

Concurrent Disorder Capacity Project: South East Ontario

**Results of a Focus Group
Study of Community Addiction Workers and Mental Health Workers**

September 2009

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Executive Summary – CD Capacity Project Focus Group Study (2009)

This project was undertaken as part of the Concurrent Disorder Capacity Project in South Eastern Ontario to assess the capacity of staff in the mental health and addictions sectors to (a) identify and appropriately screen and treat clients with concurrent substance and mental health problems, and (b) fully implement the Concurrent Disorders Policy Framework (2005), which calls for coordinated and integrated care. Results are based on a focus group approach involving three focus groups: one involving six mental health workers from Kingston and Hastings/Prince Edward areas, one involving six mental health workers from Brockville/Smith's Falls, and a third involving seven addictions workers from across the region.

Mental health workers described clients with concurrent disorders as difficult to engage, slow in developing trust, and, at times, emotionally draining. Lacking basic knowledge about street substances, psychotropic medications, and how these might interact, workers felt that they were unable to effectively counsel or advocate for clients, and were less effective in motivating them to adopt harm reduction techniques. When viewed as a strategy to empower clients and provide integrated care across the full continuum of substance use problems (not just addictions), harm reduction was heavily supported in principal, but used more sporadically; usually later in the therapeutic encounter when substance issues were fully disclosed and then only to justify non-abstinence. Perceived barriers to providing integrated treatment included:

- The tendency of some clients to minimize or actively hide their substance use problems;
- Perceived increasing pressures to push clients through the system quickly, without allowing time to build trust and allow for full disclosure of substance use problems;
- Worker's lack of knowledge, skills, competencies or confidence in applying harm reduction techniques, and sometimes a general discomfort in identifying with clients with substance use concerns;

- Lack of understanding of drug lingo and the effects of street drugs, psychotropic medications, and their interaction effects; and
- Misunderstanding of harm reduction approaches.

In light of these difficulties, mental health workers expressed a strong appetite for additional training and opportunities for professional self-development to address fundamental gaps in knowledge and build skills and competencies needed to effectively manage issues pertaining to substance use and abuse among their clients with mental health disorders, particularly in harm reduction approaches which were not completely implemented, or sometimes misunderstood. They also saw a need for multi-agency and multi-system training opportunities.

Addictions workers did not identify personal discomfort in dealing with the mental health needs of their clients or harm reduction approaches, but expressed considerable frustration concerning system-level barriers that made it difficult or impossible to integrate care across health, mental health, addictions, social services, and legal agencies. They experienced difficulties obtaining timely psychiatric assessments for their clients because of poor access to family doctors (and the inability to obtain a formal psychiatric diagnosis), the expectation of some mental health programs that substance abuse issues be under control first, or because some substance abuse treatment facilities object to having clients on psychotropic medications. Addictions workers also considered that their knowledge of psychotropic medications and their interactions with specific substances was insufficient. They identified the need for improved knowledge exchange across programs and systems, particularly having quick access to information on psychotropic medications and substance interactions.

These findings suggest that workers do not have sufficient knowledge, essential skills, or capacities to implement integrated care for patients with concurrent disorders according to the model outlined in the Policy Framework.²

With respect to mental health:

- The workers' belief that there is a need to determine diagnostic primacy of the mental illness or the substance abuse problem in the therapeutic process runs contrary to the Policy Framework which indicates that "each disorder should be considered primary". ^(p. 13) Workers tend to provide interventions sequentially (rather than concurrently) and do not appear to fully understand the parameters or broader sense of integrated care.
- Workers do not address the full continuum of substance use problems proactively, often delaying the identification and treatment of what they perceive to be less serious substance use problems in order to solidify a therapeutic relationship and build trust.
- Workers did not fully understand the purpose or scope of harm reduction. It was often viewed as an alternative to abstinence, or as an expedient method of dealing with clients who were not considered able to become abstinent, rather than an approach to care that maximizes healthy development and recovery.
- Workers were unable to adequately engage clients in therapeutic conversations about substance use. They perceived a range of barriers from clients' fear of stigma and reluctance to disclose, to their own lack of technical knowledge about substances and their effects, and in some cases, inability to relate to clients with substance use problems.

With respect to addictions:

- Workers do not have sufficient knowledge of psychotropic medications or their interactions with substances.
- Workers are unable to adequately engage clients in therapeutic conversations about their use of psychotropic medications in combination with other substances or assess the risks associated with interactions. Potential risks are compounded by client's lack of access to general practitioners or psychiatrists.

Implications for Training

Based on this focus group analysis, and the essential skills outlined in the Concurrent Disorders Capacity Project Report,¹ the following training is recommended to enhance care for clients with concurrent substance and mental health disorders in Southeastern Ontario:

- Access to a resource manual concerning the role and mandate of various community agencies and partners across systems who deal with clients with concurrent disorders;
- Information on the various street terms used to identify substances and their amounts;
- Information on the effects of substances, psychotropic medications, and their interactions;
- Training on the use and proper application of substance use screening tools;
- Opportunities for self-development pertaining to basic knowledge, skills, and competencies in the identification and management of substance use, addictions, and concurrent disorders;
- Increased knowledge about the scope and application of harm reduction approaches;
- Information about the scope of integration strategies and concept of “one team with one plan for one person” contained in the Policy Framework;²
- Examination of beliefs, attitudes and personal values related to substance use and mental health disorders to reduce stigmatization by sector workers;
- Opportunities to connect with community partners in the context of structured training workshops;

¹ CD Capacity Project, Champlain and South East Partners (2008) Concurrent Disorders in South Eastern Ontario and Champlain: A Proposed Process to Measure CD Capacity among Addictions and Mental Health Partners.

- Training opportunities that are locally provided, flexible to access, inexpensive, and where attendance is supported by program managers.

Recommendations

In light of the foregoing analysis and discussion, we recommend that organizations that provide mental health services and/or addictions services in Southeastern Ontario:

- Designate minimum annual requirements for front line worker training to demonstrate support for on-going skill enhancement;
- Mandate the use of screening tools to identify clients who may benefit from concurrent disorder services;
- Implement standard protocols to systematically manage positive indicators on screening tools for mental health concerns and/or problematic substance use, and effectively address clients' preferences and readiness to explore issues related to substance use or mental health concerns in both screening and treatment processes;
- Negotiate service integration agreements between local mental health and addiction services that confirm the obligation to offer clients coordinated and integrated services and that outline referral, consultation, and collaboration protocols to provide concurrent care;
- Develop a human resource plan—both at the agency level and the regional level—to identify resources needed to bring the system up to capacity to appropriately manage clients with concurrent disorders according to the Policy;
- Implement compulsory instruction/training for all employees related to attitudes, core values, beliefs and ethics to ensure client access to and consistent provision of recovery-based services.

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Purpose

This project was undertaken to assess capacity of staff in the mental health and addictions agencies in Southeastern Ontario to identify and appropriately manage clients with concurrent substance and mental health problems (termed concurrent disorders). Results from this investigation are intended to inform policy changes, system planning, and staff training. The findings reported in this report represent one phase of a larger project to determine the current capacity of the mental health and addictions sectors to provide appropriate services to clients with concurrent disorders. This project was designed to assess potential gaps in knowledge, skills, and competencies in front-line staff and suggest training opportunities to enhance system capacity.

Background

In 2005, the Concurrent Disorders Ontario Network issued a Policy Framework to address the needs of people living with concurrent substance use and mental health issues.² The Policy Framework recognizes that the degree of harm and severity of concurrent substance and mental health problems varies across individuals and that people with concurrent disorders may access care through either the mental health or addictions systems. Therefore, the vision was to create seamless, integrated care, whatever the point of entry. These themes have been reiterated in the recent discussion paper released by the Ministry of Health and Long Term Care entitled, *Every Door is the Right Door*.³

² Concurrent Disorders Ontario Network. (2005) Concurrent Disorders Policy Framework. September 2005.

³ Ministry of Health and Long Term Care (2009) Every Door is the Right Door. Towards a 10-Year Mental Health and Addictions Strategy. Discussion Paper.

While there are many components to a comprehensive system of care for people with concurrent disorders, key among these are the ability of program staff to identify clients who have concurrent substance use and mental health problems, provide appropriate, evidence-based care that meets minimum standards of integrated care, and follow referral protocols to access more specialized addictions services or mental health services.

The Policy Framework identifies four levels of programming, each with a corresponding level of expertise in the management of clients with concurrent disorders. Staff in **basic** programs provide treatment for one disorder, but screen for the other and can access specialized consultations. Staff in **intermediate** programs focus primarily on one disorder, but also address some of the needs of the other. Staff in **advanced** programs provide integrated substance use and mental health treatment by adding needed expertise and relevant interventions either internally, or through collaboration with other services. Finally, staff in **fully integrated** programs actively combine substance use and mental health interventions.

In the South East, a working group was formed to undertake the Concurrent Disorder Capacity Project, the goals of which were to implement the Policy Framework and to measure and define levels of program capacity in concurrent disorders. The resulting position paper, *Concurrent Disorders in South East Ontario: a Proposed Process to Measure CD Program Capacity among Addictions and Mental Health Partners*, was based on consultations with the addiction and mental health sectors. It outlines guidelines to allow the systems to assess the current level of concurrent disorder capability within individual programs. In addition, the guidelines provide direction so that agencies can develop their capacity to meet the needs of their clients. Not all agencies need to provide specialized concurrent disorder services, but all agencies are expected to achieve an essential level of concurrent disorder capability. These levels of capacity are based on the competencies, knowledge, and skills that are required for staff. It is important that there are flexible and diverse program response capabilities to address the variable needs of the concurrent disorder population.

There are three critical pillars to a comprehensive concurrent disorder system:

1. The capability of the staff to provide concurrent disorder intervention;
2. The program capacity to provide the appropriate intervention; and
3. The program model within which the interventions are provided by staff.

In order to implement the Policy Framework and meet the needs of clients with concurrent substance and mental health problems, and provide integrated, evidence-based care, all mental health and addictions staff in the Southeastern Ontario LHIN are expected to have essential skills, knowledge, and competencies in the management of concurrent disorders. This project grew out of the need to explore the practices, procedures, beliefs, and knowledge surrounding concurrent disorders with the addiction and mental health sectors in Southeastern Ontario.

Approach Used

To gain a better understanding of the skills and capabilities of staff in the management of clients with concurrent disorders, and to assess their training needs, we used a qualitative approach based on focus group interviews with front line mental health and addictions workers. Two groups were held with mental health workers and one group was held with addictions workers. The first focus group was held in Kingston involving six mental health workers from the Kingston/Hastings Prince Edward areas. A second group was held in Kingston with seven addictions staff from across the region. The third group was held in Brockville involving six mental health workers from the Brockville and Smith's Falls areas. Focus group members were recruited through the Executive Directors of agencies. Directors were asked not to nominate concurrent disorders specialists.

We began each focus group with introductions and background on the project. We asked individuals to speak in general terms without identifying particular agencies or people. We asked that they feel free to provide a broad view of practices in the field

based on their own personal experiences, the experiences of their colleagues, and what they know of agency practices. The flow of the interview was as follows:

- ***Setting the Context:*** Initially, participants described their experiences with clients having concurrent substance and mental health problems, concluding with a summary of a typical client.
- ***Processes of Care:*** Next, we asked them to describe the process of care typically used in the management of clients with concurrent disorders. They were probed to identify how they know when a client has a concurrent disorder; whether they use particular screening approaches; how they set priorities for treatment; how they know if their client is receiving integrated care; when they refer to a specialist; and how they interact with colleagues and programs from the other sector.
- ***Key Challenges:*** We asked participants to identify the key challenges they experience when working with clients with concurrent substance and mental health problems. They were asked to consider what made working with these clients complex; what they liked and didn't like about working with this client group; and whether the key challenges they faced pertained to client characteristics, staff characteristics, program characteristics, or system characteristics.
- ***Staff Skills and Competencies:*** We asked whether participants thought that front-line staff who work with clients with concurrent disorders require special skills or competencies and, if so, what these might be; or if not, why not. Participants were then asked to consider whether they thought most front line staff had the skills and competencies required to provide high quality, integrated care to clients with concurrent disorders.
- ***Training Needs:*** Finally, participants were asked what, if any, training needs would be helpful to assist front line staff in providing better care and whether they saw any barriers to putting these into place in our region.

The conversations were free flowing with no attempt to provoke consensus. Participants were told that we were interested in a range of experiences and that we expected diverse opinions. We asked that participants feel free to disagree with each other and present alternative views, because these would be particularly informative. Conversations were animated and generally required little guidance from the Facilitator. At the close of each section, the Facilitator summarized the range of discussion and the key points made, and asked participants to elaborate on anything that was missed or correct any misperceptions.

All focus groups were taped and transcribed. Edited transcripts (removing names and other individual and agency identifiers) were reviewed by the Advisory Committee members to discuss themes that were considered to be most relevant to the project objectives. The Facilitator used these discussions to provide conceptual grounding for the qualitative analysis. Transcripts were then reviewed in detail by the Facilitator and comments were organized into theme-based sections. The content in each section was summarized and illustrative quotes were abstracted. Detailed quotes are presented to provide support for the summary statements made and to give the reader a better understanding of the richness of the discussions.

Findings from the Mental Health Focus Groups

Typical Clients

Clients with concurrent substance use and mental health problems were described as some of the most complex and challenging on workers' caseloads because they were the most difficult to engage and to treat.

People get frustrated and they give up. It's almost like they're not applying common sense and they are not trying to help themselves.

He got very abusive in one of his drinking sessions with me on the telephone—very abusive, and he didn't like the fact after that I told him

for the next few meetings that we had to meet with a third person in the room because it wasn't appropriate to be abusive to me. I was trying to help him.

It's not just you're dealing with this one client with all the complex problems on top of a caseload of many people... and if you end up with two or three cases like that on your caseload, it can be very challenging for a worker.

If they relapse, they feel that you don't want to work with them any more because they've let you down.

The lack of a simple treatment trajectory and the need to engage multiple stakeholders in the therapeutic process was also experienced as frustrating.

...or you get them into contemplative and into making changes and they slide right back into pre-contemplative like you want to see them going through the logical stages and getting an action plan and getting better, but they just never have that chance.

It's like you just wasted that whole time.

So, it was a really challenging case in that aspect because I was dealing with the family doctor and trying to get this man what I felt was going to help him get to the point that he needed so he could survive outside.

When you get so many people involved, like a GP that isn't all that up on the psychiatric or substance abuse, its sometimes hard to get everybody on the same page. It can be frustrating for the client and for yourself.

...it's hard to meet the client where they are at when you have to deliver short term treatment and not everyone is on board.

Challenges Posed by Clients with Concurrent Disorders

Perceived Need to Determine Diagnostic Primacy

Determining diagnostic primacy was an important preoccupation for mental health workers and considerable time and energy was spent assessing whether the substance use or the mental health problem should be addressed first—always with the

recognition that the focus of treatment must shift from one issue to the other as circumstances changed or crises emerged.

Given that clients had accessed a mental health program, the mental health issues were often considered to be the most urgent, and were often perceived as the likely root cause of the addiction. Substance use was seen as a coping mechanism; a way of managing an undiagnosed mental illness, traumatic life event, or a difficult childhood. There was a prevailing opinion that, to successfully deal with the substance use issues, the underlying mental disorder first had to be successfully managed. In some cases, the addictions issues clouded the picture, making it difficult to address the mental health problems. Workers also thought that determining whether the substance use or mental health problem was at the forefront of treatment could be frustrating and time-consuming.

I think the important part, which takes a lot of time, is to try to get a proper diagnosis so that you know whether it's the substance use issue that is forefront, or whether it's the mental health issue that's feeding the substance use issue.

It also helps the frustration of the worker in knowing which issue you should be addressing at that current time.

It is really hard to get to the gist of the mental health issues because there are a lot of addictions issues in the way...

Identification and Engagement

Workers indicated that it was not unusual for their clients to down play substance problems or actively hide them. Often, substance issues would only emerge with time and trust, after a therapeutic relationship had been established. While some clients would acknowledge that they used substances, they typically would not view it as an addiction. Reframing the substance use as an addiction problem not only seemed like a betrayal of trust, but it might make clients feel stigmatized or that they were being judged. Thus, there was the sense that pushing clients to divulge substance related problems, when they were not ready, was a good way to scare them off.

They down play the addiction side because, to them, it was, “well that’s how I cope”, and then if you really sit back and look at it, they didn’t have an easy life. They have a form of mental illness that was not diagnosed and that gets down played.

You know that you have a good relationship when they’re willing to tell you things that you really don’t want to hear.

Sometimes I worry having people shut down if I push too hard in that area.

After I’d established relationships with some of them, and once the trust issues were gone, I found they were a lot more open to it, but the trust relationships, you can’t build overnight. These guys, unfortunately, have a lot of mistrust—whether it be delusionally based in the mentally ill population or whether it be based in social relationships they’ve had in the past.

In addition, mental health clients were described as generally reluctant to seek out specialized addictions help owing to the stigma associated with addictions. Workers described clients as unwilling to be labelled as having an addiction problem. They preferred the stigma associated with mental illness. An important consequence of this was that workers might not find out about the existence or magnitude of substance related problems until considerable time has passed.

They would rather be stigmatized for their mental health issues. ...They just don’t want to be labelled and I’ve had them say that exactly, “I just don’t want to be labelled”.

There are certain things that they actually hide from you so we find out after the fact.

The client was embarrassed.... So that makes integrated care really difficult.

It’s because they don’t see it as a problem, or they know they have a problem and they’re actively trying to hide it from you.

Screening tools, though used, were considered to be ineffective for identifying many substance use problems. Scepticism about the effectiveness of screening tools centred

on client's tendency to hide or minimize their substance use issues. Consequently, screening tools didn't seem to speed up the process of disclosure or appreciably widen the therapeutic window. One worker indicated that peer specialists were more helpful because they encouraged clients to identify substance problems in the context of a safe and non-judgemental relationship.

...if they're intentionally hiding or minimizing it.. then that's not going to pick it up. Nothing's going to pick that up as far as we have right now.

I find it helpful to be able to go into the person's home, because lots of time we have our initial screening process, you know, asking them about their drinking patterns. ...and then you go to visit the home and you see cases to the ceiling or on the porch. ..but they call themselves, "I am just a social drinker", so, I think that to actually find out what is really going on in that person's life takes a process of time...

Harm Reduction

Workers described harm reduction as an important and pragmatic therapeutic strategy. It was seen as a useful tool to engage clients, but also as a way of encouraging smaller incremental changes when the pressures to move clients through the system and close cases did not allow sufficient time to address the enormous and life-altering task of becoming abstinent. In other cases, harm reduction was portrayed as a helpful approach in order to do something with clients who workers did not expect could beat their addiction.

I guess I do a lot of harm reduction, because there are some people—let's face it—they are never going to come off the stuff.

They don't want to give up this stuff.

I find that [harm reduction] very useful to me. A lot of my clients, and particularly the younger ones, because it's easier for them to accept that I am saying, "we're going to cut back" or "we would like you to cut back", or "it would be healthier for you to cut", than to have someone, particularly an older adult sitting in front of them saying, "no, no, no, you have to quit and you have to stop now!"

It's funny. You have all-or-nothing thinking, and if you try and use that all-or-nothing treatment, that usually doesn't work.

If you really want to make any changes, for a lot of people, they have to change their friends, they have to change their daily habits—where they go, what they do, how they get up in the morning—just the very basic things have to change, and that's their whole life!

You have to give up your whole life! You have to give up your whole life in order to deal with your addiction issue!

...I totally agree that harm reduction really needs to be embraced, because at this rate, we are not engaging these clients quickly enough to help them efficiently. So, at the very least, we can reduce harm. At least we're getting somewhere.

Despite the utilitarian value of harm reduction approaches, workers described a number of system pressures that limited in their ability to implement harm reduction techniques. This occurred when key programs, such as residential treatment programs, disability insurance, or employee benefit plans, practice a policy of abstinence requiring clients to be free from all substances, including sometimes methadone and psychiatric medications.

I think there is a lot of stigma still around the harm reduction approach versus an abstinence approach, and it's leading to a lot of frustration for workers. I think there's an assumption that, if someone continues to be using, then we can write them off because they're not following through with what we would like them to do.

I think there are a lot of clinicians who want to be able to use a harm reduction approach, but then they are into a situation where they can't use it because of other governing bodies. For example, it's next to impossible to get someone onto ODSP if they are a substance user. ...and that's the same with insurance companies. A lot of insurance companies request that treatment include a residential treatment program; that the person be abstinent in order for them to get their sick benefits through their employer. ...so, clinicians are being forced into using an abstinence approach, which again causes a lot of frustration for the clinician as well as the individual.

Knowledge, Skills, and Competencies

Mental health workers identified important gaps in their knowledge, skills, and competencies. Some expressed discomfort in dealing with substance use issues when they felt ill-prepared to do so. Others expressed difficulty identifying with someone who had substance use concerns. More formal training, combined with greater access to specialists, and opportunities for on-line resources and instruction, were thought to be needed to help improve the care provided, reduce some of the uncertainty and frustration associated with this client group, and allow workers to become better advocates for their clients when dealing with health and social service agencies.

I would definitely say I wouldn't be comfortable having a lot to do with the addictions issues. I can't identify a lot with somebody that has an addiction issue. I've never been down that road, so I don't know where they're coming from, and I don't have the skill set—I believe—to really help them. I can get them with addiction services—I can do that—but to figure it out myself, I don't feel comfortable.

Basically, I don't know that what I am telling them is right.

It's not that I don't want to listen. I do, but I just don't know if I have what it takes to give advice....to help.

I don't think I would be comfortable in saying someone has an addiction. I am not aware enough about what an addiction is.

We need more formal training and accessibility to people who are specialists.

I think a lot of formal training could be given to people who are strictly working in mental health because, I mean let's face it, a big majority of the mental health clients have an addiction of some sort or another.

..it sounds like if you get the formal training, you are more aware of things like harm reduction. ...but we don't have that kind of training. I mean, you have the knowledge, maybe, that you learned going to school. It's quite a draining job at times.

You can't motivate people if you don't know what you are talking about. If you don't know about the addiction piece, you can't really motivate them to do too much.

Professional Development

Professional development was recognized as important in principle, but in practice, it was deemed to be out of reach for most front line workers. Busy schedules, the need to meet accountability quotas, costly conference registration fees, and lack of travel resources meant that few workers could attend seminars or conferences. Local opportunities for professional development, particularly opportunities that brought people together from across different systems, that were inexpensive, and where attendance was supported by program managers, were emphasized. Courses that were overly structured, such as university-based courses or seminars, that required staff to attend on a regular basis (during certain hours) were also considered to be out of reach of most who work shifts. Flexibility, accessibility, and cost were the key themes.

It should be part of professional self-development, to have ongoing educational program, provided, you know of course, that they are easily accessible and not costly.

I think that anyone who has a nursing license, it's part of our yearly licensing requirement to have a certain amount of self-development. ...I think that kind of thing would be a good idea—to have mandated a certain amount of hours of education for professionals who are within the mental health/addictions fields. ...if it were made, as I said, accessible and economical for people to do that.

Community Resources and Connecting with Others

Workers would appreciate more opportunities to understand how various components of health, justice, and social service systems work to meet client needs; what resources are available; and how agencies might work together more closely. In addition to having basic information, they also identified the importance of opportunities for active learning. Toward this end, they thought that there should be more formal opportunities to bring people from across the various systems together—to discuss mock cases for example—in order to better understand how to integrate their efforts.

It would be nice to know what everyone does; what the resources are out there. ...I think it's sort of been taken for granted.

It's the importance of bringing everyone together from the various agencies and talking about whatever issue it is about. ...We are all on the same page. We are all feeling the same way. It just helps to normalize the frustrations that we have and kind of puts it on the page too.

Sometimes, it's just helpful to put a face to a name. I talk to people all the time. I have no idea what they look like and they have no idea what I look like. You get to see people on a different level, and you do feel more comfortable consulting and talking about things, and things just come up more. We tend to keep a lid on things because we don't have time or we don't know the person.

Drug Lingo and Drug Effects

Mental health workers were unanimous in wanting more information on the street terms used to refer to drugs and to their effects; particularly how they might interact with psychotropic medications. Staff members with a nursing background were more comfortable with psychotropic medications, but the majority of front line staff were described as from non-nursing disciplines, with little knowledge of psychotropic drugs and their effects. Clients were often their key source of information about street drugs, though this was recognized as problematic. Workers thought they could be more effective in promoting harm reduction and in educating clients if they could understand street terms, describe the effects of drugs, and identify harmful drug combinations.

I think we would like some more information on that. ...people will come forward: "Oh yeah, I use this much or that much" and we're like, "OK". ...you make a note of it.

..and in the same context, we were talking about they will also reveal what they are taking and we are just writing the notes down. I do the same thing with the medication. "I take so many milligrams of this", and I don't really know exactly, or "this is in combination with this", and I don't know if that was a wise thing.

I might talk to somebody in addiction or I'd look it up on the internet, or often, I will ask the client and it will lead to more information.

So many people I see are coming because their anxiety is so severe they can't function, and they reach more and more for alcohol and drugs and coffee. ...all I can say to them is, "it attacks your nervous system". ...I feel if I were standing in a more educated place, I could talk to them a little bit more.

We don't even know what all the medications are, and how are they supposed to know? ... I think it's a big issue. People don't know what they are taking or why they are taking it!

The social workers...I mean we are all clueless. We are not trained in medications. We have no idea. We just learn through experience. We try to get in-services, but for us, it's a real challenge because we don't have the background.

...a piece to build into that education is the impact of street drugs or alcohol with medications. I can say, "well, it's not good", but I can't back it up with why, or what happens.

Findings from the Addictions Focus Group

Typical Clients

Addictions workers described a broad range of clients with concurrent disorders, ranging from those with serious mental illnesses who self-medicate with substances, to young people with undiagnosed learning disorders. Indeed, they had some difficulty describing the 'typical' client. Clinical profiles differed depending on client characteristics such as age or gender, or geographic factors that may govern drug availability. Often, however, clients had been using a variety of substances for many years, usually starting in adolescence.

As far as a typical client, I don't know that that's really an easy question to answer, because it's really trying to determine, so if someone identifies that substance abuse is their primary concern, we don't ignore other things that may have been presented...

Depression and anxiety are very common. ...but Bipolar and Schizophrenia; I'm seeing a lot of it with their physician, so they are being prescribed a lot of medications.

They have huge trauma histories from sexual abuse, family violence, child abuse, rape. It's all coming through the door and it's continuous.

The majority of our clients will identify anxiety, depression—they say they think they are Bipolar or some sort of PTSD.

The majority of clients we deal with do have mental health issues, but as other people have been saying, they don't identify.

System-Level Barriers to Integrated Care

Addictions workers were generally comfortable dealing with clients who had concurrent disorders and were more likely to identify system-level barriers to integrated care rather than a lack of essential skills. Key problems were the inability to obtain a psychiatric assessment (for purposes of diagnosis) without a medical referral, the requirement of some mental health agencies to have active substance abuse issues resolved prior to accessing mental health services, and the fact that some residential facilities have restrictions against certain psychiatric medications.

We cannot get an official diagnosis because they don't have a family doctor, and no psychiatrist will see them without a family doctor. We cannot refer.

They do not have access to a family doctor in our area, which negates them from getting a psychiatric assessment for mental health, which means we don't have quite as much success referring to a mental health program.

Some of the issues are that we may have family doctors that aren't on board either and will not forward a request for psychiatric assessment if we say we would like the client to get one.

When I make a referral to mental health, if there's an active substance use, they will generally send them back and say, "get that under control because we can't diagnose mental health properly if they are under the influence of drugs or alcohol". Yet, we are saying, "Unfortunately, they are quite often using drugs and alcohol to try and deal with their mental health so we need to work together".

They can get to see an intake worker fairly quickly, but then if there is any follow-up to be done, it's months down the road.

The one thing that always stands out in my mind is the sense of what came first—the chicken or the egg; and "we need to do this before you can move onto that so, you know we can't work on your mental health

before your substance abuse is under control”, and vice versa. I think what we know now is that’s it’s not always the best way to manage those clients.

A lot of our clients are on medications for mental health and some of the medications are not permitted in the treatment centres.

I have a client that’s waiting to go somewhere... and a lot of the meds he is on right now, he can’t take, so not only is he withdrawing from his opiates, he is withdrawing from benzos and his anti-psychotics. How stable is he going to be when he’s clean from his opiates and completely psychotic...?

If a client comes to our door, if we get them first, we get them forever. We’re their worker. . .

Knowledge, Skills, and Competencies

Like mental health workers, addictions workers identified a need for information on the nature and effects of psychotropic drugs and their interactions with substances as a key area for increased training.

*The best training is, “what are the medications? What are the options?”
The big thing is the side-effects and how do other drugs interact.*

...withdrawal symptoms, because sometimes people come over for that.

I prefer more of a quick reference than a whole module. At least, it’s something I can go back to, versus sitting and having to go through things.

Sometimes what we notice with clients who are affiliated with us as well as a mental health program, and they do have mental health issues, and they are also taking medications for those....the program workers will ask us about the interactions. ...and that’s information that we don’t necessarily know as quickly as someone who deals with mental health, but if the client is not affiliated with mental health, then we’re seen as the experts in that area.

I have a client that I have been seeing for a long time, and he is on a methadone program, and he has never told his doctor... But, he is also taking an antipsychotic, a benzodiazepine, and he drinks energy drinks... That’s a lethal combination. He relies on me to be able to give him that information...

Like mental health workers, addictions workers also identified the need for cross-training, through mechanisms such as job coaching or job shadowing and outreach, and information sharing with a wide multi-system audience, including mental health, justice, corrections, and Children's Aid. However, there was recognition that, with increasing accountability demands and the need to see increasing numbers of clients, there was less and less room for these types of exchanges.

I think it's important when we do training, that when we talk about cross training, it's the same players at the same table, at the same time, so that we're all hearing the same information.

It's hard to be an effective case manager if the other parties involved aren't effective case managers.

We are just starting to do some work with the Children's Aid. We identified that we needed training—cross training between their agency and ours.

We are expected to see so many clients, in so many hours, in so many weeks, and we have to account for that. So, if we are taking out of our day to try and make these connections with mental health or the Children's Aid, or whatever, there's no room built in for that.

I think that collaboration piece is really key, and I don't think we have it. We all seem to be—our territory is guarded—and we do need to have more open communication between all players; not just mental health, because we share the same clients.

Summary of Findings

Mental health workers described clients with concurrent disorders as difficult to engage, slow in developing trust, and, at times, emotionally draining. Lacking basic knowledge about street substances, psychotropic medications, and how these might interact, workers felt that they were unable to effectively counsel or advocate for clients, and were less effective in motivating them to adopt harm reduction techniques.

When viewed as a strategy to empower clients and provide integrated care across the full continuum of substance use problems (not just addictions), harm reduction was not

completely implemented or understood by mental health workers. Although heavily supported in perceived principal, it was used more sporadically; usually later in the therapeutic encounter when substance issues were fully disclosed and then only to justify non-abstinence. Perceived barriers to providing integrated treatment included:

- The tendency of some clients to minimize or actively hide their substance use problems;
- Perceived increasing pressures to push clients through the system quickly, without allowing time to build trust and allow for full disclosure of substance use problems;
- Worker's lack of knowledge, skills, competencies or confidence in applying harm reduction techniques, and sometimes a general discomfort in identifying with clients with substance use concerns;
- Lack of understanding of drug lingo and the effects of street drugs, psychotropic medications, and their interaction effects; and
- Misunderstanding of harm reduction approaches.

In light of these difficulties, mental health workers expressed a strong appetite for additional training and opportunities for professional self-development to address fundamental gaps in knowledge and build skills and competencies needed to effectively manage issues pertaining to substance use and abuse among their clients with mental disorders. They also saw a need for multi-agency and multi-system training opportunities.

Addictions workers did not identify personal discomfort in dealing with the mental health needs of their clients or harm reduction approaches, but expressed considerable frustration concerning system-level barriers that made it difficult or impossible to integrate care across health, mental health, addictions, social services, and legal agencies. They experienced difficulties obtaining timely psychiatric assessments for their clients because of poor access to family doctors (and the inability to obtain a formal psychiatric diagnosis), the expectation of some mental health programs that substance abuse issues be under control first, or because some substance abuse treatment facilities object to having clients on psychotropic medications. Addictions

workers also considered that their knowledge of psychotropic medications and their interactions with specific substances was insufficient. They identified the need for improved knowledge exchange across programs and systems, particularly having quick access to information on psychotropic medications and substance interactions.

Interpretation

These findings suggest that workers do not have sufficient knowledge, essential skills, or capacities to implement integrated care for patients with concurrent disorders according to the model outlined in the Policy Framework.²

With respect to mental health:

- Workers need to determine diagnostic primacy of the mental illness or the substance abuse problem in the therapeutic process runs contrary to the Policy Framework which indicates that “each disorder should be considered primary”.^(p. 13) Workers tend to provide interventions sequentially (rather than concurrently) and do not appear to fully understand the parameters or broader sense of integrated care.
- Workers do not address the full continuum of substance use problems proactively, often delaying the identification and treatment of what they perceive to be less serious substance use problems in order to solidify a therapeutic relationship and build trust.
- Workers did not fully understand the purpose or scope of harm reduction. It was often viewed as an alternative to abstinence, or as an expedient method of dealing with clients who were not considered able to become abstinent, rather than an approach to care that maximizes healthy development and recovery.
- Workers were unable to adequately engage clients in therapeutic conversations about substance use. They perceived a range of barriers from clients’ fear of stigma and reluctance to disclose, to their own lack of technical knowledge about substances and their effects, and in some cases, inability to relate to clients with substance use problems.

With respect to addictions:

- Workers do not have sufficient knowledge of psychotropic medications or their interactions with substances.
- Workers are unable to adequately engage clients in therapeutic conversations about their use of psychotropic medications in combination with other substances or assess the risks associated with interactions. Potential risks are compounded by client's lack of access to general practitioners or psychiatrists.

Implications for Training

Based on this focus group analysis, and the essential skills outlined in the Concurrent Disorders Capacity Project Report,⁴ the following training is recommended to enhance care for clients with concurrent substance and mental health disorders in Southeastern Ontario:

- Access to a resource manual concerning the role and mandate of various community agencies and partners across systems who deal with clients with concurrent disorders;
- Information on the various street terms used to identify substances and their amounts;
- Information on the effects of substances, psychotropic medications, and their interactions;
- Training on the use and proper application of substance use screening tools;
- Opportunities for self-development pertaining to basic knowledge, skills, and competencies in the identification and management of substance use, addictions, and concurrent disorders;

⁴ CD Capacity Project, Champlain and South East Partners (2008) Concurrent Disorders in South Eastern Ontario and Champlain: A Proposed Process to Measure CD Capacity among Addictions and Mental Health Partners.

- Increased knowledge about the scope and application of harm reduction approaches;
- Information about the scope of integration strategies and concept of “one team with one plan for one person” contained in the Policy Framework;²
- Examination of beliefs, attitudes and personal values related to substance use and mental health disorders to reduce stigmatization by sector workers;
- Opportunities to connect with community partners in the context of structured training workshops;
- Training opportunities that are locally provided, flexible to access, inexpensive, and where attendance is supported by program managers.

Recommendations

In light of the foregoing analysis and discussion, we recommend that organizations that provide mental health services and/or addictions services in Southeastern Ontario:

- Designate minimum annual requirements for front line worker training to demonstrate support for on-going skill enhancement;
- Mandate the use of screening tools to identify clients who may benefit from concurrent disorder services;
- Implement standard protocols to systematically manage positive indicators on screening tools for mental health concerns and/or problematic substance use, and effectively address clients’ preferences and readiness to explore issues related to substance use or mental health concerns in both screening and treatment processes;
- Negotiate service integration agreements between local mental health and addiction services that confirm the obligation to offer clients coordinated and integrated services and that outline referral, consultation, and collaboration protocols to provide concurrent care;
- Develop a human resource plan—both at the agency level and the regional level—to identify resources needed to bring the system up to

capacity to appropriately manage clients with concurrent disorders according to the Policy Framework.

- Implement compulsory instruction/training for all employees related to attitudes, core values, beliefs and ethics to ensure client access to and consistent provision of recovery-based services.