services, correctional services assessment, and other support group / program services.

6. Complete the **Medical Assessment form** and return to our Intake Worker. Depending on current medical conditions, our Intake Team may request Medical Clearance prior to acceptance into our treatment program (seizure history, heart irregularities, MRSA infections, etc).

7. Our Centre has an agreement with a local pharmacy within Thunder Bay, Ontario to provide all **medication(s)** to clients while admitted to our treatment program. It is important that the Intake Worker is aware of the **client's current pharmacy name and telephone number.** All medications, including benzodiazepines or any controlled prescribed medications, will be reviewed and require rationale/ approval from both prescribing medical professionals and our Intake Team. We will take into consideration **medical withdrawal tapering programs** prior to the client's admission date.

8. Once the Intake Team has reviewed all the documentation, the Intake Worker will complete an **intake interview and discuss upcoming treatment dates** and availability. Clients may need to be referred to a withdrawal management program; this situation can be addressed during this interview.

9. **We expect** Referents and / or Clients to follow up on the status of Applications for Admission. The r**eferent is responsible** to inform our Intake Worker of follow-up or changes in circumstances of the client's needs. The **client is responsible to** adhere to the weekly contact schedule which secures upcoming treatment admission date.

10. **Transportation confirmation and arrival** information is required the week prior to the client's admission date. On date of client admission, any worker at our Centre will assist with transportation concerns (i.e. change of pick up times, etc). Guarantee of return travel is the client's responsibility.

(Bagnall, 2013)

Appendix D: Withdrawal Management Kit

When the stabilization period was introduced to the Dilico Adult Residential Treatment Centre, we developed the Withdrawal Management Kit to help increase the comfort of the clients entering the program and assisting them with acute withdrawal symptoms they may be struggling with in early recovery.

Items in the kits are:

- **"Sleepy-Time" Tea and "Tummy" Tea**: The tea is used to assist clients with both difficulties sleeping and sore stomach issues without the use of prescription or over the counter medications.
- **Candies:** Often individuals who are experiencing withdrawal from substances use crave sweets due to the connection with pleasure centers in the brain. f the individual is struggling with alcohol use, candies may also assist with sugar cravings.
- **Grounding Stones:** If the individual becomes triggered, grounding stones are said to refocus the client on something external. The idea is for the client to live in the moment, focusing on the feeling and sensation of the stone rather than triggering or intrusive thoughts. We are currently adding to this method. Cedar Oil may be used in the same format, allowing for our senses to assist with the grounding process.
- **Chap Stick:** Assisting client with the discomfort (and sometimes pain) of chapped lips.
- **Eye Masks:** Sleep is an important part of stabilizing to ensure the clients are well rested for the post stabilization/treatment period. Some clients are triggered or sensitive to light when trying to sleep and need to adapt the individual's body and mind to the new sleep setting. For this we supply them with sleep masks to assist them with sleeping difficulties ensuring they are able to sleep and are well rested.
- **Ginger Ale Pop:** Ginger Ale is said to assist with sore or upset stomachs because of the ginger root ingredient in the ginger ale. Ginger helps to reduce nausea, vomiting and diarrhea. Plus, it is a clear liquid that tends to settle the stomach by neutralizing some of the acid.
- **Cup-a-Soup:** Individuals struggling with withdrawal symptoms have a reduced appetite. To ensure they are still consuming some food and liquid they are encouraged to make a Cup-a-Soup. The soup is easily made and digested.
- **Wet Wipes:** A symptom of withdrawal is increased perspiration. Wet wipes give the clients the opportunity to clean up quickly without having to shower several times per day.
- **Slippers:** Slippers are available both to increase client comfort and for health and safety as opposed to wearing uncomfortable shoes or nothing at all

We have found the kits to be effective in assisting clients in coping with the effects of withdrawal symptoms. This tool has also been a way of encouraging clients to approach staff and develop a trusting relationship, acknowledging their struggles and assisting them in their comfort levels while engaged in treatment services.

(Bagnall, 2013)

References

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed. Washington, D.C.: American Psychiatric Association, 2013.

Assembly of First Nations and Health Canada. *First Nations Mental Wellness Continuum Framework.* Ottawa: Health Canada, January 2015. Online. Available: http://publications.gc.ca/collections/collection_2015/sc-hc/H34-278-1-2014-eng.pdf

Assembly of First Nations, National Native Addictions Partnership Foundation, and Health Canada. *Honouring Our Strengths.* Ottawa: Health Canada, 2011.

Babor, T. F. and J.C. Higgins-Biddle. *Brief Intervention for Hazardous and Harmful Drinking - A Manual for Use in Primary Care.* Geneva: World Health Organization, 2001.

Bagnall, Cheryl, *NNADAP Adult Residential Treatment Program Manager at Dilico Anishinabek Family Care Personal interview.* 17 December 2013, Thunder Bay. Interview by Rose Pittis.

Barry, K. L. TIP 34: *Brief Interventions and Brief Therapies for Substance Abuse: Treatment Improvement Protocol (TIP)* Series 34. Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1999. Rockwall II: DHHS Publication No. (SMA) 99-3353.

Black, Nancy, Director of Concurrent Disorder Services at St. Joseph's Care Group. 4 January 2013. Interview by Rose Pittis.

CAMH Knowledge Exchange. *Screening and Assessment.* 2009. Retrieved from CAMH Knowledge Exchange: http://knowledgex.camh.net/amhspecialists/Screening_Assessment/screening/Pages/default.aspx

Canadian Centre on Substance Abuse. *Substance Abuse in Canada - Concurrent Disorders.* Ottawa: Canadian Centre on Substance Abuse, 2009.

Cline, C. and K. Minkoff. *A Strength-based Approach to Creating Integrated Services for Individual with Co-occuring Psychiatric and Substance Use Disorders.* New Mexico Department of Health, 2002.

Concurrent Disorders Ontario Network. *Concurrent Disorders Policy Framework.* Toronto: CAMH, 2005.

Currie, S. *Knowledge notes: What exactly are Concurrent Disorders?* 2005. Retrieved January 2013, from Alberta Mental Health Research Partnership: http://www.albertahealthservices.ca/2770.asp

Dell, Colleen Anne, Raymond Tempier, and Debra Dell. "*From Benzos to Berries: Treatment offered at an Aboriginal Youth Solvent Abuse Treatment Centre Relays the Importance of Culture.*" The Canadian Journal of Psychiatry 2011, 75-83.

Dixon, John, Director of Mental Health and Addictions at Dilico Anishinabek Family Care. 17 December 2013. Interview by Rose Pittis.

Gone, J. and L. Kirmayer. *The Wisdom of Considering Culture and Context in Psychopathology*. In Contemporary Directions in Psychopathology. New York: Guilford Press, 2010.

Guajardo, J.F. *The Effects of Pretreatment Preparation with Clients in a Substance Abuse Treatment Program.* Dissertation - Ohio University, 2008.

Hay, H.and S. Holliday. *Regional Program for Complex Mental Health/Addiction Populations.* VCH Aboriginal Mental Health and Addictions Forum. Vancouver: Aboriginal Health Strategic Initiatives and Vancouver Coastal Health, 2009, 8.

Health Canada. *Best Practices: Concurrent Mental Health and Substance Use Disorders.* Ottawa: Minister of Public Works and Government of Canada, 2002.

Health Canada, Assembly of First Nations, and National Native Addictions Partnership Foundation, *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada*, Ottawa: Health Canada, 2011.

Herper, M. "*Why Psychiatry's Seismic Shift Will Happen Slowly.*" Forbes (online), 8 May 2013.

Kirmayer, L.J. "*Cultural competene and evidence-based practice in mental health: Epistemic communities and the politics of pluralism.*" Social Science and Medicine 2012, 249-256.

Klinic Community Health Centre. *The trauma-informed toolkit.* Winnipeg: Klinic Community Health Centre, 2008.

Marlatt, G.A., and D.M. Donovan. *Relapse Prevention: Maintenance Strategies in the Treatment of Addicitve Behaviours.* New York: Guilford Press, 2005.

Minkoff, K. Developing *Standards of Care for Individuals with Co-occurring Psychiatric and Substance Use Disorders*. May 2001. Retrieved December 23, 2012, from Psychiatric Services: http://psychiatryonline.org/data/-Journals/

Mueser, K.T. *Integrated Treatment for Dual Disorders.* New York: Guilford Press, 2003.

Mueser, K., D. Noordsy, R. Drake, and L. Fox. *Integrated Treatment for Dual Disorders:A Guide to Effective Practice.* New York: The Guilford Press, 2003.

Mulzer, Paul, Psychiatrist at Northwestern Ontario Concurrent Disorders Program. 4 January 2013. Interviewed by Rose Pittis.

Mushquash, Christopher, Assistant Professor at Lakehead University's Department of Psychology and Northern School of Medicine. September 2013, Thunder Bay. Interviewed by Rose Pittis.

National Native Addictions Partnership Foundation. *A Cultural Safety Toolkit for Mental Health and Addiction Workers In-Service with with First Nations People*. NNAPF, 2013. Online. Available: http://nnapf.com/nnapf-document-library

Native Addictions Partnership Foundation. *Developing a Basket of Mental Health and Addiction Screening and Assessment Tools for Use with First Nations Clients.* NNAPF, 2015. Online. Available: http://nnapf.com/nnapf-document-library

National Native Addictions Partnership Foundation. *Discussion Paper: Mental Health & Addictions Screening and Assessment Tools [Draft].* NNAPF, 2012.

National Native Addictions Partnership Foundation. *Guidebook Supporting the Use of Natural Medicines in Culturally-Based Healing Practices for NNADAP/NYSAP Counsellor.* NNAPF, 2013. Online. Available: http://nnapf.com/nnapf-document-library

Robbins, S., M. Coulter, and N. Langton. *Fundamentals of Management.* Toronto: Pearson Prentice Hall, 2008.

Rush, B., D. Urbanski, S. Bassani, T. Castel, C. Wild, D. Strike, et al. "*Prevalence of co-occuring substance use and other mental disorders in the Canadian population.*" Canadian Journal of Psychiatry 2008, 800-809.

Schaeffer, A. *The Advantages and Disadvantages of DSM IV.* 2013. Retrieved from eNow Health.

Skinner, Wayne, Deputy Director at CAMH Addictions Program. 17 January 2013. Interviewed by Rose Pittis.

Skinner, W., C. O'Grady, C. Bartha, and C. & Parker. *Concurrent Substance Use and Mental Health Disorders: An information guide.* Toronto: Centre for Addiction and Mental Health, 2004.

Smith, J. *Co-Occurring Substance Abuse and Mental Disorders: A Practitioner's Guide.* USA: Rowman and Littlefield Publishers Inc., 2007.

St Jospeh's Care Group *Mental Health and Addictions*. 2013. Retrieved November 2013, from www.mha.sjcg.net

West, R. "*Time for a Change: Putting the Transtheoretical (Stages of Change) Model to Rest.*" Addiction, 100 (8), 1036-1039.

Thunderbird Partnership Foundation