Co-occurring Disorder Educational Curriculum (CODEC)
Clinical Explorations - Day 1

Shared health Soins communs Manitoba

Introduction

WELCOME

HIGHLIGHT OF PRE-READ CONTENT

GOALS FOR THE SESSION

Land Acknowledgment

- Health services across Manitoba are provided in facilities located on the original lands of First Nations, Inuit, and on the national homeland of the Red River Métis Nation.

  Manitoba's health authorities respect that First Nations treaties were made on these territories, acknowledge harms and mistakes, and we dedicate ourselves to collaborate in partnership with First Nations, Inuit, and Métis peoples in the spirit of reconciliation.

  We acknowledge discrimination and racism still exist (and caused harm) across Manitoba's healthcare system today, affecting Indigenous, Black and racialized Individuals and communities and we resolve to take real and impactful steps to disrupt and dismantle racism and discrimination in all forms across Manitoba's health system.

Housekeeping (Virtual)

1. Additional resources and recommend training can be found on the CODEC Webpage: Mental Health - Health Providers - Shared Health
2. Please remain muted while watching the presentation. You can unmute during activities and Q&A's.
3. Keep your video camera on to stay more virtually present and to allow for connection.
4. Use the chat box for comments and questions:
    a. Comments may not immediately be responded to or may be missed (we are all humans here).
    b. We'll try to answer as many question as we can, some may be saved to the end, but there may be time limitations.
5. Technological issues may arise:
    a. If your connection is poor try leaving and returning. If it is still not working try turning off your video.
    b. Contact the facilitator who is not currently presenting if necessary through the question box.

Housekeeping (Virtual)

Today's Facilitators are:

- Name
- Name

Getting the most out of today

KEEP DISTRACTIONS TO A MINIMUM

BE INTERACTIVE – USE THE CHAT BOX

TAKE NOTES

TAKE A BREAK DURING BREAKS

BE OPEN MINDED

Activity: Getting to know the group…

Please share with the group:

1. Where you work and your current role.
2. What are you hoping to get out of today's training?

Welcoming and Addressing Barriers to Care

Objectives

Awareness of barriers to care

Addressing barriers to care

Barriers for specific groups

Co-Occurring Disorder Principles

Co-occurring Disorders are an expectation - not an exception!

The core of success in any setting is the availability of **empathic, hopeful**, integrated and continuous relationships.

What helped you feel welcomed into services?

"[the] doctor was my first point of contact and introduced me to the CODI program. When I met him, I had little faith in any sort of recovery program, let alone psychiatrists. **He spoke to me like I was an actual person** not just a bipolar, addict or diagnosis"

Was there anything else that made you feel comfortable?

"Everyone knew/knows my name, always ask how I'm doing, even if they are busy, I always feel **safe, welcome**, **not judged**. Feels like a safe place, door open or closed."

MJW, CODI Outreach participant

Barriers to Care

1. Individualized Characteristic Barriers:
   a. Personal Attributes including symptom experiences, cognitive, social, and functional impairments.
   b. Personal Beliefs including individual, cultural and stigma related.

2. Structural Barriers:
   a. Service availability and access.
   b. Under identification of co-occurring needs.
   c. Provider training and competencies.
   d. Organizational/systemic.
   e. Service provision (how and what services are offered).
   f. Cultural and racial disparities.

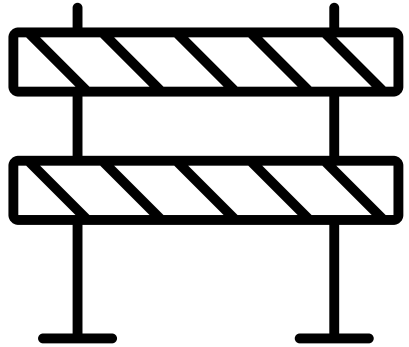
(Priester et. Al 2015)

What barriers to care have you experienced while seeking support and/or services to assist you in your recovery journey?

- “It's hard to be taken seriously especially when you are claiming to be bipolar and a crackhead. I’ve been dropped at the ER sleep deprived, high, off of my meds and barely in control of my own body, only to be dismissed.”

- “It was incredibly difficult to find a program like CODI [. . .] my team remained patient, hopeful and understanding.”

MJW, CODI Outreach participant



Overview of Reducing Barriers to Care

1. Use of Recovery Oriented principles and practices.
2. Providing individualized, illness/stage matched, and developmentally. appropriate interventions
3. Improving Primary Care and Mental Health Spectrum service integration.
4. Collaboration and communication between services and with the individual.
5. Incorporation of technology.
6. Addressing stigma.
7. Workforce development.
8. Addressing operational and structural barriers.

(Pyle 2020 and Marel et al., 2016)

Reducing Barriers through Service Coordination

1. Barriers lead to lower usage rates, particularly for certain population groups such as men, those of certain ethnocultural backgrounds and older Canadians.
2. Unmet needs in those with co-occurring disorders remain high and service coordination across partners can help address gaps.
3. Models include:
    a. Consultation
    b. Collaboration
    c. Integrated Services

(Manitoba Health-CODI Training, 2005)

Barriers to Healthcare access for Indigenous Canadians can be Aligned into Three Categories:

Proximal

Intermediate

Distal

(Nguyen et al, 2020)

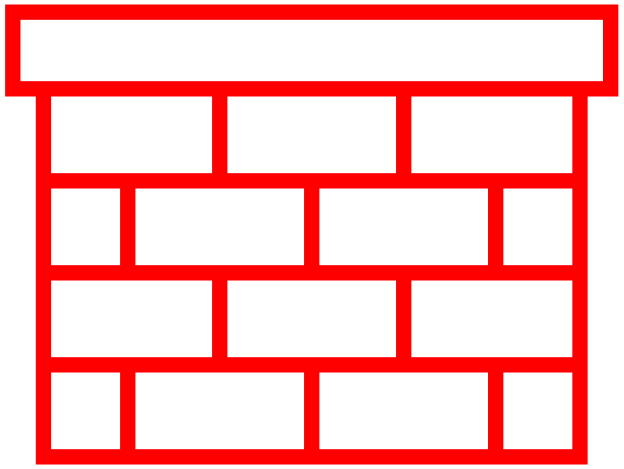
Proximal Barriers

“Proximal barriers include geography, education attainment, and negative bias among healthcare professionals resulting in a lack of or inadequate immediate care in Indigenous communities” (Nguyen et al, 2020).

Photo from https://www.vecteezy.com/photo/7664831-black-and-white-fence-beside-the-rural-road

Intermediate Barriers

“Intermediate barriers comprise of employment and income inequities and health education systems that are not accessible to Indigenous people” (Nguyen et al, 2020).



Distal Barriers

- “Distal barriers include colonialism, racism and social exclusion, resulting in limited involvement of Indigenous people in policy making and planning to address community healthcare needs” (Nguyen et al, 2020).

- “Distal barriers have the most profound influence on the healthcare access of Indigenous populations because these create intermediate and proximal barriers. Distal barriers can be the most difficult to change, yet, if transformed can significantly reduce health inequities and have the greatest health impacts” (Nguyen et al, 2020).

- Please visit LMS for Additional Recommended Training Section to find links to workshops/training on Cultural Safety and Cultural Awareness.

Barriers to Care for People New to Canada

People new to Canada have lower rates of receiving and using care services across the mental health spectrum.

Newcomers, including first- and second-generation individuals, often face barriers to accessing and engaging in care for co-occurring disorders which include:

1. Lack of access to basic needs and limited social supports.
2. Limited English/French language and literacy skills.
3. Lack of familiarity with the Canadian health care system and difficulties navigating services.
4. Precarious finances and health care eligibility issues.
5. Factors related to gender, culture, and stigma.
6. Lack of cultural understanding and competency of service providers.

(Caulford and Mayhew, 2014; Urbanoski et al 2017; Abdulrehman et al 2016)

Barriers to Care for People New to Canada: What Can be Done?

- Go slow, work to build the relationship and allow time for the person to share their background and the changes in their lives they have experienced since coming to Canada.
- Assist people to navigate insurance/health services or connect them to an agency that can.
- Provide assistance to meet basic and practical needs by helping newcomer families connect with social services that support care (e.g., housing, transportation, interpreter services, financial aid, settlement agencies).
- Develop a better understanding of newcomers' mental health concerns within their social context, particularly culture of origin and the challenges of migration (cultural competency).
- Acknowledge the importance of cultural and spiritual beliefs and practices.
- Support engagment with their community and with other social groups and activities.
- Use formal interpreter services and provide written materials in multiple languages.
- Integrate services with primary care providers and understand the links between physical health and physical symptoms as expression of mental health difficulties.

Activity: Substance Use and Needs of the 2SLBGTQ+ Community

https://www.youtube.com/watch?v=PJspLQpsRUI

Clinical Knowledge

Objectives

Explore Models of Etiology - BPSS

Discuss Co-occurring Disorders, Social Determinants of Health and ACEs

Examine the Neurobiology of Mental Health Spectrum Needs

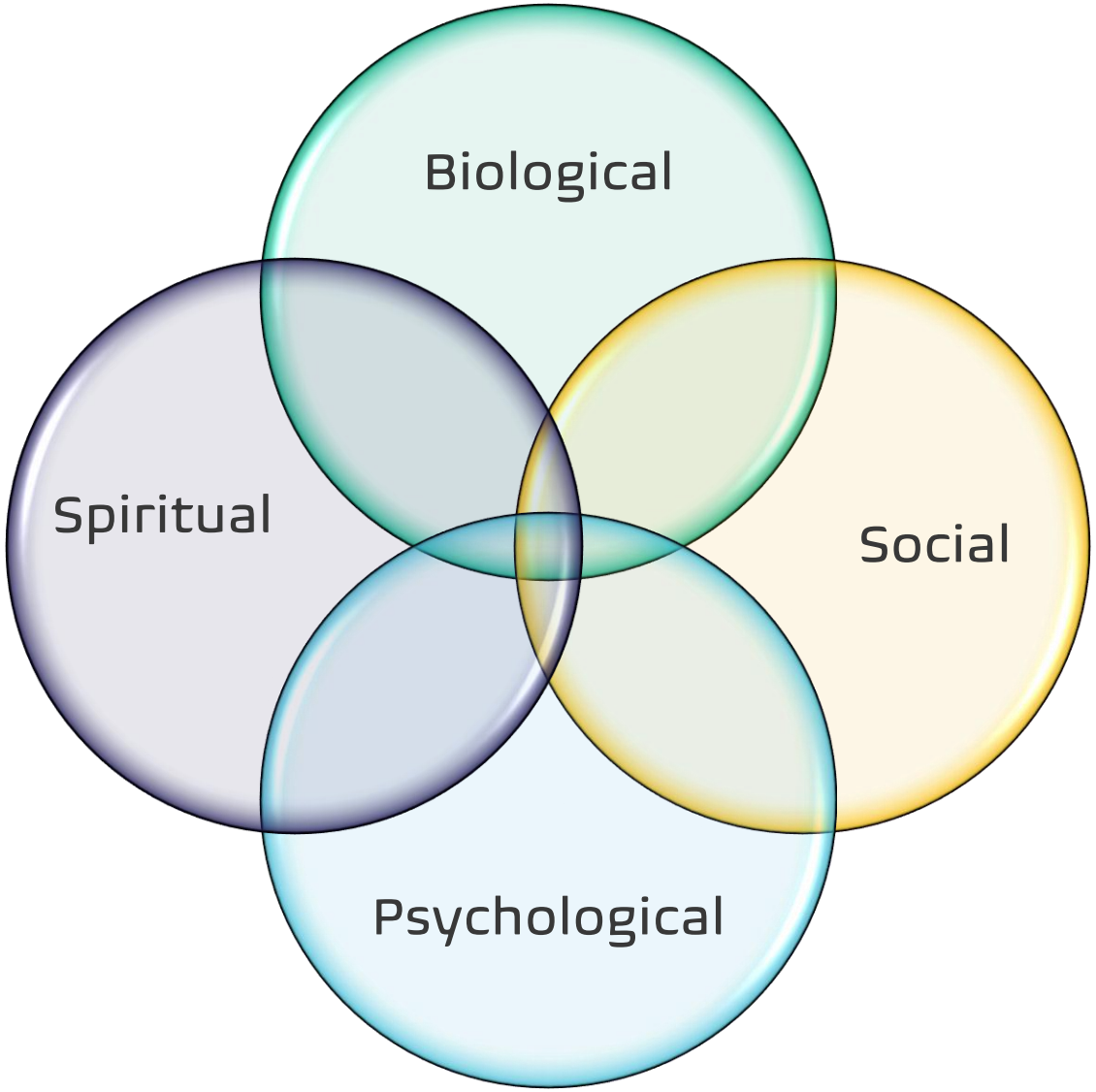
Types of Co-occurring Relationships

What is Recovery?

- Themes of Recovery:
  - Hope
  - Empowerment
  - Improved wellness and health
  - Strength-based
- There are many pathways in recovery and it is a personal journey towards well-being.
- Recovery is multi-dimensional and extends beyond the individual, it requires collaboration and involves everyone.

Biopsychosocialspiritual Model

- An individual's development of co-occurring disorders can result from different combinations of biological, psychological, social and spiritual factors that increase or decrease risks and protections.
- Difficulties arise from the interplay of these multiple influences.
- There are no singular factors that "guarantee" a person will develop a co-occurring disorder. (e.g "alcoholic gene")



Etiology of Co-Occurring Disorders

- The Diathesis-Stress Model:
  - Disorders develop through an interaction between individual predispositions and the degree of stressors experienced.
    - Simplified example: Having certain genes and a higher cognitive sensitivity to threat threshold, plus a very stressful and demanding school year can lead to symptoms of generalized anxiety
  - Diathesis are aspects of an individual that increases their risk or vulnerability
  - Helps explain why two people with similar experiences (e.g being in a fire) can have different outcomes (one develops PTSD and the other doesn't)

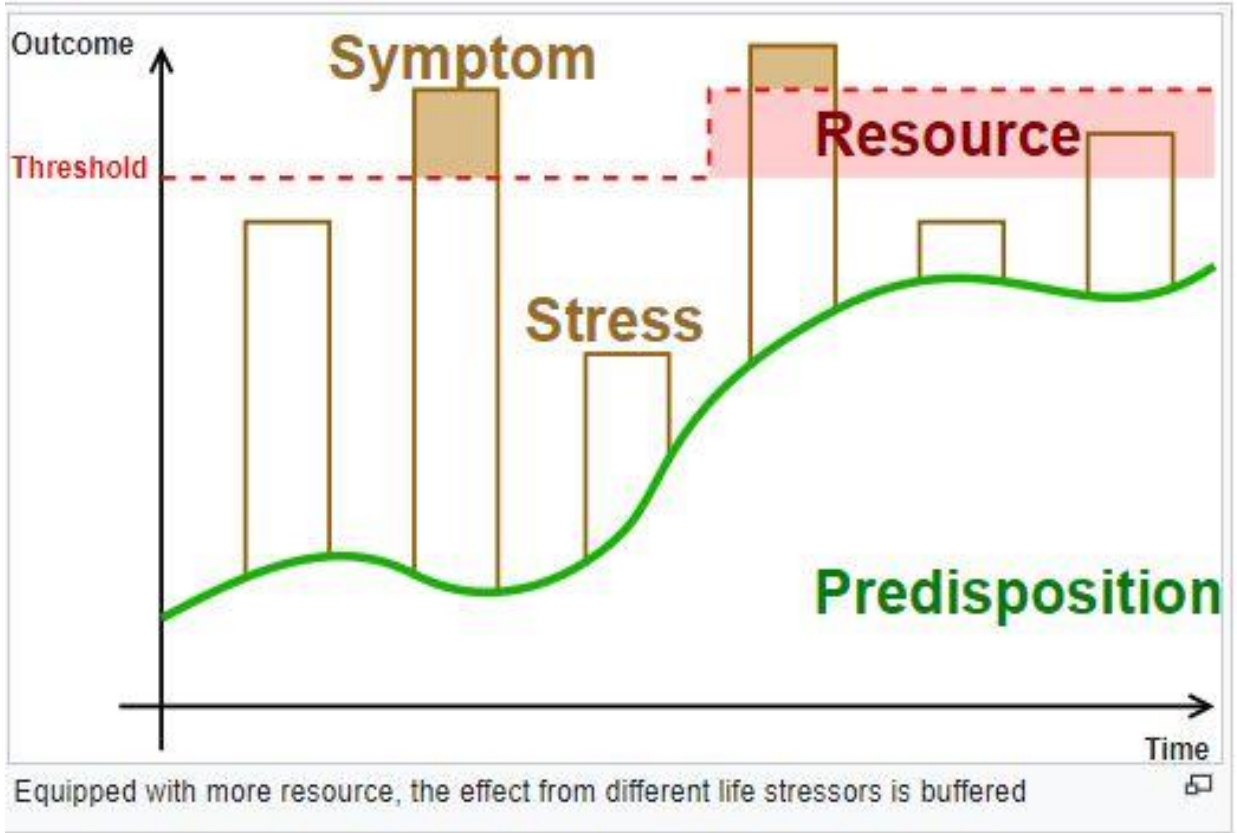
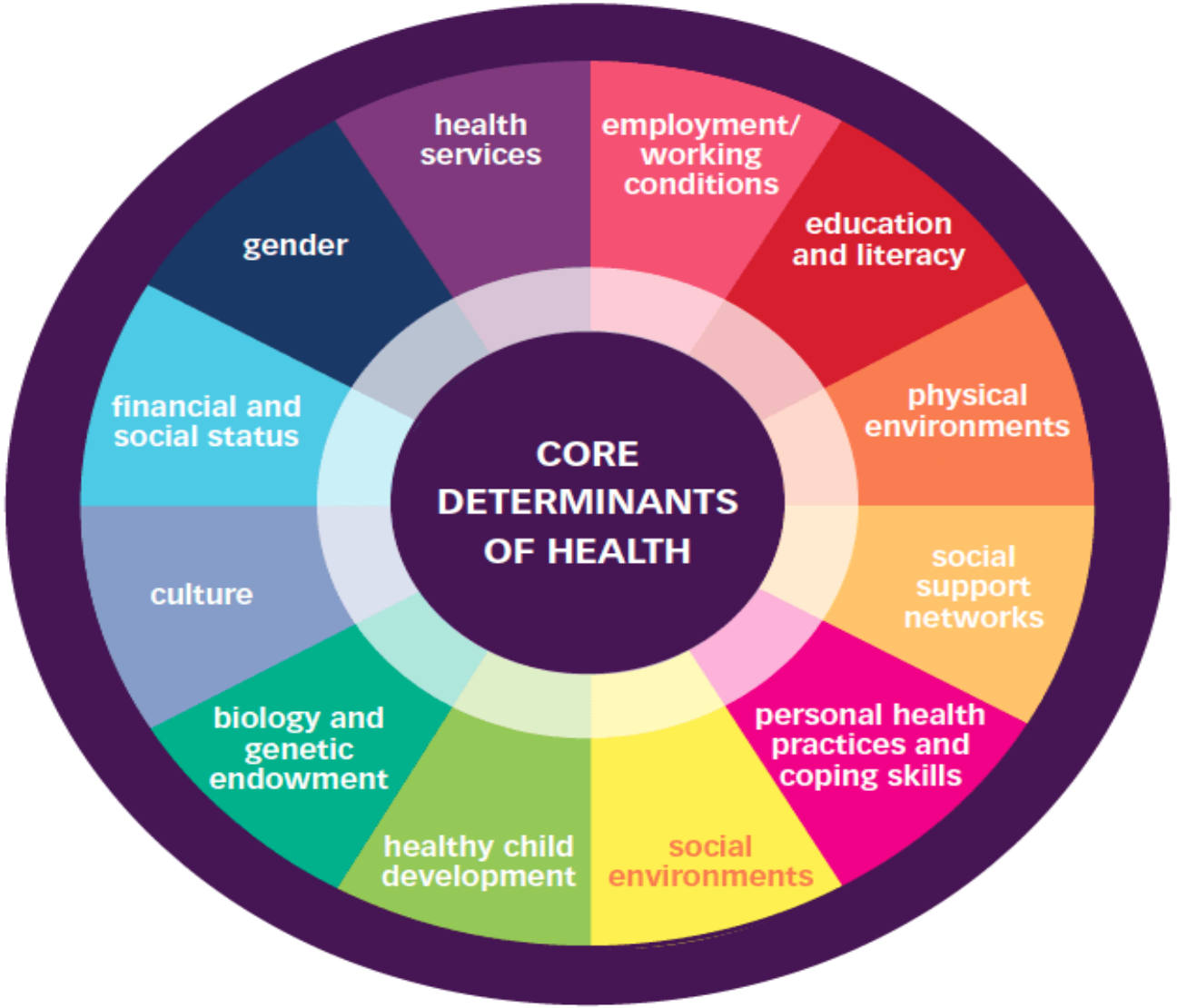


Image Blacktc 2019

(Lumen, n.d.; Windle, 2010.; Zuckerman, M. 1999.)

Social Determinants of Health



(World Health Organization, 2021 and Centre for Family Research and Evaluation, 2021)

Social Determinants of Health: Through the Lens of Trauma

Trauma is the lasting emotional response that often results from living through a distressing event. Experiencing a traumatic event can harm a person's sense of safety, sense of self, and ability to regulate emotions and navigate relationships.

Determinants that can increase risk for experiencing trauma include:

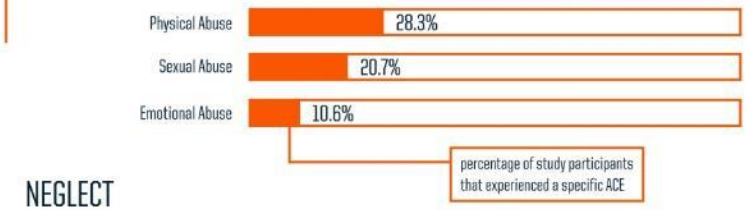
- Poverty
- Neighborhood Crime and Violence
- Racism

(Galindo, 2021)

HOW PREVALENT ARE ACEs?

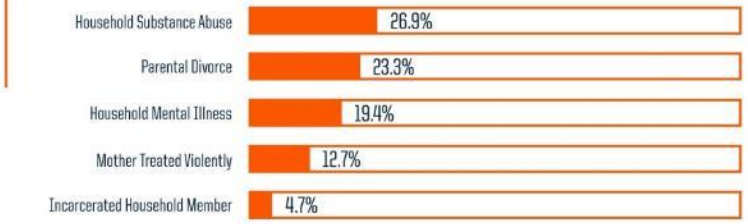
The ACE study revealed the following estimates:*

ABUSE

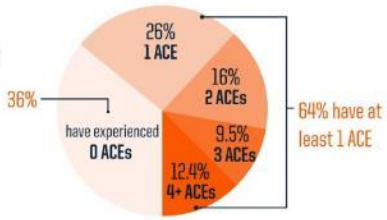


NEGLECT

HOUSEHOLD DYSFUNCTION

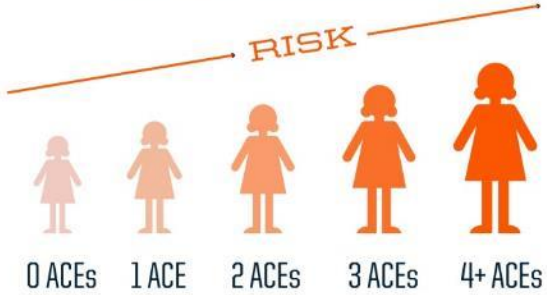


Of 17,000 ACE study participants:

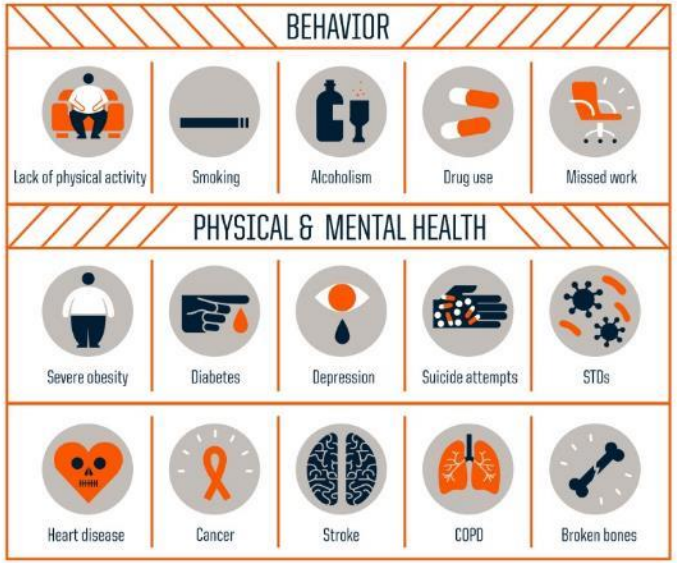


WHAT IMPACT DO ACEs HAVE?

As the number of ACEs increases, so does the risk for negative health outcomes



Possible Risk Outcomes:



rwjf.org/aces

Robert Wood Johnson Foundation

Co-Occurring Disorders and ACEs

- Strong correlations were shown to exist between various ACEs and later symptoms or diagnoses of depressive and anxiety disorders in persons misusing drugs or alcohol.

- Child abuse and family violence show to have a major impact on the future mental health of individuals. For example:
  - Emotional, sexual and physical child abuse has been found to be an important risk factor for the development of depression.
  - Sexual child abuse and family violence were strongly related to the development of anxiety
  - Strong correlations were also found between family violence or physical neglect and substance use.

- Training: Brain Story Certification https://www.albertafamilywellness.org/training

(De Venter et al., 2013)

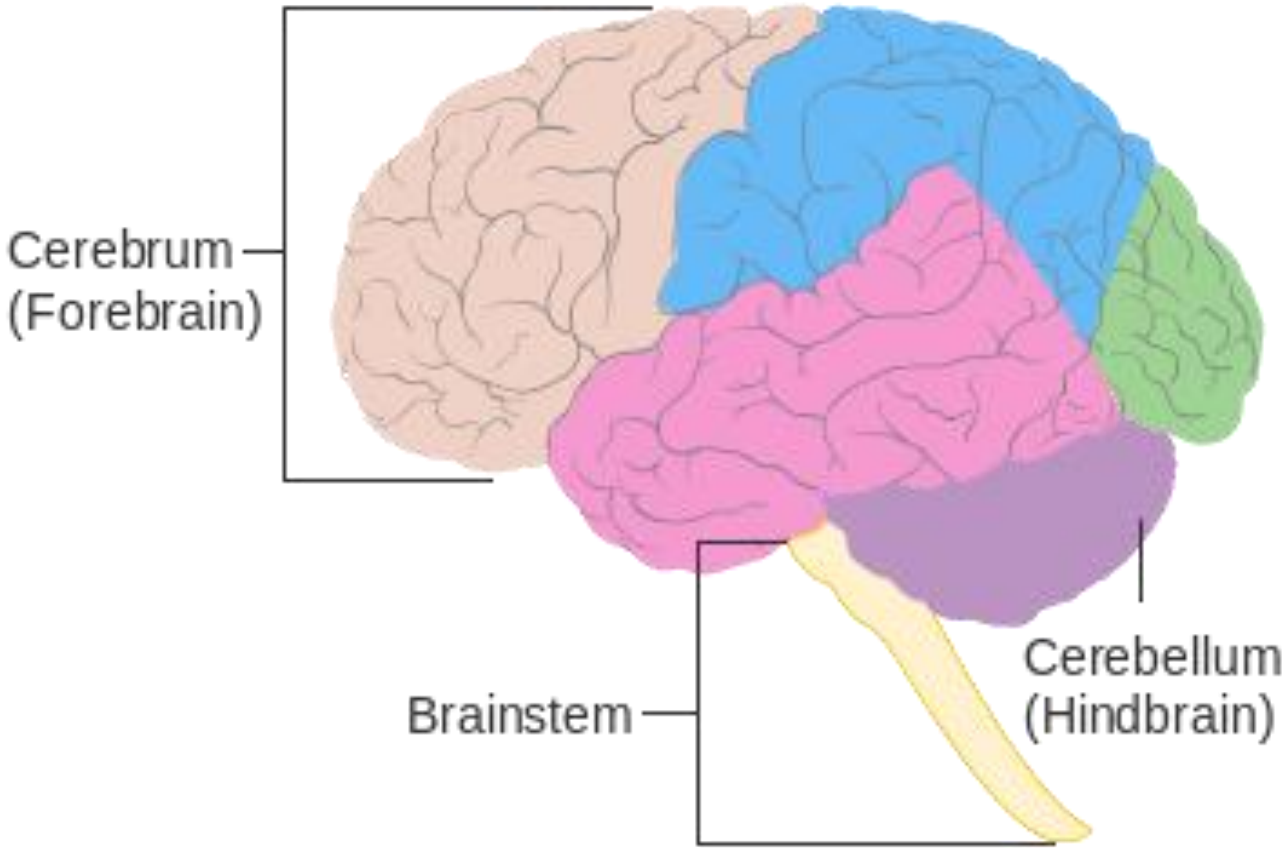
Working with individuals who have had ACEs and Co-occurring Disorders

1. Advocate for policies and programs that strengthen economic supports to families and individuals.
2. Connect youth to caring adults and activities, such as mentoring programs or after-school programs.
3. Practice cultural competency and cultural humility within and outside your organization.
4. Encourage continuous learning around working with marginalized communities and reducing implicit bias.
5. Create partnerships with health providers in your community to bring awareness to trauma and social determinants of health
6. Emphasize the resilience of those in your care who have experienced trauma and those with a large number of barrier-causing social determinants to contend with.
7. Maintain a strengths-based perspective and focus interventions focused on building protective factors for the individual.

Break

Neuroscience and Co-Occurring Disorders

The Brain



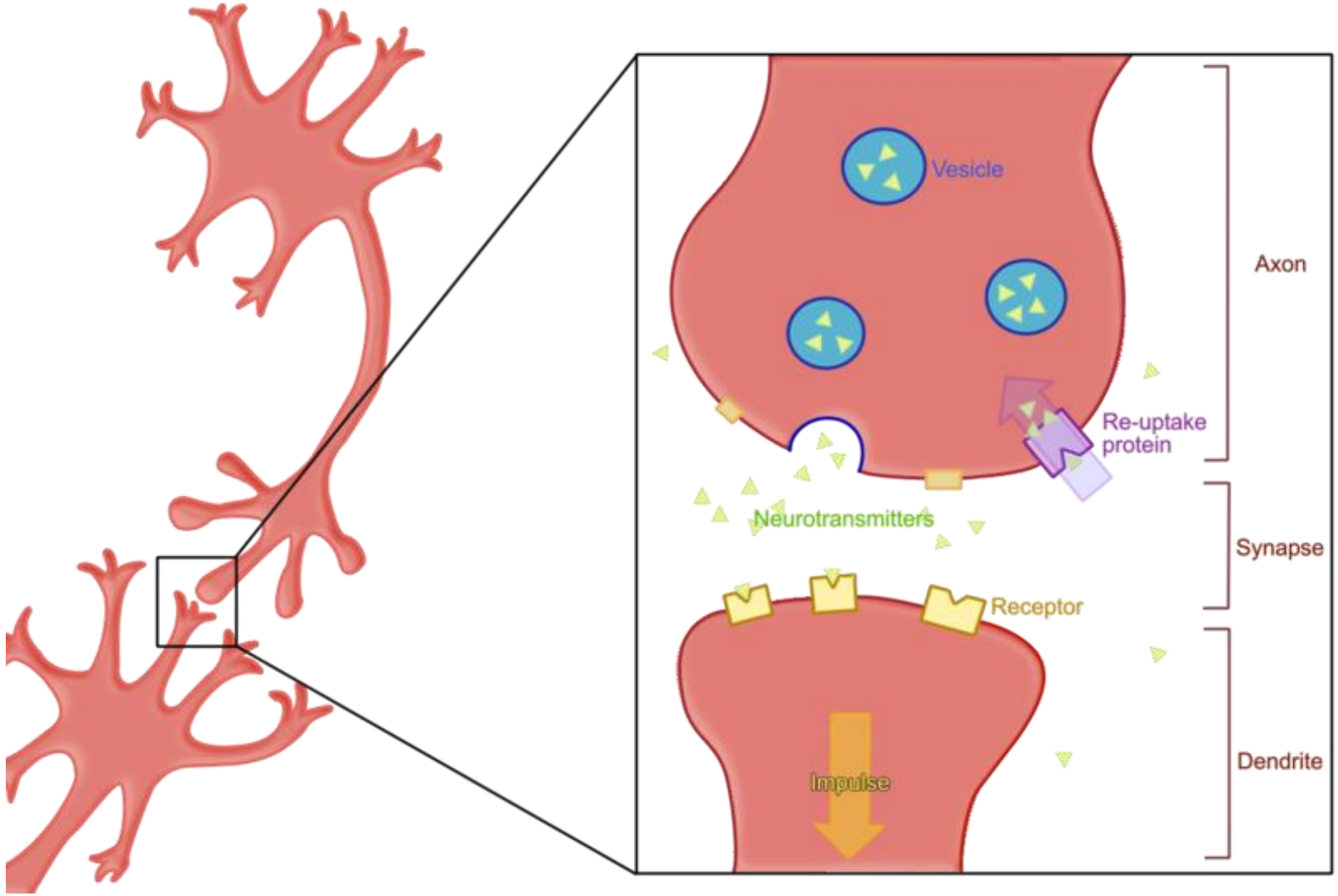
(Cherry, 2019; John Hopkins Medicine, 2023)

Neurobiology – Brain Region Examples

Brain Region	Function	Related Mental Health Concerns
Hippocampus	Memory, mediates learning	Mood Disorders, PTSD, Dementia, Borderline PD
Thalamus	Sensory processing, cognitive processing	Autism Spectrum Disorder, Mood Disorders, Schizophrenia,
Hypothalamus (*hypothalamo-pituitary-adrenal [HPA] axis*)	Stress response, autonomic function	Mood Disorders, Schizophrenia, PTSD, Eating Disorders
Prefrontal Cortex	High-level cognition and working memory, executive functions such as problem solving, self-regulation and attention	ADHD, Schizophrenia, Mood Disorders, Addictions, PTSD, Borderline and Antisocial PD
Amygdala	Emotions, emotional memory, stress/fear response	Anxiety Disorders, PTSD, OCD, Addiction, Borderline and Antisocial PD
Basal ganglia	Movement, attention and memory, reward processes	Tourette's, OCD, Addiction

(Select references - Brady et al, 2005; Bremner, J.D. 2006; Ehlert et al 2001; Guy-Evans 2021 and 2022; McCloseky et al 2005- see reference list)

Neurotransmitters



Basso & Suzuki, 2017; Cleveland Clinic, 2022; Deslandes et al., 2009

Neurotransmitters

Neurotransmitter	Function	Effects/Role	Fun Fact
Acetylcholine	Excitatory	memory, learning, and cognitive performance, psychotic illnesses, dementias	This was the first identified neurotransmitter
Dopamine	Modulator	Motivation/reward, learning, social behaviours, emotion regulation, attention and movement. Influence on psychosis, addiction, ADHD/impulse, PTSD, mood disorders	Also implicated in other neurological disorders including Parkinson's and Huntington's
Endocannabinoids	Modulator	Regulation/homeostasis of other systems for cognition, motor control, pain, emotion and memory, impacts with psychosis, substance use	Umbrella of multiple chemicals that are similar to those found in cannabis, but are natural to the body
Epinephrine/ adrenaline	Excitatory	memory, alertness, fight or flight response, relates to anxiety, PTSD, and mood disorders	This is also the main chemical in an "Epipen" used for severe allergic reactions

(Klein, et al., 2018; Lajtha, & Vizi, 2008; Pan, et al.,2018; Paul et al., 2020; Strominger, et al., 2012; Zanettini, 2011.)

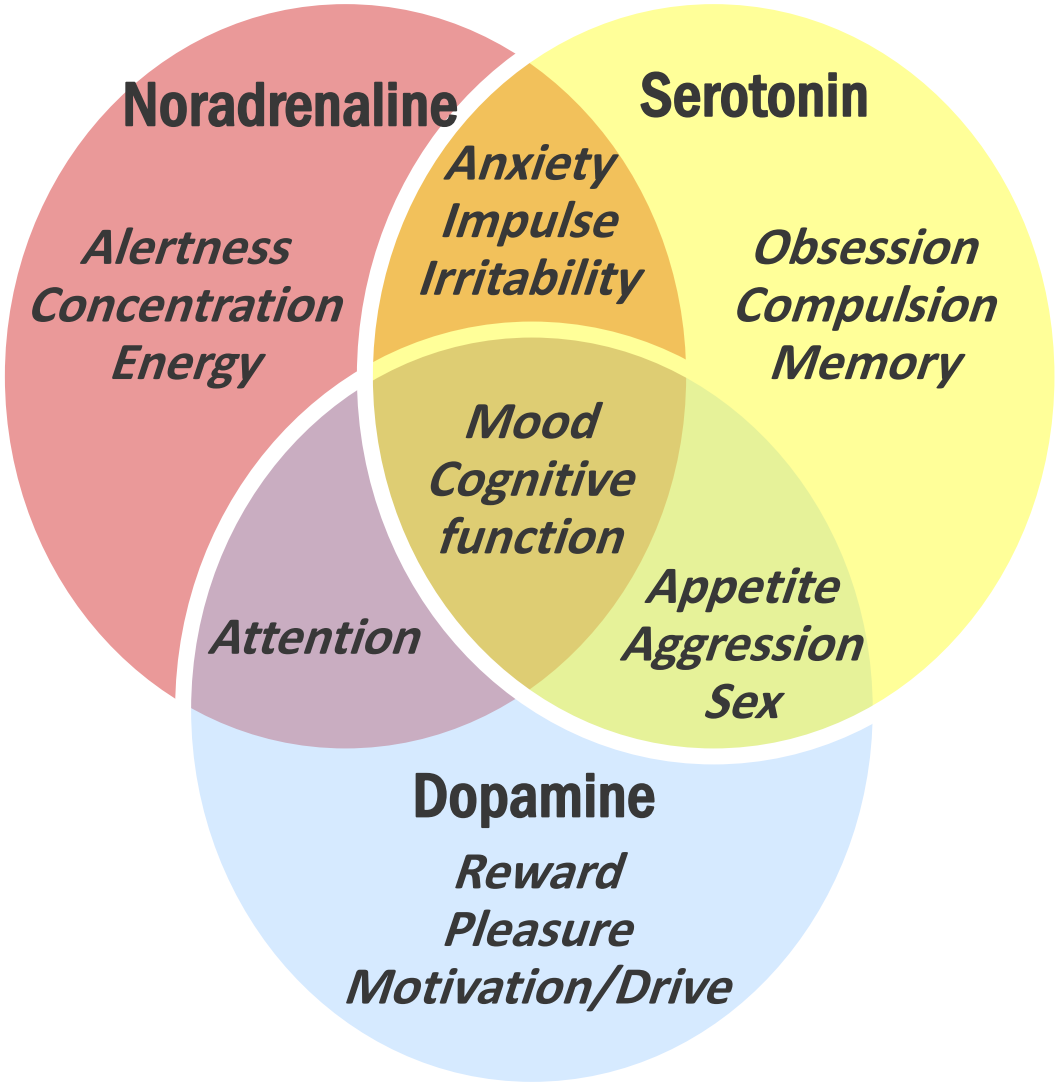
Neurotransmitters

Neurotransmitter	Function	Effects/Role	Fun Fact
Gamma-aminobutryic acid (GABA)	Inhibitory	Stress and emotion regulation, movement, psychotic illnesses, anxiety disorders and autism spectrum disorder	Can mediate the effects of benzodiazepines and barbiturates
Glutamate	Excitatory	thinking, learning and memory. Increased levels associated with depression, bipolar and psychotic illness	Most common excitatory transmitter and is synthesized from glucose we eat
Norepinephrine/ noradrenaline	Excitatory	circadian rhythms, focus/fatigue, apathy/dysphoria, stress reactivity and cognitive dysfunction, relates to PTSD, mood disorders	Is synthesized from dopamine with the help of another enzyme
Serotonin	Mainly excitatory/ modulator	arousal, mood regulation, aggression, sensory processing, memory. Has been associated with mood and anxiety disorders	Synthesized from the essential amino acid tryptophan (yes, the stuff in turkey and many other foods)

K(lein, et al., 2018; Lajtha, & Vizi, 2008; Pan, et al.,2018; Paul et al., 2020; Strominger, et al., 2012; Zanettini, 2011).

When considering the areas of the brain/neurotransmitter systems that impact mental health & addiction issues, it is important to remember:

- They are *interrelated*
- They are *interdependent*
- They are *interactive*



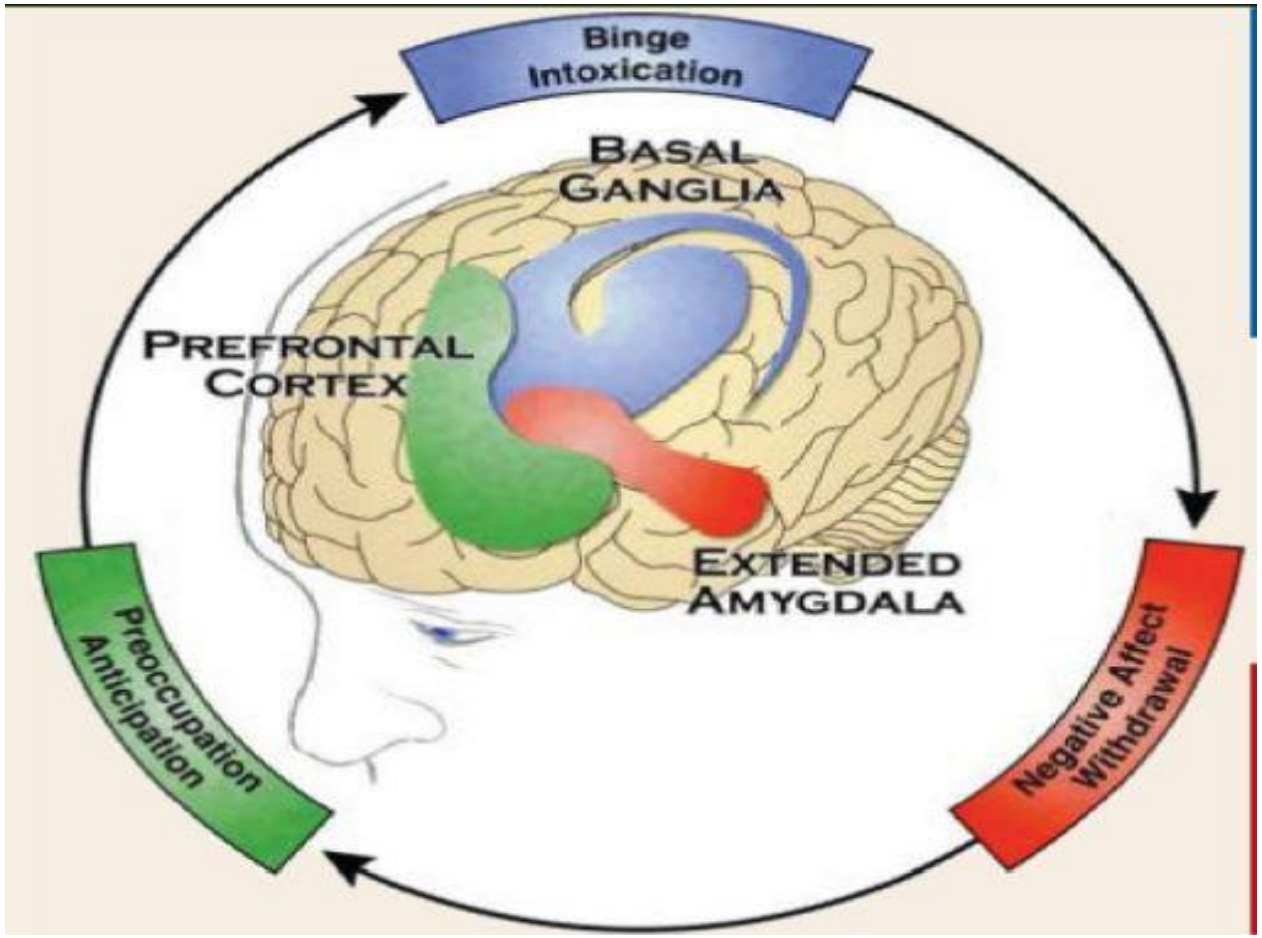
(University of Pennsylvania, 2003)

Activity: Pathways and Neurotransmitters – the Reward System

https://youtu.be/f7E0mTJQ2KM

(Rao, 2020)

A Cycle of Addiction



(Mckenna 2020; Volkow & Boyle 2018; Volkow, Kook & McLellan 2016)

Activity: Cognition and Co-occurring Disorders

Impact of co-occurring disorders on cognition

- What do you see in your work?
- Most mental illnesses lead to some degree of cognitive difficulties
- Different people will experience lesser or greater degrees of impairment
- Substances intoxication and withdrawal are associated with cognitive difficulties
- Long term substance use can lead to cognitive difficulties
- Being aware and attentive to these difficulties, which are often subtle, is important to guide interactions and treatment

(Manning et al, 2009; Medalia and Revheim, 2023; Morozova et al, 2022)

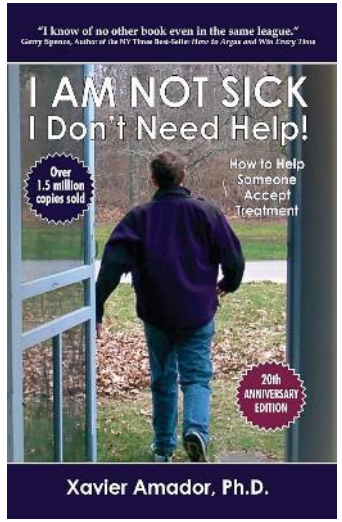
Special Topic – Neurological Disorders and Mental Health

- Wernicke's Encephalopathy and Korsakoff Syndrome are interrelated degenerative brain disorders caused by a lack of thiamine-Vitamin B1
- Early phase Wernicke's causes mental confusion, paralysis of eye muscles and lack of muscle coordination. Quick treatment can reverse symptoms.
- Later phase Korsakoff's leads to losses in memory and cognition which can impair functioning. Generally more permanent damage. "Confabulation" is commonly seen where the person fills in memory gaps with made up stories.
- Acute treatment involves replacement of thiamine (vitamin B1), followed by nutrition and support.
- Increasing thiamine levels by stopping alcohol use and improving nutrition may prevent further nerve and brain damage.

(Cassiano et al 2022; Covell and Siddiqui, 2020; NINDS, 2019; Vasan and Kumar, 2018)

Anosognosia and Insight

- **Anosognosia** refers to a neurological phenomenon in the brain which leads a person to be unaware of the impact of a neurologic deficit (such as impairment after stroke) or a mental health condition. It can affect a person's awareness of their deficits including impairments in judgement, emotion, memory and other functions.
- Anosognosia is common in various mental health disorders such as schizophrenia, bipolar disorder, and certain types of dementia.
- **Insight** in the context of CODs pertains to an individual's level of awareness and understanding and acceptance of their condition and the impact it is having on their daily life.
- Adequate insight is associated with better outcomes, impaired insight can relate to poor decision making and difficulty accepting help.
- Anosognosia is a type of impaired insight, which can be more enduring.
- Consider the use of the LEAP model by Dr. Amador https://leapinstitute.org/



(Acharya and Sanchez-Manso, 2020; Amador, 2020; Lehrer and Lorenz. 2014; Little and Bell, 2020)

Neuroplasticity

- Neuroplasticity is the brain's capacity to change and adapt in response to experiences, behaviors, and environmental factors.
- Throughout life, neurons form new connections, strengthen existing ones, and reorganize their functions, influenced by our actions and experiences, both positive and negative.
- Co-occurring disorders and related experiences or behaviours can lead to negative neuroplastic changes.
- Neuroplasticity highlights the dynamic balance between the brain's vulnerability to negative influences and its potential for positive change.
- A range of interventions from therapy to exercise and medications can help induce positive changes and support recovery.

(Kays et al 2012; Kourosh-Arami, 2022; Puderbaugh and Emmady, 2022)

Types of Co-occurring Relationships

Four Types of Co-Occurring Relationships

1. Precipitating

One may have a causal relationship with the other.

e.g. THC has been shown to trigger Schizophrenia in adolescents.

(SAMHSA TIP 42, 2020)

Four Types of Co-Occurring Relationships

2. Masking

The presence of one hides the other.

e.g. Alcohol use disorder behaviours may hide underlying social anxiety

(SAMHSA TIP 42, 2020)

Four Types of Co-Occurring Relationships

3. Mimicking

Symptoms of one are mistaken for the other.

e.g. Methamphetamine-induced psychosis is often mistaken for primary psychosis.

(SAMHSA TIP 42, 2020)

Four Types of Co-Occurring Relationships

4. Exacerbating

One worsens the symptoms of the other.

e.g. Cocaine use heightening arousal and anxiety which can amplify obsessive thoughts in OCD

(SAMHSA TIP 42, 2020)

Activity: Meet Judy

Judy is a 63-year-old Indigenous woman who lives alone in an apartment in the North Point Douglas neighborhood of Winnipeg. She is a member of the Long Plain First Nation and grew up in the Long Plain Reserve No. 6. She was made to attend a residential school as a child. As a young adult she got her GED and then went on to get a college certificate as a Health Care Aide. She moved to Winnipeg after graduation.

Judy is divorced and has 2 adult children. She has a history of depression, as well she has had problematic substance use for the past 7 years. Judy's substance of choice is gin, and she drinks approximately 8-10 ounces daily. She began drinking more frequently following separation from her ex-husband 3 years ago. Judy worked as a health care aid in a senior's residence but retired after her divorce. Judy no longer drives and uses a cane to ambulate due to weakness in her right leg from a previous fall down a flight of stairs that occurred in the context of intoxication. Judy has had 2 visits to the Emergency Department in the past year for suicide attempts (overdose), one of which resulted in an admission to hospital. Her primary supports are a neighbor and a sister who lives out of province. She has shared that her daughter also struggles with substance use and she infrequently sees her son, who has "pulled away" from her in recent years to focus on his own family.

Activity: Meet Judy

- Of the 4 types of co-occurring relationships, which ones might be applicable to Judy? Explain your answer.
  - Precipitating
  - Masking
  - Mimicking
  - Exacerbating

- Based on above, what do you need to consider when treatment planning with her? How might you help her to prioritize her goals? What potentially adverse secondary outcomes do you want to be aware of or monitor for as treatment progresses? (e.g. symptom substitution)

Motivation and Change

Objectives

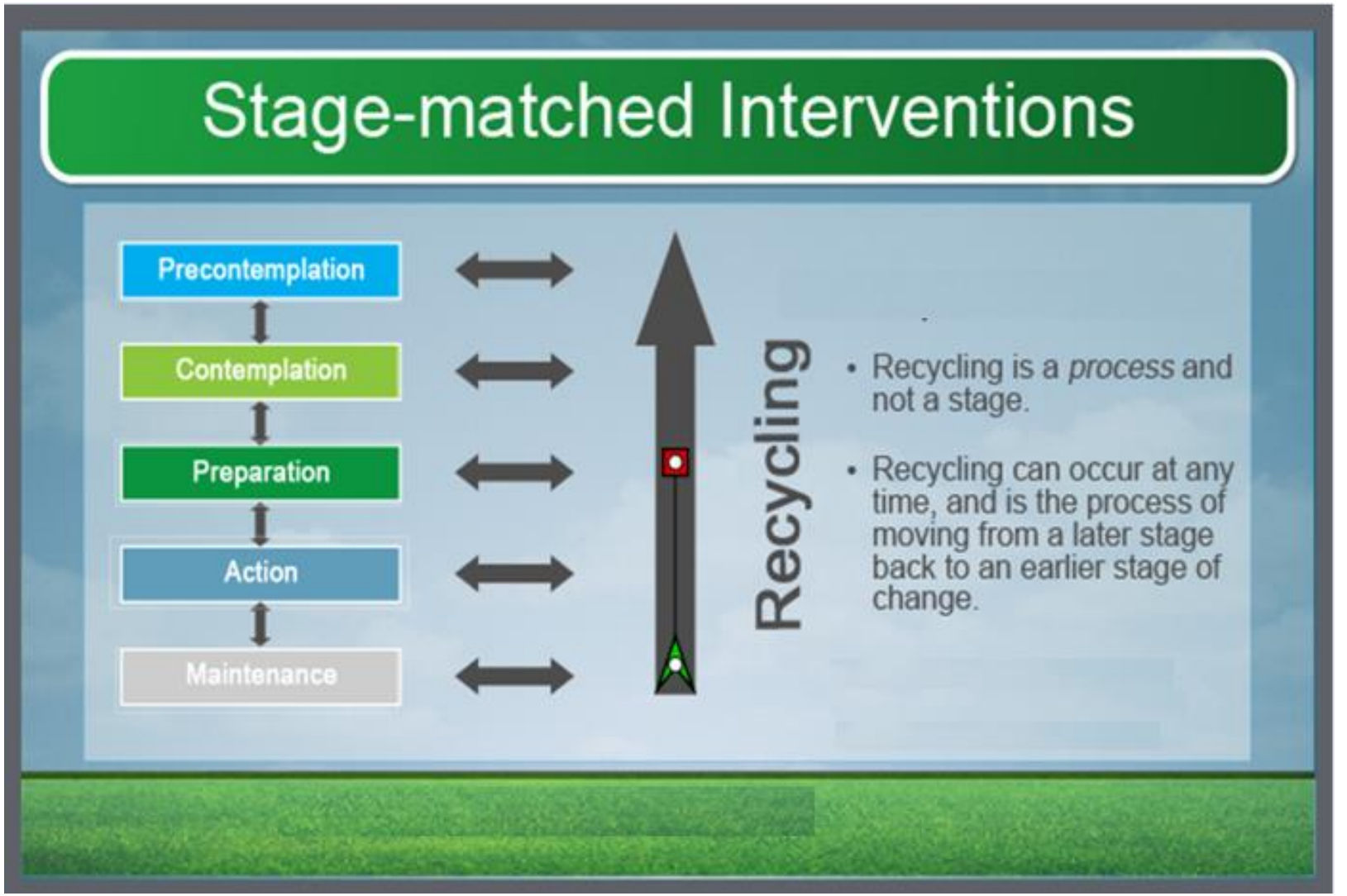
Transtheoretical Model of Change and Stage-Matched Interventions

Motivational Interviewing discussion

Motivational Interviewing with Co-occurring disorders

Case Study Activity

Stages of Change



(WRHA-HBC, 2021)

Stages of Change – Staged Matched Interventions

Pre-Contemplative	Build alliance/relationship building
	Understand perspectives
	"plant seeds" for change
Contemplative	Active listening
	Providing information with permission
	Pros/cons activities
	Elicit change talk
Preparation	Assist in problem solving/support self efficacy
	Encourage small steps
	Identify other supports (including peer and family)
Action	Skill development
	Build structure
	Find ways to reinforce change
Maintenance	Discuss relapse prevention/management
	Maintain supportive contract
	Set new short- and long-term goals

(SAMHSA Tip 35, 2019; WRHA-HBC, 2021)

Motivational Interviewing - Review

- “a collaborative conversational style for strengthening a person’s own motivation for commitment to change” Rosengren, 2018, p. 12.

-a person-centred counselling style that recognizes ambivalence is normal and to be expected in change.

-acknowledges that change is non-linear and readiness for change is not static.

(SAMHSA TIP 35, 2019)

Activity: MI Discussion

1. How do you use MI?
2. What are some of your favourite strategies/techniques?
3. Do you have any tips you would share with others?
4. Do you have other staged matched interventions using MI?

Additional Strategies – Thinking About Change

1. Ask about a “Typical Day” (helps assess daily habits/patterns, environment/relationships). Ask permission to provide feedback and summarize problem areas
2. Elaboration – asking for specific examples of situations and digging into them
3. Looking Forward
    a. “What would be the best results you could imagine, if you make a change?”
    b. “If you were to have a week off from your problems/symptoms, what would you do first?”
4. Looking Backwards
    a. “Do you remember a time when things were going well for you? What has changed and how?’
    b. ‘What were things like before you started using?’
5. Querying extremes
    a. Worst consequences. “What are your worst fears about what might happen if you don’t make a change?”
    b. Best consequences “What could be the best results if you did make the change?”

(Marel et al 2022)

Modifications to MI for those with Co-occurring disorders

1. Motivational Interviewing isn't right for everyone, and some modifications can help adjust it to be a better fit for those with different types of co-occurring needs

2. Focus on an integrated approach that holds space for both problems areas concurrently and understand how they may interact now and with change. Provide feedback that includes this information, while keeping in mind a person may be at a different SOC for certain issues.

3. Use open-ended questions to explore interactions "how does your drug use affect your anxiety symptoms?"

4. Targets for change go beyond substance use and include behaviours essential to overall recovery including motivation for further psychotherapy or medication adherence.

(Carey et al, 2001; Martino et al, 2002; Martino and Moyers, 2008)

Modifications to MI for those with Co-occurring disorders

Accommodating cognitive impairment and related symptoms such as disordered thinking

1. Individuals may be experiencing compounding cognitive difficulties including problems with attention, word generation, speed of information processing, memory, organization and abstract thinking and mental flexibility.
2. Increase the amount of repetition, summaries, and paraphrasing. Use simplified verbal and visual materials, use metaphor/simile, and consider breaks and length of sessions. Ensure structure and guide organization of thoughts, which can be supported with reflection and summary.
3. Simplify open-ended questions and avoid compound questions.
4. Avoid repeated reflections on psychotic content or disparaging statements and negative life events, shift the focus to change talk.
5. Provide extra time for individuals to respond, while also monitoring for when active assistance, such as memory prompts, is helpful to support the conversation.

(Carey et al, 2001; Martino et al, 2002; Martino and Moyers, 2008)

Modifications to MI for those with Co-occurring disorders

Accommodating cognitive impairment and related symptoms such as disordered thinking

1. Increase use of affirmations
2. Focus on “approach motivation” towards goals and benefits.
3. Include the use of written and visual materials.
4. Standard activities may need to be streamlined or simplified. Provide assistance in completing worksheets to accommodate symptoms.
5. Be aware of when symptoms interfere to a degree that interrupts the process and when other interventions may be needed. Shift between MI and other tasks like grounding and skill building. Monitor for and address risk/crisis.
6. Seek consultation and supervision

(Carey et al, 2001; Martino et al, 2002; Martino and Moyers, 2008)

Activity: Back to Judy

1. As we learned, Judy is 63 years old with a history of depression and a 7-year history of problematic alcohol use. She is a residential school survivor, retired, divorced, has two adult children, lives alone and has mobility issue. She has a recent history of suicide attempts.

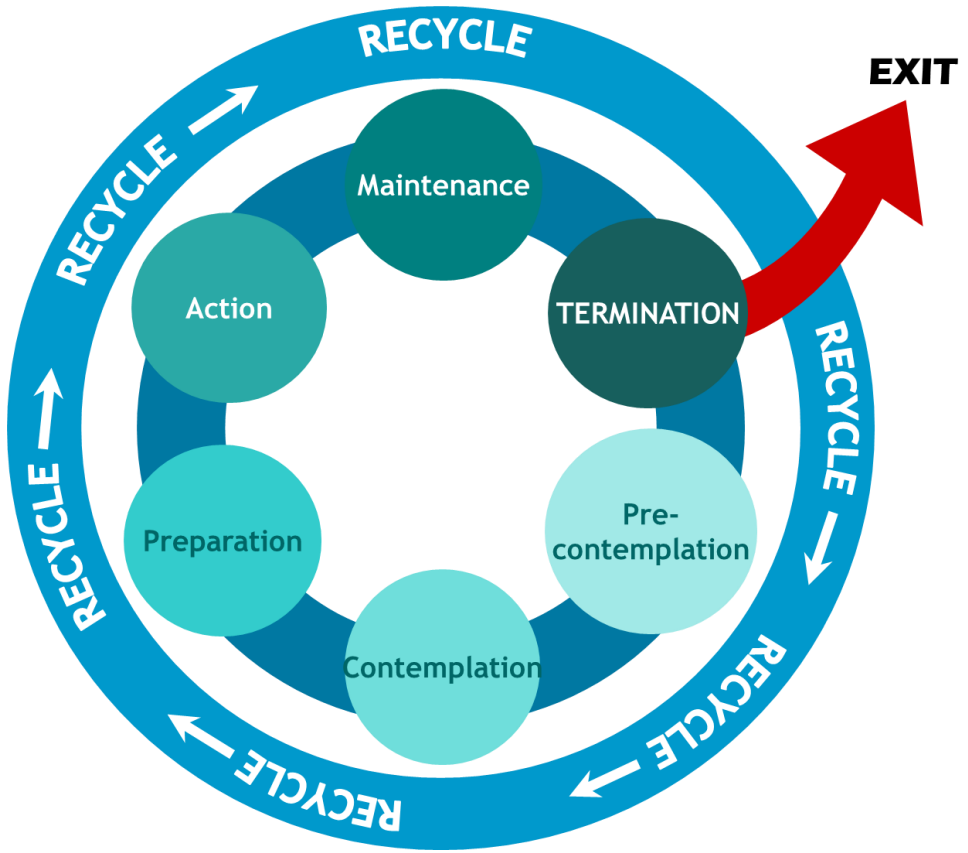
1. Judy has been referred to you for therapy. Her family doctor had discovered she is having liver issues exacerbated by her alcohol use. She agrees to meet with you following an appointment with a nurse on her primary care team, telling them “I can’t keep doing this, I know my liver is failing. I just don’t know what to do. I’ve tried to quit before, but it’s never stuck”.

Activity: Back to Judy

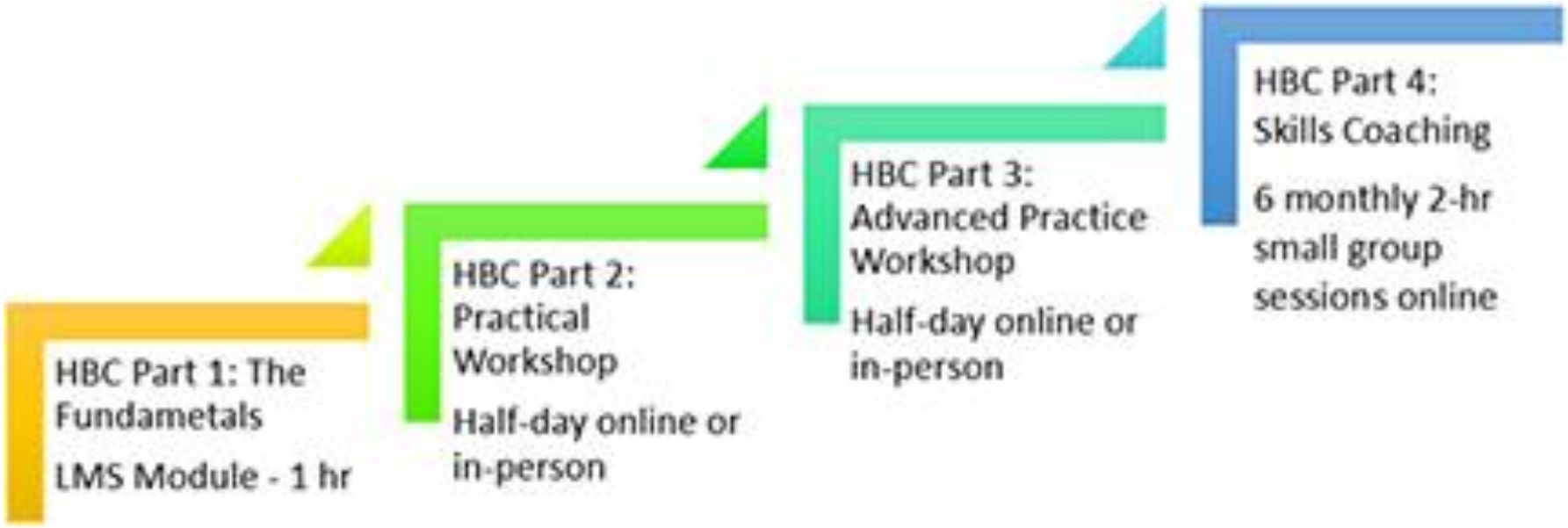
1. What Stage of Change could Judy be in?

2. What specific MI skills might you apply with Judy?
   a. Share an example of a question you might pose

3. Remember to focus on stage-matched interventions to draw out change talk



Motivational Interviewing Training through LMS
“Health Behaviour Change”



(WRHA-HBC, 2021)

Break

Recovery Interventions

Objectives

Intervention and Treatment of Various Mental Health Spectrum Needs

Psychiatric Medications

Therapy and Counselling Including CBT and DBT (Day 2)

What are Treatment and Recovery Interventions?

a. Treatments/recovery interventions are specific interventions that service providers do in order to facilitate recovery.

b. Treatment is a part of recovery, but recovery is more than just treatment.

c. Focused on specific biological/medical interventions or psychological and social interventions.

Treatments for Co-occurring Disorders

There is no "one size fits all" treatment

Individual's voice in recovery planning

1. **Can you share some of your experiences working with a variety of team members?**

   "My first therapist, was incredible, patient with me, encouraged me to find things that made me busy and happy. Helped with creating a routine [. . .] helped with housing, found places to look at, and took me. [Other team members have] seen me thru the worst, most awful parts of the past 10 years. [They were] present and available for important doctors' appointments, helped me thru schooling (adult Ed), gave me tough love and support "NO MATTER WHAT"."

2. **Have you been involved in developing plans for your recovery, including setting goals? If yes, what has this experience been like and how has this impacted your recovery?**

   "Being involved in plans gave me the feeling I was not only in control, but that I was fully supported in my recovery and the maintenance of my sobriety."

   "Long term goals were never "my thing", but keeping goals simple at first, and being reminded with encouraged made a huge difference in my ability to set/reach goals."

   - *MJW, CODI Outreach participant*

Interventions and Treatment Options for…

- Anxiety Disorders
- Mood Disorders
- Psychotic Disorders
- Personality Disorders
- Trauma Disorders
- Neurodevelopmental Disorders
- Neurocognitive/Dementia disorders
- Substance Use Disorders

Anxiety Disorders Interventions

1. Psychotherapy:
    a. Cognitive Behavioral Therapies (CBT)
        - Exposure-based CBT
        - Mindfulness-based CT
2. Medications:
    a. Antidepressants
    b. Anti-anxiety medications
3. Education, Self-Help and Peer Support.

(Lewis et al, 2021: NIMH, 2016a; Katzman et al, 2014)

Mood Disorders Interventions

1. Psychotherapy
   a. CBT Based Therapies (including behavioural activation, cognitive, mindfulness-based)
   b. Interpersonal Psychotherapy
   c. Problem Solving Therapy
   d. Family Focused Therapy
2. Medications
   a. Antidepressants
   b. Mood Stabilizers
   c. Antipsychotic Medications
3. Lifestyle
   a. Exercise /Nutrition and diet
   b. Reducing Smoking/Substances
   c. Social Support
4. Chronobiological (sleep hygiene, light therapy)
5. Physical/Brain Stimulation

(NIMH, 2018; CAMH, 2013a; Cleveland Clinic, 2018; Mahli et al, 2020; Society of Clinical Psychology, 2016a)

Psychotic Disorders Interventions

1. Medications
2. Psychosocial Treatments:
    a. Psychotherapy/Education/Cognitive Remediation
    b. Family Education and Peer Support
    c. Case Management/Assertive Community Treatment (ACT)
    d. Supported Employment/Housing

(Galletly et al, 2016; NIMH, May 2020, CAMH, 2015; Guideline Central, 2021; Society of Clinical Psychology, 2016b)

Personality Disorders Interventions

1. Assessment

2. Addressing Concurrent Difficulties

3. Relationship and Engagement

4. Psychotherapy
    a. DBT
    b. CBT

(Ward, 2014; Simonsen et al, 2019; Herpertz et al, 2007; Dingfelder, 2004; APA, 2008)A

Trauma Disorders Interventions

1. Psychotherapy

2. Medication

3. Coping and Support
    a. Peer and Family support
    b. Helping the individual to think better about themselves, others and the world
    c. Teaching the individual skills to address symptoms
    d. Learning ways to cope if symptoms arise again

(Blanch et al, 2012; Mayo Clnic, 2021a; APA, February 2017; NIHE, 2018)

Neurodevelopmental Disorders Interventions

1. Psychoeducation for parents/caregivers
2. Non-pharmacological treatments
    a. Behaviour/Psychological Therapy - (e.g. PCIT, ABA, CBT and others)
    b. Speech/Language Therapy
    c. Physical Therapy
    d. Social Skills Therapy
    e. Special Educational Services
3. Medications

(Sulkes, 2020 and University of South Florida, 2014)

Substance Use Disorders Interventions

1. Harm Reduction practices
    a. Lower Risk Guidelines
2. Psychotherapy/Behavioural Therapies
3. Contingency Management
4. Medications (pharmacotherapy)
5. Traditional Medicine
6. Peer Support/Self-help
7. Development of Recovery Capital

(Best & Laudet, 2010; KniAght, E., n.d. community forum presentation)

Activity: Substance Use Disorders – Recovery Capital

https://peerrecoverynow.org/product/what-is-recovery-capital/

Substance Use Disorder – Pharmacotherapy

1. Alcohol Use Disorder Treatment: Pharmacotherapy
    - Naltrexone
    - Acamprosate
2. Opioid Use Treatment: Pharmacotherapy
    - Methadone
    - Suboxone/Sublocade
    - Naltrexone

(Poulin, n,d,; Stokes, M. et al, 2021; SAMHSA, 2021)

Contingency Management

1. Contingency management is a form of psychosocial intervention based on the behavioral principles of operant conditioning.
2. Tangible rewards are given in response to the individual engaging in recovery or goal related behaviours
3. To be effective the rewards must be applied appropriately taking into consideration things like the target behaviours, the individual's needs, nature and value of the reward and the intensity, frequency, and timing.
4. Decades of research show it is effective in treating SUDs
    a. Increased engagement, reduced use, reduced hospitalization
5. Despite this barriers to consistency management exist, which is why we don't see many of these programs
    a. Costs, administration, moral concerns, etc.

(Petry, 2011; Proctor, 2022; The Recovery Village, 2020)

Psychiatric Medications

Medication Education is Important

(NAMI, 2021)

Psychiatric Medications - Categories

Medications for mental health conditions fall into the following major categories:

1. Anti-Anxiety Medications
2. Antidepressants
3. Mood Stabilizers
4. Stimulants
5. Anti-psychotics

Antidepressants

- These medications improve symptoms of mood, anxiety and related symptoms by affecting the brain chemicals associated with emotion such as serotonin, norepinephrine and dopamine.

- Classifications:
  - Selective serotonin reuptake inhibitors (SSRIs)
  - Selective norepinephrine reuptake inhibitors (SNRIs)
  - Tricyclic antidepressants (TCAs)
  - Monamine Oxidase Inhibitors (MAOIs)
  - Others

(Casarella, 2019; CAMH, 2012; Mayo Clinic, 2021; NHS, 2018)

Anti-anxiety Medications

1. Anti-anxiety medications help reduce the symptoms of anxiety, such as panic, extreme fear and worry.
2. **Benzodiazepines**
3. Antidepressants

(Bandelow, Michaelis and Wedekind, 2017; CAMH, 2021; Help Guide 2021)

Mood Stabilizers

- These substances help level out the erratic highs and lows of bipolar disorder, reducing the excessive energy and euphoria of mania states and the associated rapid mood swings.
- Examples:
  - Lithium
  - Anticonvulsants
  - Antipsychotics

(CAMH, 2021; Grunze, Schlosser, Amann & Walden, 1999)

Stimulants

- Stimulants are typically prescribed for the management of Attention Deficit Hyperactivity Disorder (ADHD) symptoms such as short attention span, inattention, impulsive behavior, and hyperactivity.
- Potential for misuse
- Examples:
  - Methylphenidate (*Ritalin)*
  - Dextroamphetamine (*Dexedrine*)
  - Dextroamphetamine + Amphetamine (*Adderall)*

(NIDA, 2018; CDC, 2021a; and APA, 2017)

Antipsychotics

- Medications that reduce or eliminate the presentation of psychotic symptoms such as delusions, hallucinations, and paranoia.
- Examples:
  - Typical antipsychotics (first generation)
    - Chlorpromazine, Haloperidol, Fluphenazine
  - Atypical antipsychotics (second generation)
    - Risperidone, Olanzapine, Clozapine*

(Casarella, 2018; CAMH, 2012 and Government of Canada, 2018)

Medication Management

1. Medication adherence is important for efficacy and safety
2. We all play a role, in collaboration with prescribers, to support Individuals
3. Things you can do:
    a. Have honest conversations about medication adherence, risks/benefits and the role of medications in mental health recovery
    b. Share accurate psychoeducation from reliable sources (handouts, websites)
    c. Have conversations about concerns and misconceptions, how to manage side effects
    d. Encourage them to participate in developing medication plans and to discuss issues with their prescriber
    e. Collaborate with Individual and prescriber around goals and monitoring of symptoms/changes
    f. Support the use of reminder tools, bubble packs, dispensing schedules etc

Angell, 2006; Mortari & Pino, 2013

Wrap Up: Next Steps

1. End of Day 1, will return tomorrow for the second session.
2. Thank you for your participation!

Co-occurring Disorder Educational Curriculum (CODEC)
Clinical Explorations Training - Day 2

Shared health
Soins communs
Manitoba

Recovery Interventions, Part two

Shared health
Soins communs
Manitoba

Objectives

Cognitive Behavioural Therapy

Dialectical Behaviour Therapy

Brief Interventions Techniques

Indigenous Traditional Healing and Wellness

Psychotherapy

Disclaimer:

1. Please refrain from using techniques that you are not fully trained in while working with individuals. Although we know aspects of each modality can be modified for use in clinical work; we encourage you to seek certified training if you are interested.

2. We continue to use the principles of trauma-informed, person-centred approaches within each of these modalities. Please be mindful of inadvertently exposing a trauma reaction while using these techniques without a way to contain them.

Psychotherapy

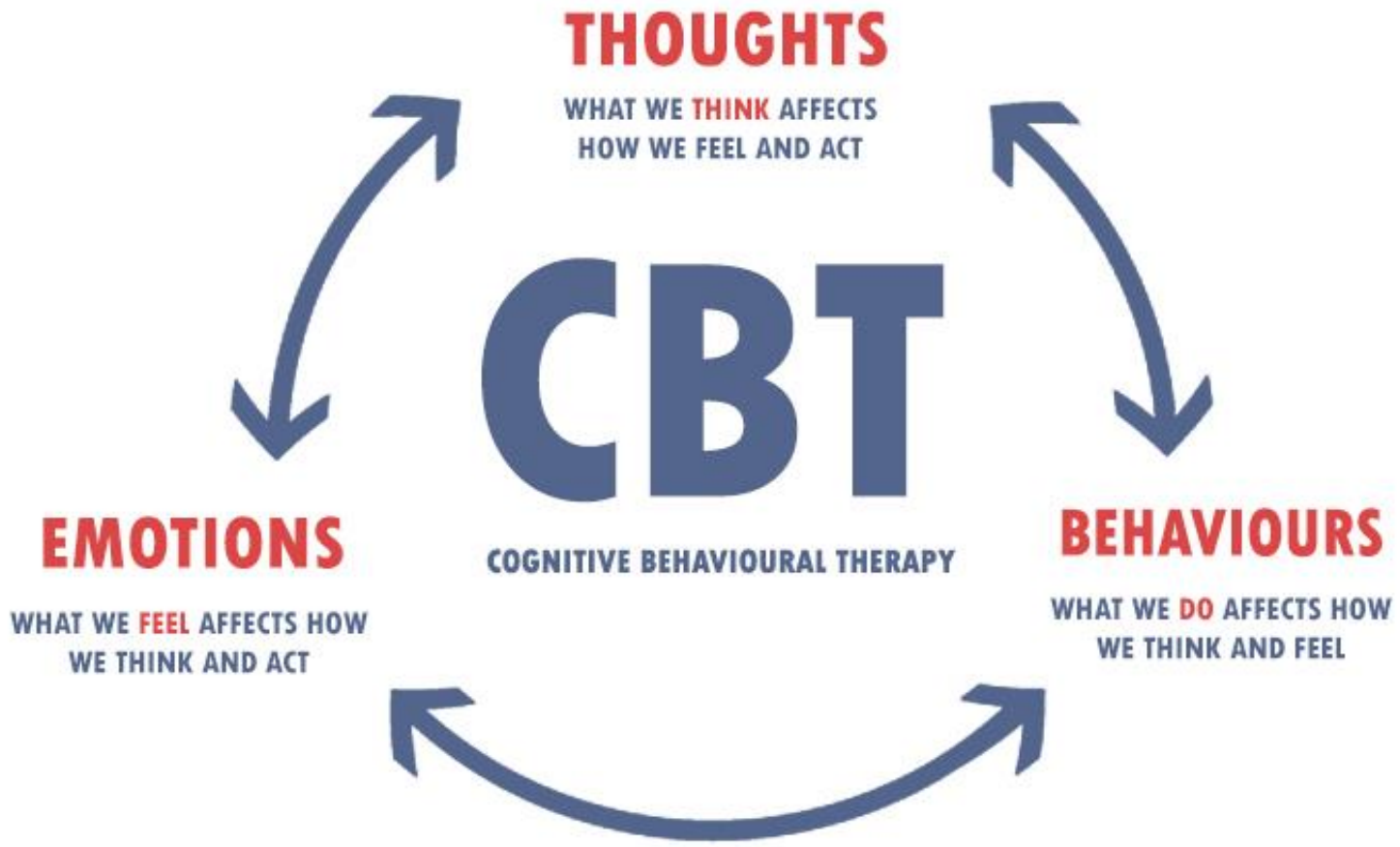
- Also known as “talk therapy,” or counselling.
- A collaborative relationship, done in a safe and confidential environment that allows the person to explore and understand feelings and behaviors and gain problem solving and coping skills.
- Offered in a variety of formats including individual, group, couple and family sessions.
- Very effective in addressing mental health spectrum difficulties.

- There are many different modalities of psychotherapy, today we’ll focus on:
  - CBT (and CBTm classes)
  - DBT
  - BIT

(APA, 2012; APA Division 12, 2017c; NAMI, n.d.)

Cognitive Behaviour Therapy

Cognitive Behaviour Therapy (CBT)



(APA Division 12, 2017c; Bodymindthearpy Clinic, 2021 (image)

CBT Continued…

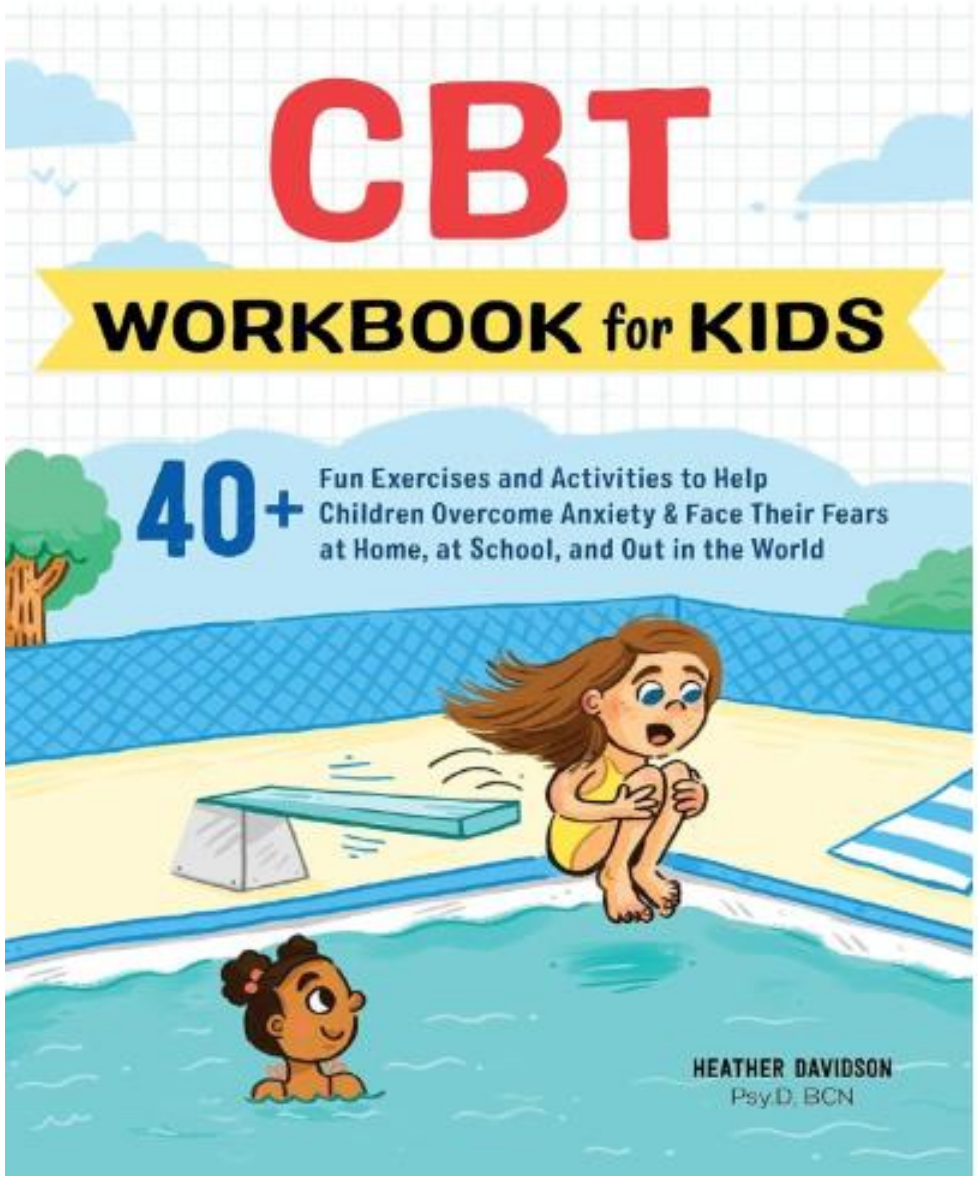
1. A present-focused style of therapy.
2. Explores the meaning we ascribe to thoughts, feeling and experiences.
3. Uses a variety of tools to help find more balanced/flexible ways of thinking.
4. CBT
    a. is structured.
    b. is time-limited (usually 6-20 sessions).
    c. is problem-focused and goal-oriented.
    d. teaches strategies and skills.
    e. involves practice (homework).
    f. is based on a proactive, shared therapeutic relationship between service provider and individual.

(CAMH, 2021c; Psychology Tools, 2021b)

Common CBT Techniques

1. Psychoeducation
2. Cognitive Restructuring or Reframing
3. Activity Scheduling and Behavioural Activation
4. Behavioral Experiments
5. Skills Training and Role Playing
6. Exposure Therapy

APA Division 12, 2017b; Bennett-Levy et al., 2004, CBT Los Angeles, 2020, Leoni, 2018; McGovern, 2014; Pietrangelo, 2019; Psychology Tools, 2021a; Selva, 2021, Therapist Aid, n.d.; Whalley, 2019



Cognitive Challenging: The Thought Log

A thought log is a tool you can use to analyze your own thought process, challenge negative and irrational thoughts, and identify alternative perspectives in order to reduce negative emotions. You'll learn how to think more rationally about certain negative instances and keep your own emotions in check.

Use each column to write about a specific situation that caused a negative emotion. Keep in mind that you need to use a *fact* for the evidence that supports or goes against an unhelpful thought; it can be easy to confuse feelings with facts.

SITUATION/TRIGGER: WHAT HAPPENED? (e.g., My child won't sleep in their own bed)	
EMOTIONS/PHYSICAL SENSATIONS EXPERIENCED (e.g., sadness, anxiety, headache, etc.)	
UNHELPFUL THOUGHTS (e.g., I'm failing as a parent)	
EVIDENCE SUPPORTING THE UNHELPFUL THOUGHT (must be a fact)	
EVIDENCE THAT GOES AGAINST THE UNHELPFUL THOUGHT (must be a fact)	
ALTERNATIVE PERSPECTIVE (e.g., My child's struggles are not indicative of my worth as a parent)	

(Images from CBT Workbook for Kids by Heather Davidson, 2019. Available in the SH-MHA Library)

CBTm classes:

1. The CBT Model
2. Mindfulness
3. Healthy & Realistic Thinking
4. Goal Setting
5. Basics of Behaviour Therapy
6. Healthy Living & Sleep
7. Anger, Assertiveness & Self-Compassion
8. Problem-Solving
9. Stress & Coping with Stress

For more information, visit: www.cbtm.ca

Dialectical Behaviour Therapy (DBT)

Dialectical Behaviour Therapy

1. Developed in the 1980s and has become an evidence-based modality
2. Supports individuals to regulate emotions, tolerate upset and distress, become more effective when interacting with others and increase mindfulness
3. Based on the concept of “dialectics”
4. Behaviour based

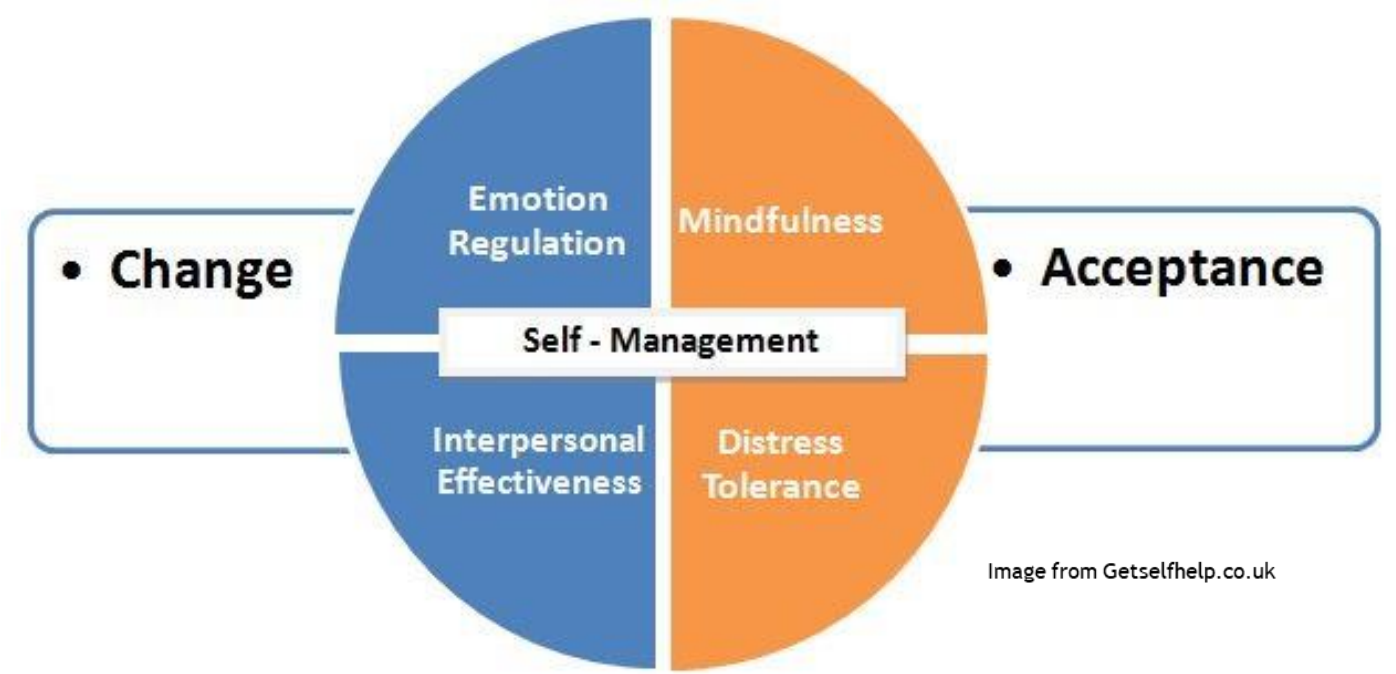


Image from Getselfhelp.co.uk

(Behavioraltech, 2021; Behavioral Research and Therapy Clinics, 2021; CAMH, 2021d; Linehan, 2015; OCMHS, n.d.; SANE, 2017)

Dialectical Behaviour Therapy – Model Components

DBT Skills Training

- **Often only this component is offered as part of "DBT-informed" services**

Individual Therapy

In-the-Moment Coaching (24 hours)

Consultation Team and meetings

(Behavioraltech, 2021; Behavioral Research and Therapy Clinics, 2021; CAMH, 2021d; Linehan, 2015; OCMHS, n.d.; SANE, 2017)

Dialectical Behavioral Therapy

DBT is a mix of CBT, behaviorism, and mindful practices, recognizing the importance of both the rational and the emotional realms of life. DBT seeks a middle path, inviting us to use our "Wise Mind" as the north star when engaging with each other and the world.

Image from: Https://www.bayviewtherapy.com/single-post/what-is-dialectical-behavioral-therapy-and-why-is-dbt-effective

Brief Intervention: Techniques and BI Therapies

Brief Interventions Techniques

- A language techniques approach used to elicit positive behavioural change. Most well know – is Motivational Interviewing

- Keep in mind principles of effective communication

(who, 2014)

Examples for Brief Interventions According to Setting

Setting	Purpose
Opportunistic setting (e.g. primary care, home health care)	•Screening and facilitate referrals for additional specialized treatment (e.g., a nurse IDing mental health spectrum needs through screening, advising to seek further assessment/treatment) •Affect substance use or harm behaviours directly via discussions of reduction in hazardous or at-risk actions (e.g., a PCP advising at-risk drinkers to cut down, Dry January/February) or establishing a plan for change.
Neutral environments (e.g., social/community sites, public health/media advertisements)	•Offer education, screen for risk behaviors and give supportive advice about harm reduction (e.g., a public health initiative to screen people in shopping malls and provide feedback and advice)
Physical Health care settings (e.g. ER, Clinics)	•Universal screening, brief motivation discussions and facilitate referrals for additional specialized treatment as needed
Mental Health and Substance Use Health Care settings	•Provide pre-treatment and readiness sessions before extended treatment for persons seeking assistance but waiting for intensive services to become available (e.g., a community-based center that offers potential individuals assessment and feedback while they are on a waiting list) •Act as a motivational for engagement in more intensive treatment (e.g., an intervention to help a individual commit to in-house treatment as clinically indicated) •Facilitate behavior change steps related to substance use or associated problems

(Adapted from Bien et al., 1993)

How Brief is Brief?

Single contact lasting less than 10 minutes to up to an hour

One or more in-person brief contacts plus materials given

In-person, phone, or mailed feedback (generic, tailored, or personalized) based on assessment/conversation

Multiple interactions of limited length and number

(SAMHSA, 2019)

Indigenous Ways to Wellbeing

Shared health
Soins communs
Manitoba

Inclusion of Indigenous Traditional Healing/Wellness Practices in Treatment

- “Traditional healing refers to health practices, approaches, knowledge and beliefs incorporating Indigenous healing and wellness while using ceremonies; plant, animal or mineral-based medicines; energetic therapies; or physical/hands on techniques” (FNHA, 2014).

- Recommended Additional Training: seek out additional trainings in your SDO or visit the CODEC webpage Additional Recommended Training Section to find links to workshops/training on Traditional Healing and Wellness.

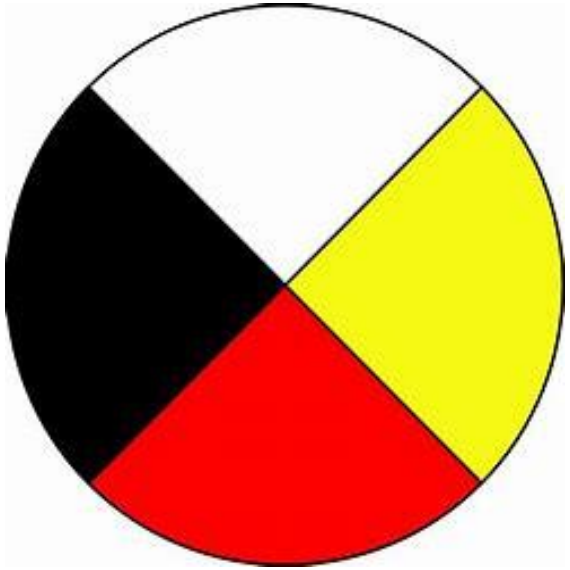


Image from: wikipedia-Littlejohn657

FNHA, 2014)

Activity: Indigenous Health – Video

https://youtu.be/IFURos_fTUE?si=2Z2HmmyykQEdTQsd

Screening and Assessment

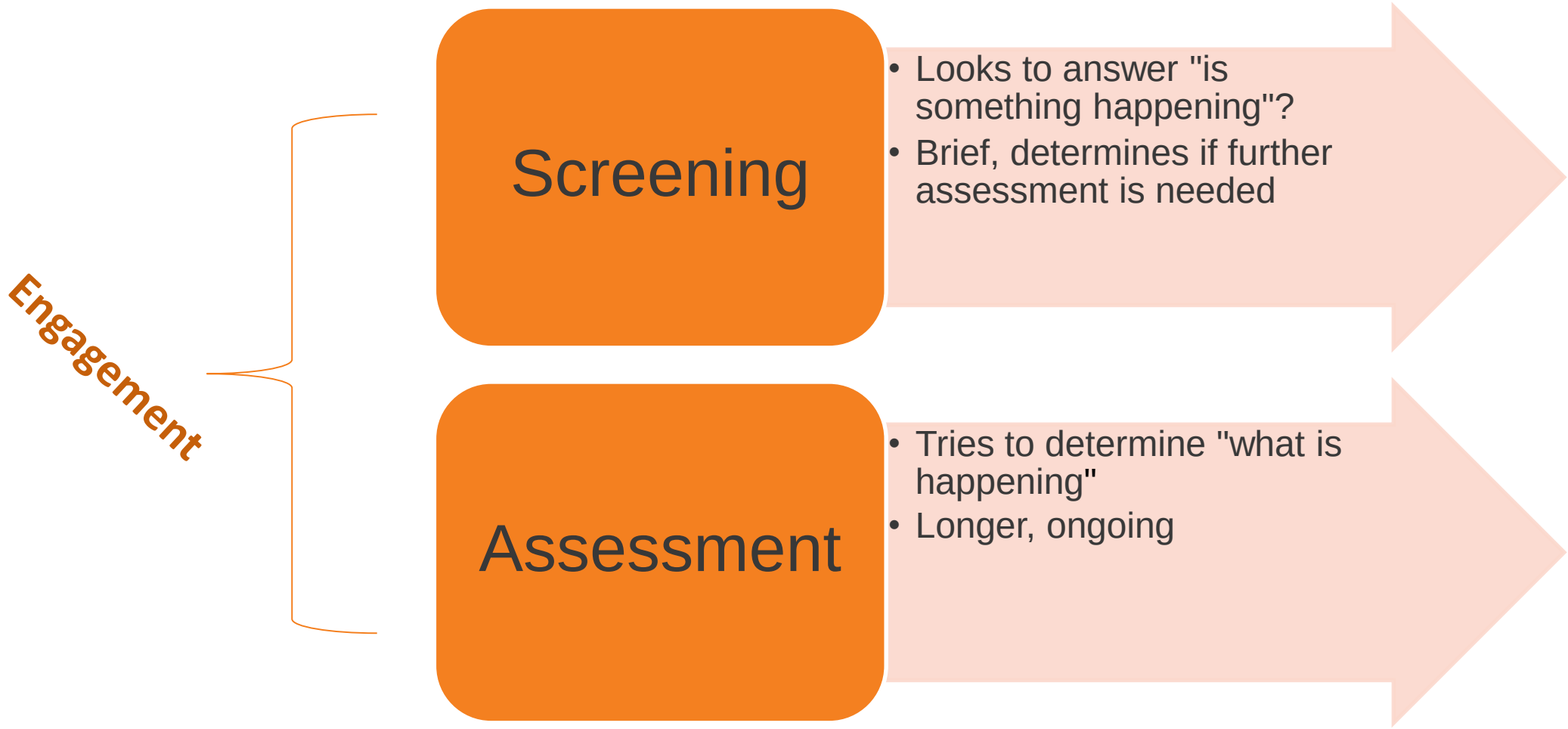
Objectives

To explore principles of co-occurring disorder screening and assessment

SBIRT model

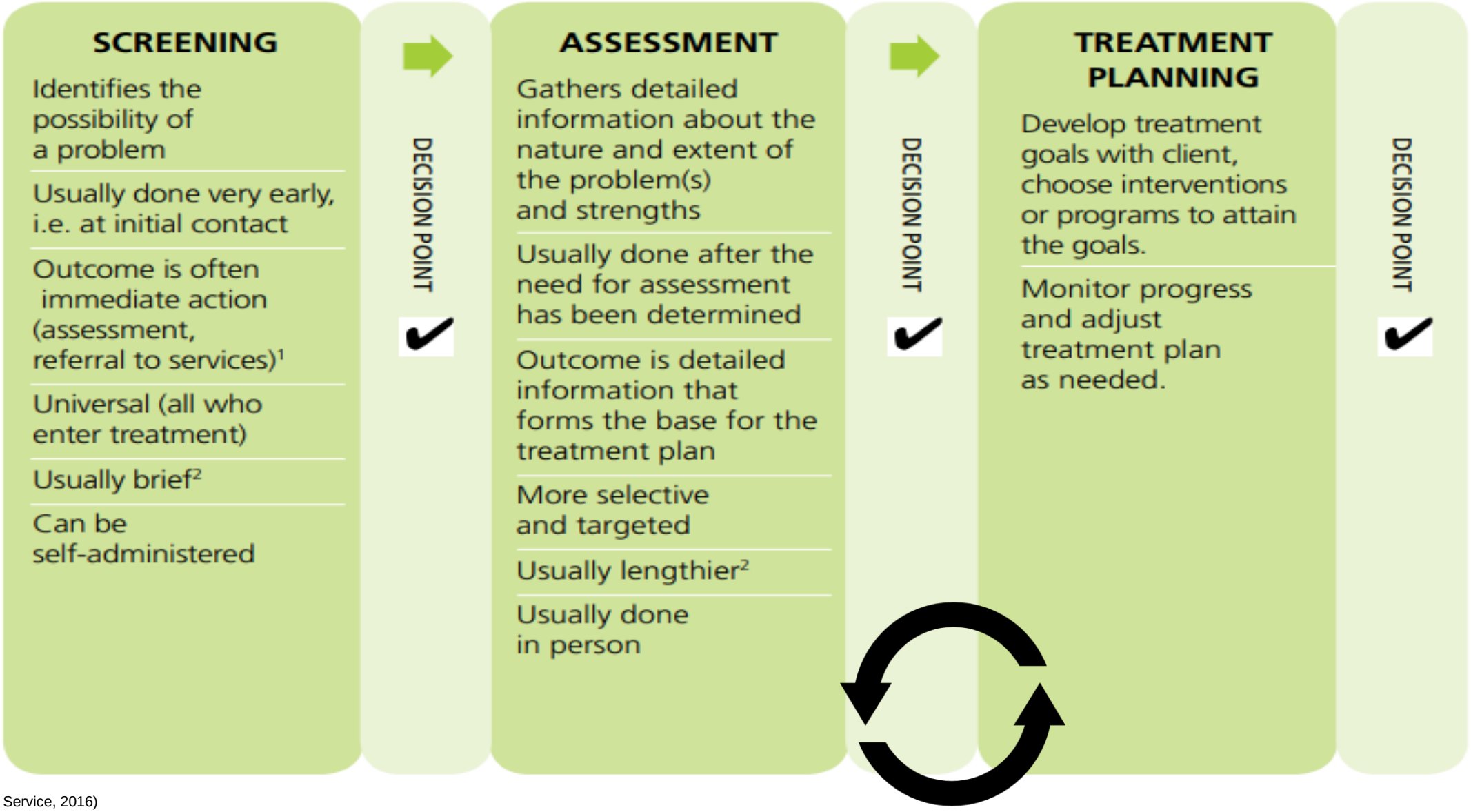
Review frameworks and tools used in screening and assessment

Screening and Assessment – Introduction



SAMHSA TIP 42, 2020

Clinical Decision-Making Process



(Alberta Health Service, 2016)

SBIRT - (Screening, Brief Intervention, and Referral to Treatment)

Screening

Brief Intervention

Referral to Treatment

To learn more check out the IRETA SBIRT Toolkit at https://ireta.org/resources/sbirt-toolkit/

Purpose of Assessment

Engage	Engage the Individual in their recovery and build a therapeutic relationship.
Identify	Identify areas of concern, strengths and resources.
Understand	Understand the interactions between the different mental health disorders including substance use/addictive behaviours.
Guidance	Guide in determining service options and levels of care.
Coordinate	Assist in coordination and collaboration across services.
Monitor	Monitor changes as they occur during service (treatment response).

(SAMHSA Tip 42, 2020; Alberta Health Services,2016 and Marel et al, 2016)

Assessment Methods and Sources

1. There are a range of different methods and sources of information that can support a comprehensive intergraded assessment for co-occurring disorders. These can help you more fully and accurately understand a person's situation, needs, strengths and goals for their recovery.
    a. Investigations of biopsychosocial spiritual functioning and wellbeing.
    b. Social and use histories.
    c. Clinical interviews.
    d. Standardized/specialized tests.
    e. Review of health, education or legal records.
    f. Examination of diagnostic information and other clinical assessments.
    g. Physical examinations and medical tests.
    h. Added information from natural supports such as friends and family.

(SAMHSA Tip 42, 2020; Alberta Health Services,2016 and Marel et al, 2016)

What to do with Assessment Information

1. As you collect, interpret and integrate assessment information this assists in determining the following with the Individual:
    a. Stage of Change
    b. Level of involvement with substances
    c. 4- Quadrant Matrix for service
    d. Their current goals for recovery and related planning

2. Provide feedback and assessment results to the individual. Include their natural supports and others in their collaborative care team as appropriate.

(SAMHSA Tip 42, 2020; Health Canada, 2002; Manitoba Health –CODI, 2005; Alberta Health Services,2016 and Marel et al, 2016)

Examples of Assessment Tools

Comprehensive Frameworks

- Integrated Longitudinal Strength-based Assessment/ILSA-Basic (Minkoff)
  - http://www.ziapartners.com/tools/ilsa-basic/
- SAMHSA 12 step screening and assessment model (TIP 42)

Functional Needs

- Camberwell Assessment of Need
  - https://www.researchintorecovery.com/measures/can/
- WHO Disability Assessment Schedule 2.0 (WHODAS 2.0)

Broad Mood and Symptom Tools

- DSM-5 Cross-Cutting Symptom Measures
- SCL-90-R*

Other Mental Health Scales

- Beck Depression Inventory
- Patient Health Questionnaire (PHQ-9)
- Generalized Anxiety Disorder 7 (GAD-7)

Substance Use Tools

- DAST/AUDIT/CAGE-AID, Modified ASSIST (Screening Tool)
- CIWA-Ar, COWS (Assessment Tools)

(Research into Recovery, n.d.; WHO, 2012; Zia partners, 2019)

Examples of Broad Mood and Symptom Tools

DSM-5 Cross-Cutting Symptom Measures

- Level 1 domains
  - Depression
  - Anger
  - Mania
  - Anxiety
  - Somatic symptoms
  - Suicidal ideation
  - Psychosis
  - Sleep problems
  - Memory
  - Repetitive thoughts and behaviors
  - Dissociation
  - Personality functioning
  - Substance use

SCL-90-R

- Symptom Scales
  - SOM - Somatization
  - O-C - Obsessive-Compulsive
  - I-S - Interpersonal Sensitivity
  - DEP - Depression
  - ANX - Anxiety
  - HOS - Hostility
  - PHOB - Phobic Anxiety
  - PAR - Paranoid Ideation
  - PSY - Psychoticism

(APA, 2021 and Pearson Assessments, 2021)

Examples of Substance Use and Withdrawal Scales

Screening Tools

DAST

- 1 Global score
- Degree of Problem
  - No problems
  - Low level
  - Moderate level
  - Substantial level
  - Severe level

AUDIT

- Domains
  - Recent Use
  - Dependence Symptoms
  - Experience of harm

Assessment Tools

The Clinical Opiate Withdrawal Scale (COWS)

- 11 items scale, clinician administered
- Helps to determine the stage or severity of opiate withdrawal and assess the level of physical dependence

Clinical Institute Withdrawal Assessment for Alcohol, Revised Version (CIWA-Ar)

- 10-item scale
  - Nausea and vomiting
  - Tremor
  - Paroxysmal sweats
  - Anxiety
  - Agitation
  - Tactile disturbances
  - Auditory disturbances
  - Visual disturbances
  - Headache
  - Orientation and clouded sensorium

Prediction of Alcohol Withdrawal Severity Scale - PAWSS

PART A: THRESHOLD CRITERIA — Yes or No, no point	
Have you consumed any amount of alcohol (i.e., been drinking) **within the last 30 days**? **OR** Did the patient have a positive (+) blood alcohol level (BAL) on admission?	
If the answer to either is YES, proceed to next questions.	
PART B: BASED ON PATIENT INTERVIEW — 1 point each	
1	Have you been recently **intoxicated/drunk**, within the last 30 days?
2	Have you **ever** undergone alcohol use disorder rehabilitation treatment or treatment for alcoholism? (i.e., in-patient or out-patient treatment programs or AA attendance)
3	Have you **ever** experienced any previous episodes of alcohol withdrawal, regardless of severity?
4	Have you **ever** experienced blackouts?
5	Have you **ever** experienced alcohol withdrawal seizures?
6	Have you **ever** experienced delirium tremens or DTs?
7	Have you combined alcohol with other "downers" like benzodiazepines or barbiturates, **during the last 90 days**?
8	Have you combined alcohol with any other substance of abuse, **during the last 90 days**?
PART C: BASED ON CLINICAL EVIDENCE — 1 point each	
9	Was the patient's blood alcohol level (BAL) greater than 200mg/dL? (SI units 43.5 mmol/L)* **OR** *Have you consumed any alcohol in the past 24 hours?
10	Is there any evidence of increased autonomic activity? e.g., heart rate >120 bpm, tremor, agitation, sweating, nausea

Photo credit: Manitoba First Nations Wellness Advisory Committee

Activity: Back to Judy

As we learned, she is 63 years old with a history of depression and a 7-year history of problematic alcohol use. She is a residential school survivor, retired, divorced, has two adult children, lives alone and has mobility issue. She has a recent history of suicide attempts. She has a primary care team and was referred to you for counselling after discovering she has liver damage.

She had participated in further screening and assessment and the results have been shared with you. During this process she obtained a score of 28 on the AUDIT (likelihood of moderate-severe alcohol use disorder). On the DSM-5 Cross-Cutting Measure she presented with elevated symptom endorsement across multiple domains including, depression, anger, anxiety, suicidality, sleep problems, repetitive thoughts/behaviours, personality functioning and substance use. You will incorporate this with the other background and referral information you have gathered on her to supplement your own assessment.

Activity: Back to Judy

1. How might you continue to engage Judy in the assessment process?

2. What more might you want to know about Judy to complete your assessment? (or additional assessments/tools)

Break

Mitigating Risk: Part 1

Objectives

Concepts of Suicide and Co-Occurring Disorders

Suicide Prevention - Screening and Assessment

Managing Behaviours or Concern (BoC) and Psychosis

Suicide in Canada: Key Statistics

DEATHS AND HOSPITALIZATIONS[1,2]

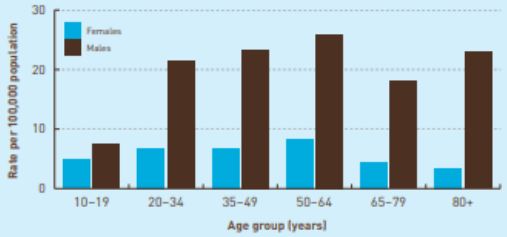
approx. **12** PEOPLE die by suicide **EACH DAY**

approx. **4,500** DEATHS BY SUICIDE PER YEAR

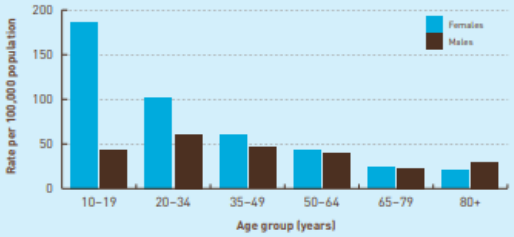
Suicide rates are approx. **3X higher** among men compared to women

Suicide is the **SECOND** leading cause of death among youth and young adults (15–34 years)

DEATH rates by suicide per 100,000 population in 2019 (by age and sex)



HOSPITALIZATION rates associated with self-inflicted injury per 100,000 population in 2020–2021 (by age and sex)



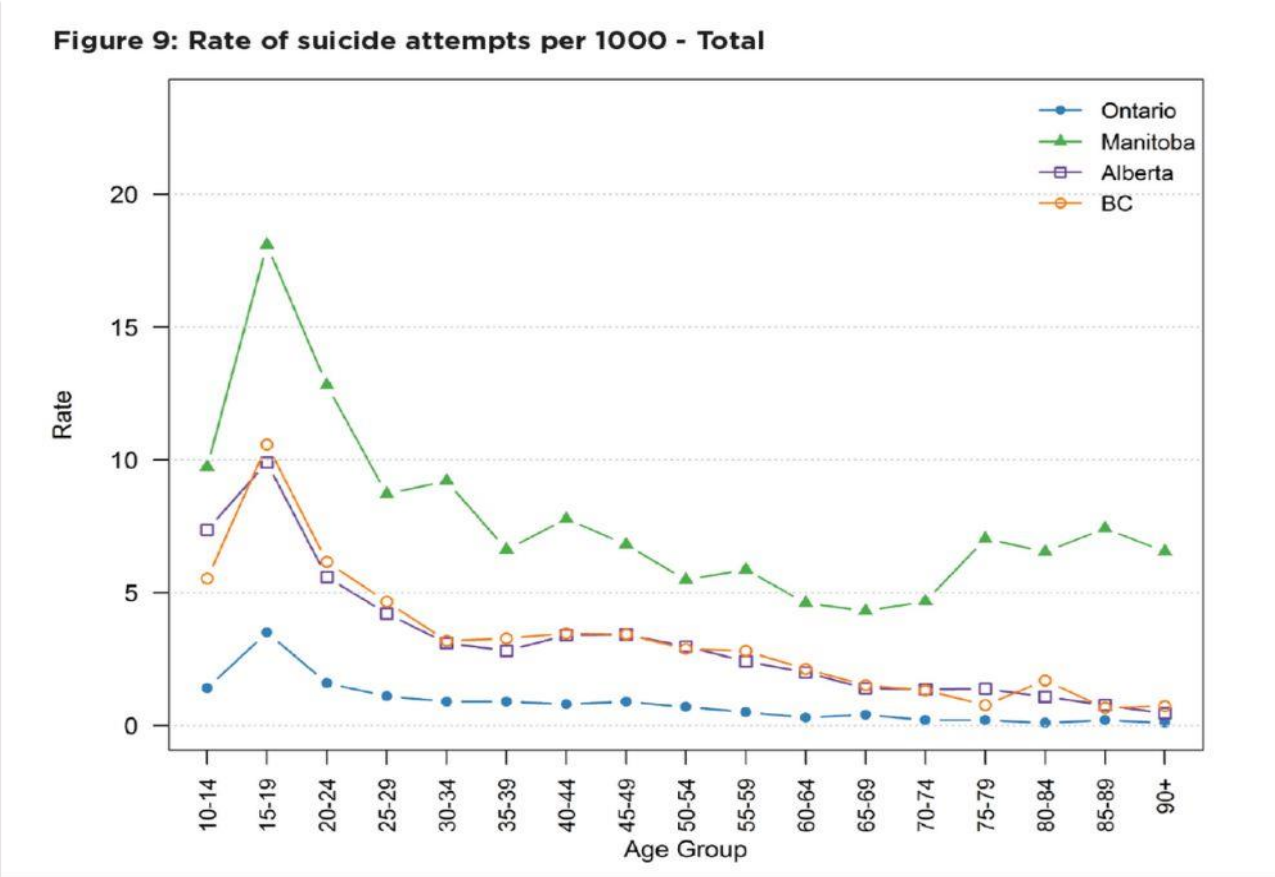
SUICIDE-RELATED BEHAVIOURS[3,4]

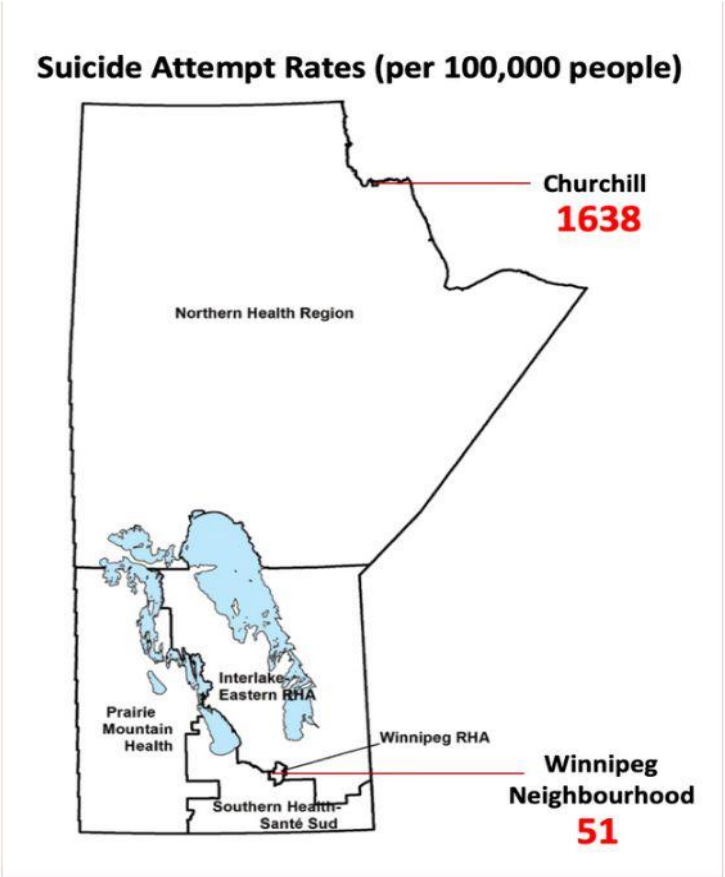
THOUGHTS	PLANS	ATTEMPTS
12.0% had thoughts of suicide in their **LIFETIME**	**4.2%** had planned suicide in their **LIFETIME**	**3.1%** had attempted suicide in their **LIFETIME**
2.6% had thoughts of suicide in the **PAST YEAR**	**0.8%** had planned suicide in the **PAST YEAR**	**0.3%** had attempted suicide in the **PAST YEAR**

9-8-8 **Suicide Crisis Helpline**

Infographic (cropped) from: Public Health Agency of Canada

MANITOBA CONTEXT: HIGHER RATES AND REGIONAL DISPARITY





Chartier, et al. (2018)

(Chartier et al., 2018)

Intersections of Substance Use and Suicide: Evidence and Key Take-Aways, CCSA Report

"Co-occurring mental illness and substance use, across substances, significantly increase the risk of suicide (thoughts, attempts and death by suicide)".

"There appears to be an increased risk of suicide during substance use treatment and in the 12 months after completion. Screening for suicide risk by health-care professionals is critical during this period".

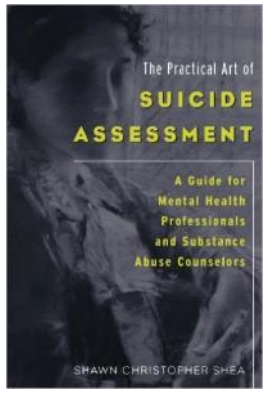
"Intersecting health and social inequities, isolation, substance use, SUDs, and experiences of mental illness and trauma, among other factors, increase the risk of suicide in some populations".

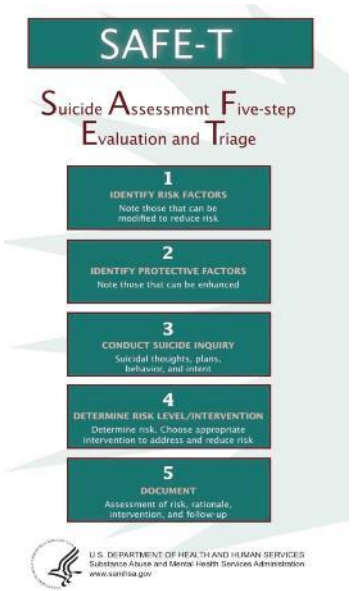
"Routine screening for suicidal thoughts and mental health status by service providers and engaging in dialogue that is both culturally safe and compassionate should be prioritized."

(Edalti etal 2024)

Suicide Prevention - Screening and Assessment

1. Suicide screening and assessment should be a regular part of your clinical practice
2. Follow your organizational or Service Delivery Organization's policy/guideline for Suicide Assessment and Intervention
3. Obtain the appropriate training relevant to your role to enhance clinical knowledge and skills and validity of assessments
   a. Your SDO will have area specific trainings
4. Seek out peer consultation and clinical supervision





Mental Health Commission of Canada; 2021

Risk of Violence and Other Critical Factors

- Current level of aggression
- History of aggression
- Triggers
- Mental state (including intoxication, psychosis, etc.)
- Weapons/access to weapons
- Endorsing plan to harm others with noted timing and intent

(Almvik et al., 2007)

Managing Behaviours of Concern (BOC)

All human beings behave according to a variety of factors. These can include:

1. • personal life experiences;
2. • attitudes and expectations of oneself and others;
3. • physical and social environments;
4. • historical and existing systems;
5. • physical and mental health.

People living with a mental illness may or may not present with BoC. For those that do, sometimes BoC are a response to the symptoms they are experiencing. This is more likely when someone is having difficulty communicating or coping with what they are going through.

While understanding the impact that various mental illnesses can have is important, there is often more than one reason someone presents with a BoC.

For a tip guide with ideas for managing BOC see: https://healthproviders.sharedhealthmb.ca/wp-content/uploads/behaviours-of-concern.pdf or consult the BRaCT service

(Shared Health, n.d)

Managing Psychosis

Sometimes symptoms of psychosis can result in behaviours or actions that may place the person at risk for harm to self or others. For example, psychotic beliefs or paranoia may put a person in dangerous situations where their own or others' safety can be compromised.

Some tips for supporting a person in a psychotic episode:

a. Ensure discussions take place in settings where privacy, confidentiality and dignity can be maintained
b. Try to reduce noise or other stimulation
c. Allow the person as much personal space as possible
d. Speak clearly and calmly, provide info in small chunks
e. Limit overt eye contact
f. Appear confident, even if you feel anxious inside

Check out the "Crack in the Ice" training cracksintheice.org.au

(Comorbidity Guidelines n.d)

Mitigating Risk: Part 2

Objectives

Intoxication and Substance Use Harm Reduction Strategies

Mental Health Harm Reduction Techniques

Substance Use Withdrawal and Interventions

Intoxication and Substance Use Harm Reduction Strategies

Alcohol

"Alcohol is the most commonly used substance in Canada. Understanding the impacts of alcohol use is essential to minimizing the risks and harms" (CCSA, 2024)

- **Early signs of intoxication**:
  - Flushed skin
  - impaired judgment
  - reduced inhibition

- **Continued signs of intoxication:**
  - impaired attention
  - reduced muscle control
  - slowed reflexes
  - staggering gait
  - slurred speech
  - double or blurred vision
  - "black out"

(CAMH, 2024, CCSA, 2024 and Paradis et al, 2023

Risk Reduction Guidelines – Alcohol (CCSA, 2023)

Infographic credit and additional resources from: resources /www.ccsa.ca/canadas-guidance-alcohol-and-health

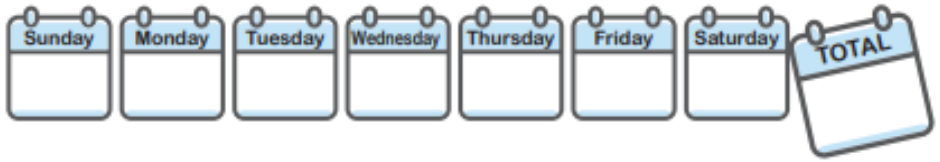
Harm Reduction Techniques: Alcohol

Aim to drink less

Drinking less benefits you and others. It reduces your risk of injury and violence, and many health problems that can shorten life.

Here is a good way to do it

Count how many drinks you have in a week.



Set a weekly drinking target. If you're going to drink, **make sure you don't exceed 2 drinks on any day.**

Good to know

You can reduce your drinking in steps! Every drink counts: any reduction in alcohol use has benefits.

It's time to pick a new target

What will your weekly drinking target be?

Tips to help you stay on target

- Stick to the limits you've set for yourself.
- Drink slowly.
- Drink lots of water.
- For every drink of alcohol, have one non-alcoholic drink.
- Choose alcohol-free or low-alcohol beverages.
- Eat before and while you're drinking.
- Have alcohol-free weeks or do alcohol-free activities.

Infographic credit and additional resources from: https://www.ccsa.ca/sites/default/files/2023-05/CGAH-Drinking-Less-is-Better-en.pdf

Canada's Lower-Risk Cannabis Use Guidelines (LRCUG)

Recommendations

- Cannabis use has health risks best avoided by abstaining
- Delay taking up cannabis use until later in life
- Identify and choose lower-risk cannabis products
- Don't use synthetic cannabinoids
- Avoid smoking burnt cannabis—choose safer ways of using
- If you smoke cannabis, avoid harmful smoking practices
- Limit and reduce how often you use cannabis
- Don't use and drive, or operate other machinery
- Avoid cannabis use altogether if you are at risk for mental health problems or are pregnant
- Avoid combining these risks

The LRCUG are an evidence-based intervention project by the Canadian Research Initiative in Substance Misuse (CRISM).

CANADIAN RESEARCH INITIATIVE IN SUBSTANCE MISUSE | INITIATIVE CANADIENNE DE RECHERCHE EN ABUS DE SUBSTANCE

Reference: *American Journal of Public Health*, 2017

The LRCUG have been endorsed by the following organizations:

Association Médicale Canadienne | Canadian Medical Association | CPHA ACSP | CSAM SMCA | camh

Council of Chief Medical Officers of Health (in principle)

Infographic credit and additional resources from: http://crismontario.ca/guidance/lower-risk-cannabis-use-guidelines

Lower-Risk Cannabis Use Guidelines for Psychosis (LRCUG-PSYCH)

- Genetic
- Age of use
- Potency
- Frequency
- Mode of use
- Mixing substances
- Existing psychotic disorder
- Medication Interactions
- Taking breaks
- Combining at risk behaviors
- Other health problems

(Fischer et al, 2023 and https://cannabisandpsychosis.ca/lower-risk-cannabis-use-guidelines-for-psychosis/)

Opioids

Signs of Opioid Intoxication:

- Intense pleasure
- Euphoria
- Sedation
- Drowsiness
- Respiratory depression

Image Credit: https://www.opiateaddictionresource.com/media/images/fentanyl_patches/

(UBC, n.d. and CAMH, 2021b)

Harm Reduction: Opioids

- Don’t use alone.
  - Mobile Overdose Prevention Site (MOPS): https://www.sunshinehousewpg.org/mops
  - National Overdose Response Services (NORS- virtual safe consumption): https://www.nors.ca/ or 1-888-688-NORS(6677)
- Provide education on the signs of overdose
- Talk over additional risks with injection
- Promote the use of Naloxone
- “Start low/go slow”
- Obtain opioids from licenced pharmacies or use drug checking services
  - https://streetconnections.ca/locations
  - https://www.sunshinehousewpg.org/mops
- Winnipeg Drug Alerts: https://streetconnections.ca/drug-alerts

(UBC, n.d. & Dr. Erin Knight, 2021 and 2023)

Benzodiazepines

Signs of Intoxication:

- Drowsiness
- Sedation
- Dizziness
- Loss of balance
- Confusion
- Disorientation
- Amnesia
- Respiratory Depression
- Depression
- Rarely- agitation
- Hallucinations and nightmares

Image Credit: www.choosehelp.com

(UBC, n.d. and CAMH, 2021b)

Benzodiazepines: Special Considerations and Harm Reduction

- “Benzo-doping” – using Nonmedical Benzodiazepines (NMB) purposefully along with opioids, stimulants or other substances to modify the high or cope with withdrawal.

- There is evidence that benzodiazepines are added to substances and consumed unintentionally or unknowingly.

- Three Key Concerns:
  1. The combination of benzos and opioids increases the risk of drug poisoning.
  2. Drug poisonings involving opioid-NMB combinations can be complicated to reverse. **Naloxone has no effect on the depressant effects of benzos.**
  3. Regular use of benzodiazepines can produce tolerance.

- Harm Reduction Recommendations: provide education on the potential risks, don’t use alone, and use drug checking services.

(CCSA, 2021)

Methamphetamine

Signs of Intoxication:

- Euphoria
- Energetic
- Heightened senses
- Reduced hunger
- Reduced need for sleep
- Increased self-control or confidence
- Increase in feeling nervous or agitated
- Tachycardia or bradycardia
- Pupil dilation
- Psychosis

(UBC, n.d. & Dr. Erin Knight, 2021 and 2023)

Factors Leading to Additional Risks: Meth

- Younger age at first use
- Amount used
- Schizotypal or schizoid personality disorder
- Genetic risk
- Polysubstance use
- Psychiatric comorbidity

**1/3 of patients with methamphetamine induced psychosis are diagnosed with schizophrenia within 5 years

(Dr. Erin Knight, 2023)

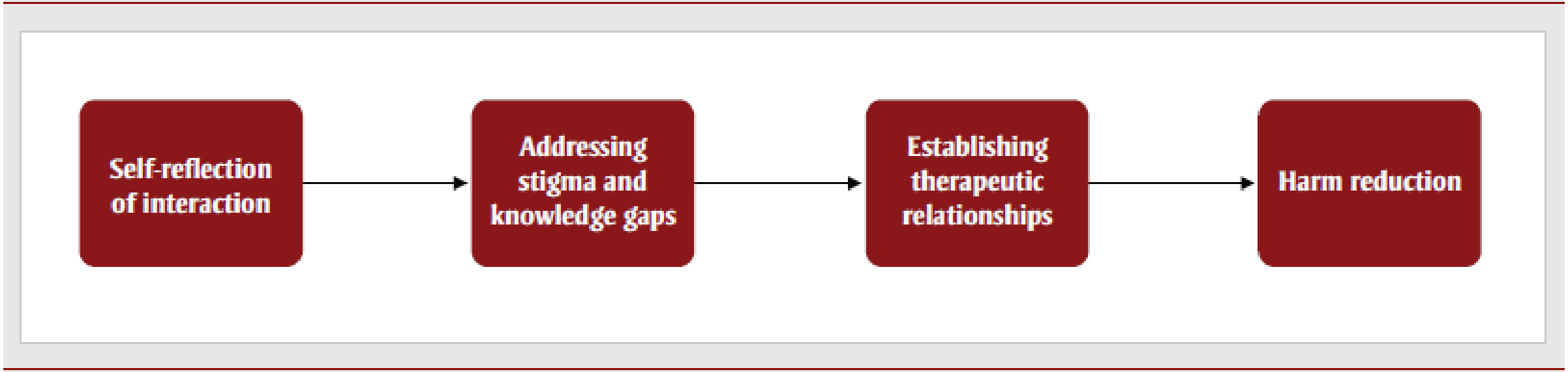
Harm Reduction Techniques: Methamphetamine

- Not using alone.
- Trying a smaller, test dose.
- Talk over additional risks with injection and encourage safer using practices. https://streetconnections.ca/
- Not mixing with other substances.
- Discussion of “rest or non-using days” to catch up on sleep.
- Eating food and drinking water regularly
- Maintaining good oral hygiene.
- Open discussion re: risks of worsening psychotic symptoms and increase of psychotic episodes with continues use.

(Dr. Erin Knight, 2021 and 2023)

Substance Use Harm Reduction in a Hospital/Health Centre Setting

FIGURE 2
Flow diagram showing the clinical implications of introducing and utilizing harm reduction strategies in the hospital setting



(Forchuk et al, 2023)

Additional Harm Reduction Training for Service Providers

1. **CATIE: Harm Reduction Fundamentals Toolkit.** “ This toolkit provides foundational information on harm reduction for service providers working with people who use drugs (including support workers, outreach workers, nurses and workers with lived and living experience)” (CATIE, 2024). https://www.catie.ca/harmreduction
2. **Manitoba Harm Reduction Network (MHRN) Workshops.** https://mhrn.ca/available-workshops
3. **Harm Reduction: LMS Module.** 60-minute online module will provide an overview of core concepts and principles of harm reduction with the focus on care relationships in the health care setting.
4. **Harm Reduction Educational Materials for Individuals:** https://orders.catie.ca/publications/prevention/harm-reduction

Mental Health Harm Reduction Strategies

Mental Health Harm Reduction

- Creating a mental health crisis plan with what the individual finds helpful/meaningful. Wellness Recovery Action Plan (**WRAP)**: https://www.wellnessrecoveryactionplan.com/what-is-wrap/

- Dignity of Choice: Encouraging people to choose which supports and resources **they** would like to utilize.

- Mental health promotion. Stress management, strategies to improve your mental wellness. **CBTm: https://cbtm.ca/**

((WRAP, 2024 and CBTm, 2024))

Mental Health Harm Reduction (continued)

- Reducing barriers. E.G. physical need being met, diet, restful sleep, physical activity, etc.

- Support System educated in mental health awareness.

  Examples:

  Mental Health First Aid (MHFA)
  https://openingminds.org/training/mhfa/standard/

  Applied Suicide Intervention Skills Training (ASIST)
  https://www.suicideinfo.ca/workshop/asist/

- Community Resources:

  https://sharedhealthmb.ca/services/mental-health/mental-health-and-wellness- resource-finder/

Are there some additional examples or resources that you can think of? Please share them in the chat.

Substance Use Withdrawal and Interventions

Activity: Alcohol Withdrawal and the Brain

- https://youtu.be/WhOvN5XoIgI

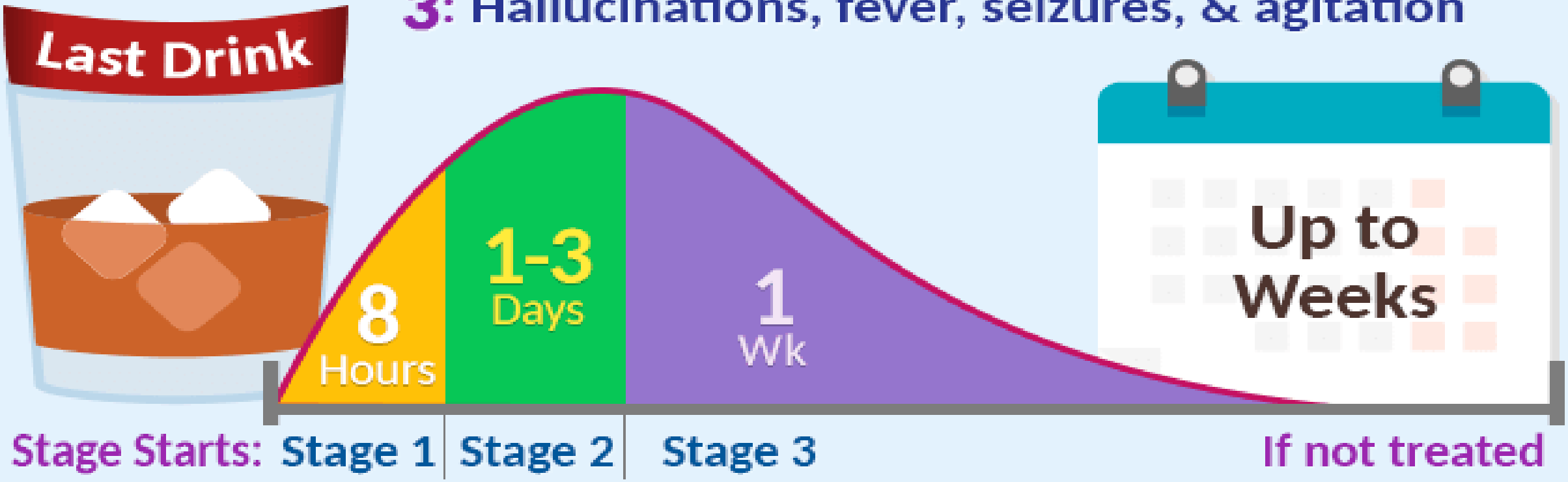
(Kattimani et al, 2013 and OMMS, 2013)

Alcohol Withdrawal Timeline

1: Anxiety, insomnia, nausea, & abdominal pain

2: High blood pressure, increased bod y temp…

3: Hallucinations, fever, seizures, & agitation



(Adapted from Dr. Knight and Dr. Poulin RAAM Knowledge Exchange 2021 presentation, Clarke et al, 2021, CAMH 2021a)

Infographic from: https://kansascityrecovery.com/alcohol-withdrawal/

Alcohol Withdrawal Management – Setting Considerations

Home Management – no history of severe withdrawal or complicating health conditions when office management is not feasible, individual is committed to abstinence. E.G. The Mobile Withdrawal Management Service (MWMS)

Office Management – no history of severe withdrawal or complicating health conditions, and setting allows for observation/monitoring

Withdrawal Management Centre – for individuals who lack social supports or safe housing and would benefit from monitoring and support E.G. Eaglewood or Main Street Project

Hospital Management – recent history of severe withdrawal, complicating health conditions, showing signs of severe withdrawal in office E.G. HSC Addictions Unit

(Clarke et al, 2021 and Klinic, 2024)

Benzodiazepine Withdrawal

"Withdrawal symptoms of benzodiazepines may be similar to the reasons why the drugs were prescribed in the first place.

The severity of withdrawal symptoms depends on the type of benzodiazepine used, the amount used and length of time it is used, and on whether the drug is stopped abruptly. (CAMH)

Dangers of abruptly discontinuing benzodiazepines: seizures, psychosis, delirium and hypertension.

(Clarke et al, 2021 and CAMH, 2021b)

Opioids

1. Withdrawal symptoms:
    a. Pulse
    b. Sweating
    c. Restlessness
    d. Pupil size
    e. Runny nose or tearing
    f. Tremor
    g. Yawning
    h. Gooseflesh skin
    i. Bone or joint aches
    j. GI upset
    k. Anxiety or irritability

Image Credit: https://www.choosehelp.co.uk/topics/detox/problems-with-rapid-opiate-detox

(UBC, n.d.)

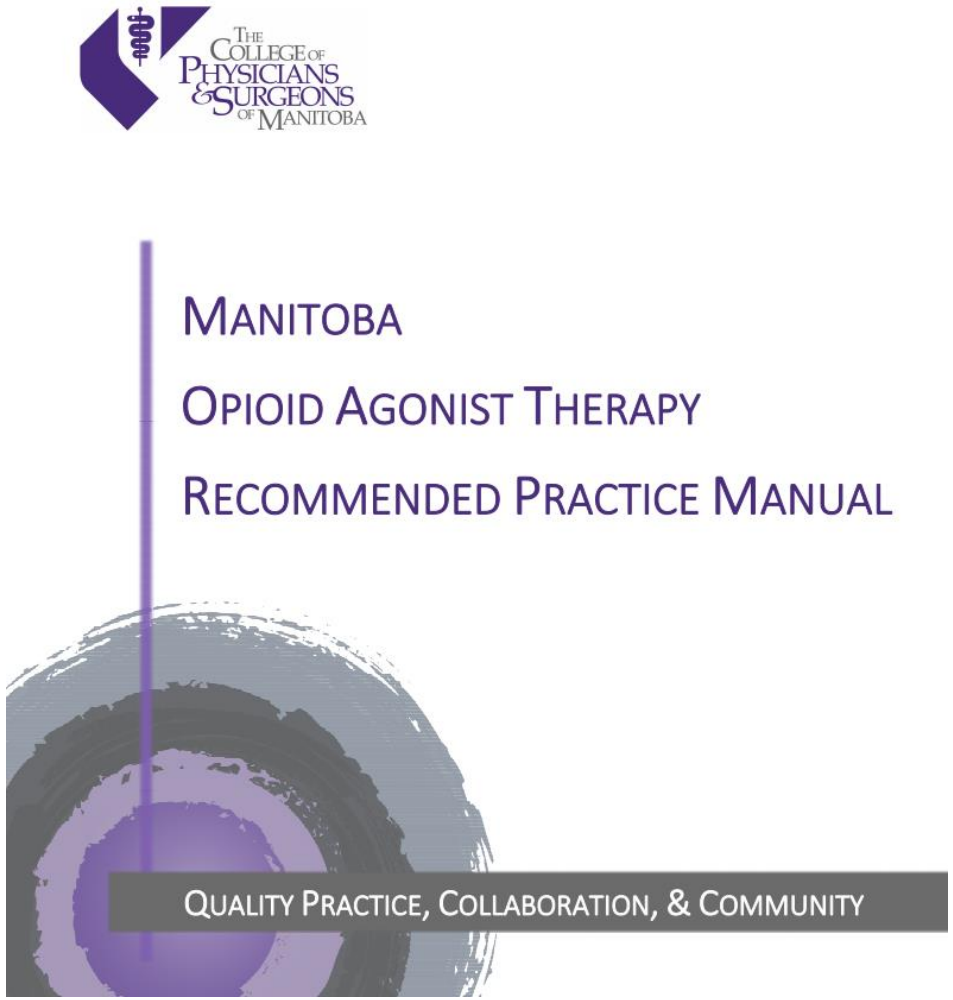
Opioids

Withdrawal Interventions:

- Withdrawal management or “detox” alone is no longer recommended as a treatment option for opioid use disorder.
- Instead, if individuals opt for “inpatient” withdrawal management, this time should be used to stabilize an individual on opioid agonist treatment (OAT).
- Many individuals with opioid use disorder, however, do not require an inpatient stay for a successful OAT induction.
- OAT treatment:
    1. Buprenorphine/Naloxone (Suboxone)
    2. Depot Buprenorphine (Sublocade)
    3. Methadone

(Clarke et al, 2021 UBC, n.d., and Dr. E. Knight, 2023)

OAT: Recommended Practice Resource



(Image and information from CPSM, 2023)

- "The manual is also intended to contribute to quality assurance in OAT practice, promote collaboration among professionals and with patients, and inspire continued growth of the OAT community" (CPSM, 2023).

- https://cpsm.mb.ca/prescribing-practices-program/manitoba-buprenorphine-naloxone-recommended-practice-manual

OAT Training for Service Providers

The *OAT 101:* This is an “in-person, interdisciplinary, accredited training program for physicians, pharmacists, nurse practitioners, nurses, and allied health professionals who wish to become involved in treating individuals with opioid use disorder in Manitoba” (CPSM, 2023).

Please contact your respective regulatory body for additional details about the application, training, & regulatory requirements to provide OAT in Manitoba.

https://cpsm.mb.ca/prescribing-practices-program/opioid-agonist-treatment-prescriber-training

(CPSM, 2023)

Stimulant Withdrawal Symptoms

1. Mild withdrawal
    a. Craving
    b. Feeling down
    c. Mood swings
2. Moderate withdrawal
    a. Fatigue
    b. Insomnia
    c. Hunger & thirst
3. Severe withdrawal
    a. Extreme fatigue – sleep ++
    b. Suicidal thoughts

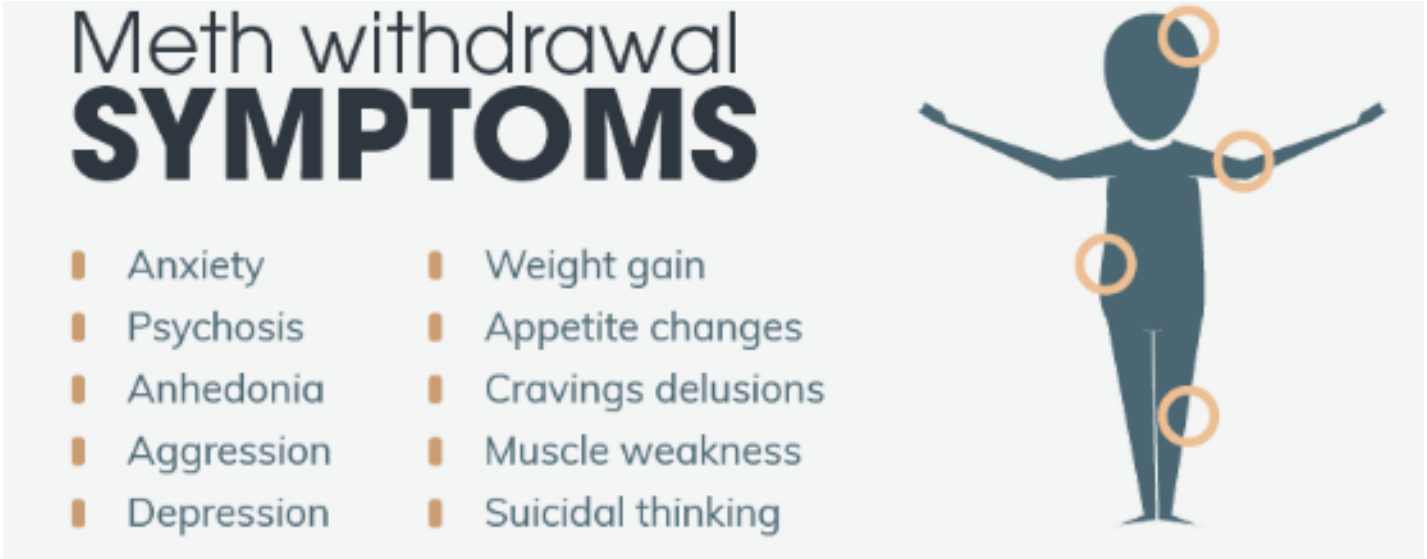


Image from: https://www.ashwoodrecovery.com/addiction-information/meth-addiction/

(Dr. E. Knight, 2023)

Stimulant Withdrawal Interventions

- There are **no specific medications** that have been shown to be effective at treating stimulant intoxication or withdrawal. **Treatment/Interventions are generally supportive** and can include:

  - Letting the individual know what to expect re: withdrawal symptoms
  - Asking what was helpful/not helpful during any previous withdrawals
  - Ensuring access to a quiet, safe place where they can sleep. Limit visitors.
  - Recommending adequate diet, rest, and increased fluid intake
  - Encouraging the person to monitor him or herself for symptoms of depression and, if symptoms persist, become severe or thoughts of self-harm occur, advise the person to seek urgent medical attention
  - Developing relapse prevention plan
  - Identifying key social supports and educate the family or carers about withdrawal

- In some cases, a person needs to be admitted to hospital in order to ensure their safety during stimulant intoxication.

(Jenner et al, 2008 and UBC, n.d.)

Harm Reduction and Co-Occurring Disorders

- “Individuals experiencing CODs are faced with the daunting task of balancing compounded, multiple issues, often resulting in deficits in life skill. The practitioner’s role is to provide support, resources, and strategies that meet the client’s various needs, dependent upon a number of factors, including safety, client identified goals, as well as internal and external vulnerabilities and assets” (Wamsley et al, 2014).

- Harm Reduction techniques can be utilized as:
  - As a tool for possible engagement in the change process. (E.G. when individuals are ambivalent about their use and/or making a change.
  - A temporary measure while managing and attending to other more pressing mental health symptoms. Abstinence may be the individual's ultimate goal.
  - As a means to find stability and relief from mental health symptoms (E.G. deceasing THC or Meth use to decease episodes of psychosis).
  - As a means to achieve a particular outcome or goal regarding their substance use (E.G. decreasing the amount of THC in their cannabis products).

(Wamsley et al, 2014)

Recovery Planning and Coordination of Services

Shared health
Soins communs
Manitoba

Objectives

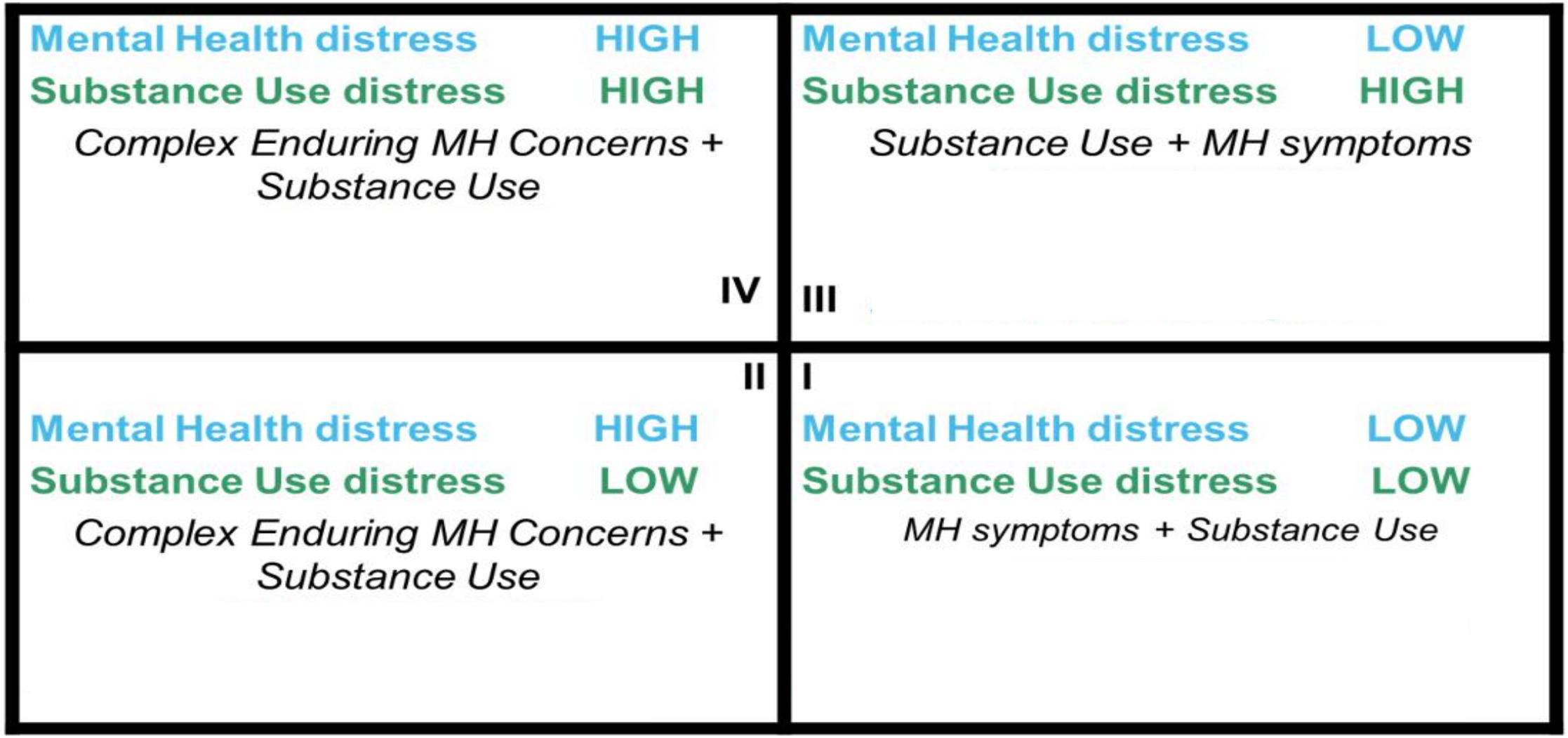
Review Co-occurring recovery treatment program types

Gain knowledge of integrated recovery planning (goals, elements, levels of services) and the importance of collaboration

Engage in reflection about our current practices and existing services and identify ways to incorporate elements of integrated care into recovery planning

Discuss concepts related to care coordination, barriers to coordination, and strategies to address barriers

Quadrants of Care



(Adapted from Manitoba Health – CODI Training 2005 and SAMHSA Tip 42, 2020)

Recovery/Treatment Program Types

1) Co-occurring capable

- Recovery focused in primary illness area (either substance use disorder or mental health disorder) but more advanced in treating individuals who have a co-occurring disorder that is deemed stable.

2) Co-occurring enhanced

- Higher level of integration of treatment, with staff competence in assessment of both disorders and providing integrated treatment of co-occurring disorder at the same time.

3) Complexity capable programs

- Aimed at meeting the needs of individuals (and families) with additionally complex conditions (physical, psychosocial) such as HIV, trauma, childcare or parenting difficulties, legal matters, homelessness, etc.

(SAMHSA TIP 42, 2020)

Recovery/Treatment Models

Recovery and Treatment can be classified into 3 Models:

1. Sequential or serial – ‘one at a time’ approach.
2. Parallel or simultaneous – treatment of both disorders but in separate systems.
3. Integrated treatment – interventions are combined within a primary service setting.

(Morisano et al, 2014; SAMHSA TIP 42, 2020; Urbanoski et al, 2017)

- **What has been your experience in receiving sequential/ “one at a time” (mental health service, then substance use support services)?**
  - “One at a time services, not great. My experience before [receiving integrated services] was a struggle. I was not seeing MH professional regularly, so I had little faith in therapy etc.”

- **What has your experience been receiving Integrated services (both mental health and substance use at the same time)?**
  - “[The team] gave me a “toolbox” and a team that continuously challenges me to be responsible and accountable. In my experience, treating **BOTH** is the most logical and successful way. For myself I feel fortunate and grateful, I have this program.”

    - *MJW, CODI Outreach participant*

Integrated Recovery Planning

1. An **integrated** recovery plan is developed with the person and their natural supports.
2. Involves consultation or collaboration with addiction and/or mental health services.
3. Coordinates with other health care services and additional areas of support (i.e. cultural supports, self-help group, etc.), and ensures basic needs are met (i.e. housing, source of income, food security, etc.)
4. One clinician or treatment team is identified as being primarily responsible for service coordination.

(Alberta Health Services, 2016; CCSA, 2019; SAMHSA TIP42, 2020)

Integrated Recovery Planning

Should Reflect:

1. The co-occurring disorders experienced by the individual.
2. Level of distress (quadrant type) and adaptable treatment options and lengths depending on need.
3. An Individual's phase of recovery or stage of change
4. ***Individual's needs and choice of goals & interventions.***

(Manitoba Health-CODI Training, 2005)

Goals of Integrated Recovery Planning

1. Meets the individual's needs in a timely fashion.
2. Actively engages the individual and their natural supports in the process.
3. Minimizes the individual having to navigate complex services.
4. Ensures treatment assesses the individual's needs from a holistic, strengths-based, and recovery-oriented approach.
5. Provides staff with shared knowledge and language for assessment and treatment options.

(Alberta Health Services, 2016)

Perspectives to Include in Recovery Planning

1. Person-centered
2. Trauma informed
3. Recovery-focused
4. Informed Consent
5. Evidence Informed practice.
6. Social determinants of health.
7. Motivation based treatment.
8. Cultural safety.

(Alberta Health Services, 2016)

Integrated Recovery Planning - Levels of Service Coordination

Consultation

- Informal relationships among providers related to identification, engagement, prevention and early intervention.

Collaboration

- More formal relationships among providers that ensure both problems are included in the recovery plan.
- Increased inter-system linkages and cross-training of staff.

Integrated Services

- Contributions from both fields are merged into a unified recovery plan, along with adjunct community and social supports.
- Recovery interventions are combined within the context of a primary treatment relationship or service setting.

(Manitoba Health CODI, 2005)

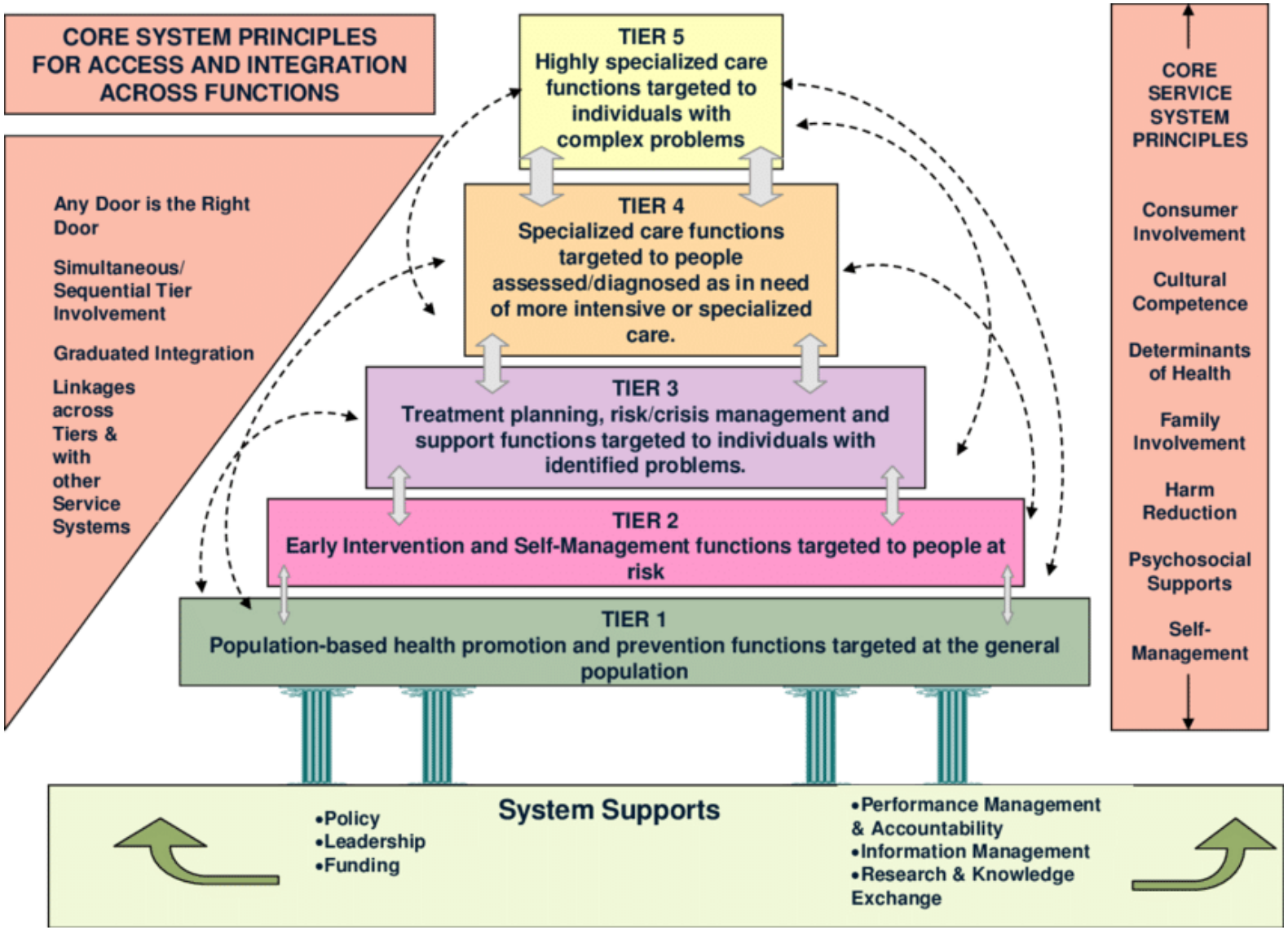
Integrated Treatment Planning – Levels of Service Coordination

1.

Mental Health distress HIGH **Substance Use distress HIGH** *Complex Enduring MH Concerns + Substance Use* ***INTEGRATION*** ***Mental Health Service System*** **IV**	**Mental Health distress LOW** **Substance Use distress HIGH** *Substance Use + MH symptoms* ***COLLABORATION*** **III** ***Addiction Service System***
II **Mental Health distress HIGH** **Substance Use distress LOW** *Complex Enduring MH Concerns + Substance Use* ***COLLABORATION*** ***Mental Health Service System***	**I** **Mental Health distress LOW** **Substance Use distress LOW** *MH symptoms + Substance Use* ***CONSULTATION*** ***Addiction or MH Service System*** ***(likely neither → Primary Care)***

(Adapted from Manitoba Health – CODI Training 2005 and SAMHSA Tip 42, 2020)

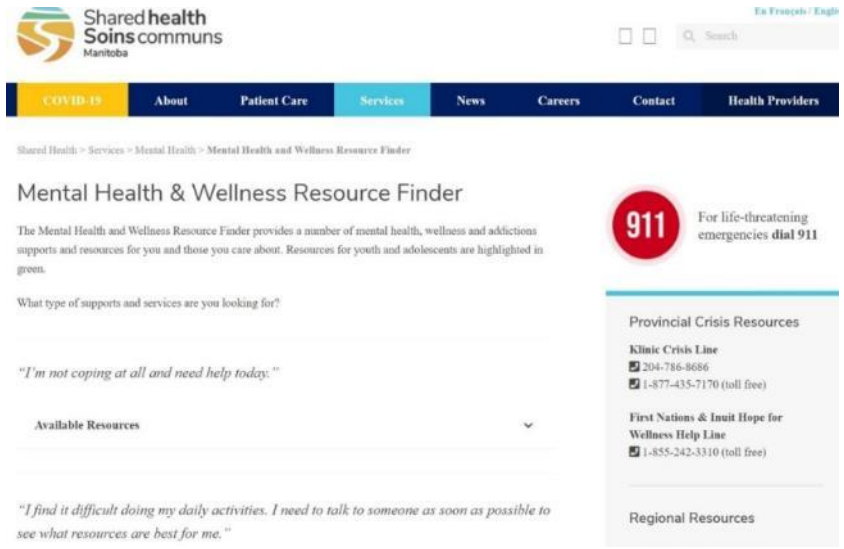
A Model of Collaboration – Stepped/Tiered

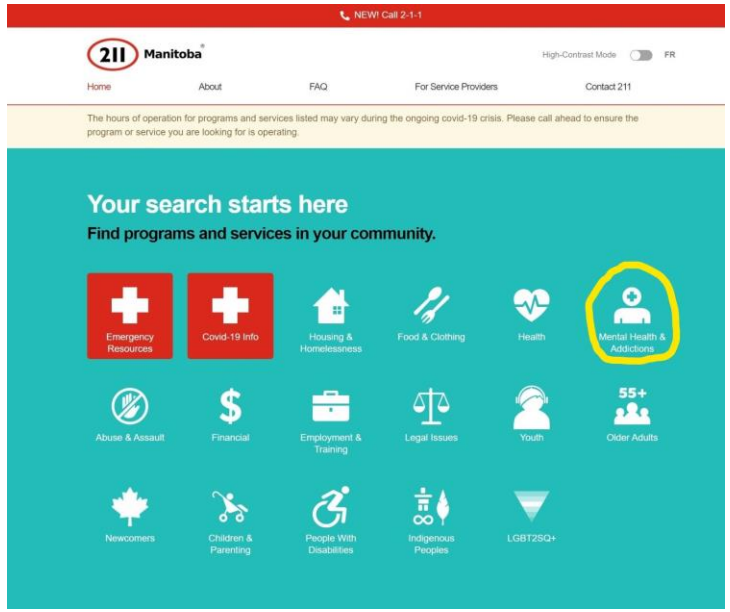


From Rush (2010) and Rush & Nadeau (2011), building upon the Tiered Model described in the National Treatment Strategy of the National Treatment Strategy Working Group (2008).

Activity: Envisioning and Achieving Collaboration Towards Integrated Care - Group Exercise

1. Take a few moments to brainstorm the programs, services, agencies or people that it would be beneficial to collaborate with for integrated treatment planning.
2. List the networks, programs, services, agencies or people with which you already connect.
3. Now list the networks, programs, services, agencies or people with which you know exist but with which you have not yet connected.
4. How could you connect with these areas?
5. Commit to re-connecting with one or two community partners selections you already have an established relationship with and reach out to one or two that you have yet to build a relationship with, but that you feel would help you better accomplish integrated treatment planning.





Knowing your Resources

- https://mbwpg.cmha.ca/
- https://sharedhealthmb.ca/services/mental-health/mental-health-and-wellness-resource-finder/
- https://mb.211.ca/
- Shared Health and Addictions MHA Library

Indigenous Health Resources

- Substance Use Treatment Centres for Indigenous Individuals: https://www.sac-isc.gc.ca/eng/1576090254932/1576090371511#a4
- Shared Health Indigenous Health https://sharedhealthmb.ca/about/community/indigenous-health/
- Indigenous Health WRHA Cultural Safety Resources: https://wrha.mb.ca/indigenous-health/cultural-safety-resources/
  - Indigenous Cultural Healing & Mental Health Supports
  - Health Navigation Supports
  - Education Opportunities

2SLGBTQ+ Health Resources

1. Two Spirited People of Manitoba Inc.: www.twospiritmanitoba.ca
2. Rainbow Resource Centre: https://rainbowresourcecentre.org/resources/health-resources
3. Trans Health Klinic: https://klinic.mb.ca/health-care/transgender-health-klinic/
4. Manitoba 2SLBGTQ+ Resources: https://rainbowresourcecentre.org/resources/organizations

https://www.edu.gov.mb.ca/k12/safe_schools/mygsa/lgbtq_resources.pdf

Newcomer Health Resources

1. Mount Carmel Clinic – Multicultural Wellness Program: www.mountcarmel.ca
2. Family Dynamics: www.familydynamics.ca
3. Immigrant Women's Counselling Service: Phone: 204-940-6624 or Email: iwcs@mts.net
4. Health Links: Phone 204-788-8200
5. Mental Health Resource Guide Winnipeg: https://mbwpg.cmha.ca/resources/mental-health-resource-guide-for-winnipeg/
   *it also has a section for Newcomers and Refugees

Tying it Together

Planning, Delivering & Coordinating Care

“The overall system of care needs to be seamless, providing continuity of care across service systems. This can only be achieved through an established pattern of interagency cooperation or a clear willingness to attain that cooperation”(CSAT, 2005, p. 42).

Clear System of Coordination

1. The individual receiving services knows who they are working with and why.
2. Staff are aware of all parties involved, including their roles and responsibilities.
3. Communication is open about information shared.
4. Service providers offer a consistent approach.
5. A coordinator is identified if required.
6. Contact in emergency situations is clear.

Transitions in Care - “Warm Handoff”

1. Introduce the person and family directly to the new referral agency (face-to-face or by phone).
2. Meet at the new office for a joint visit as the next appointment.
3. In-patient staff can introduce the individual to community providers before discharge, including having joint discharge meetings.
4. Encourage the person to ask questions, contribute and clarify information.
5. Spend time introducing the new providers and their role, highlight what they can offer to the person’s recovery.
6. Develop a collaborative relationship with partners.
7. Support the person until their initial visit.

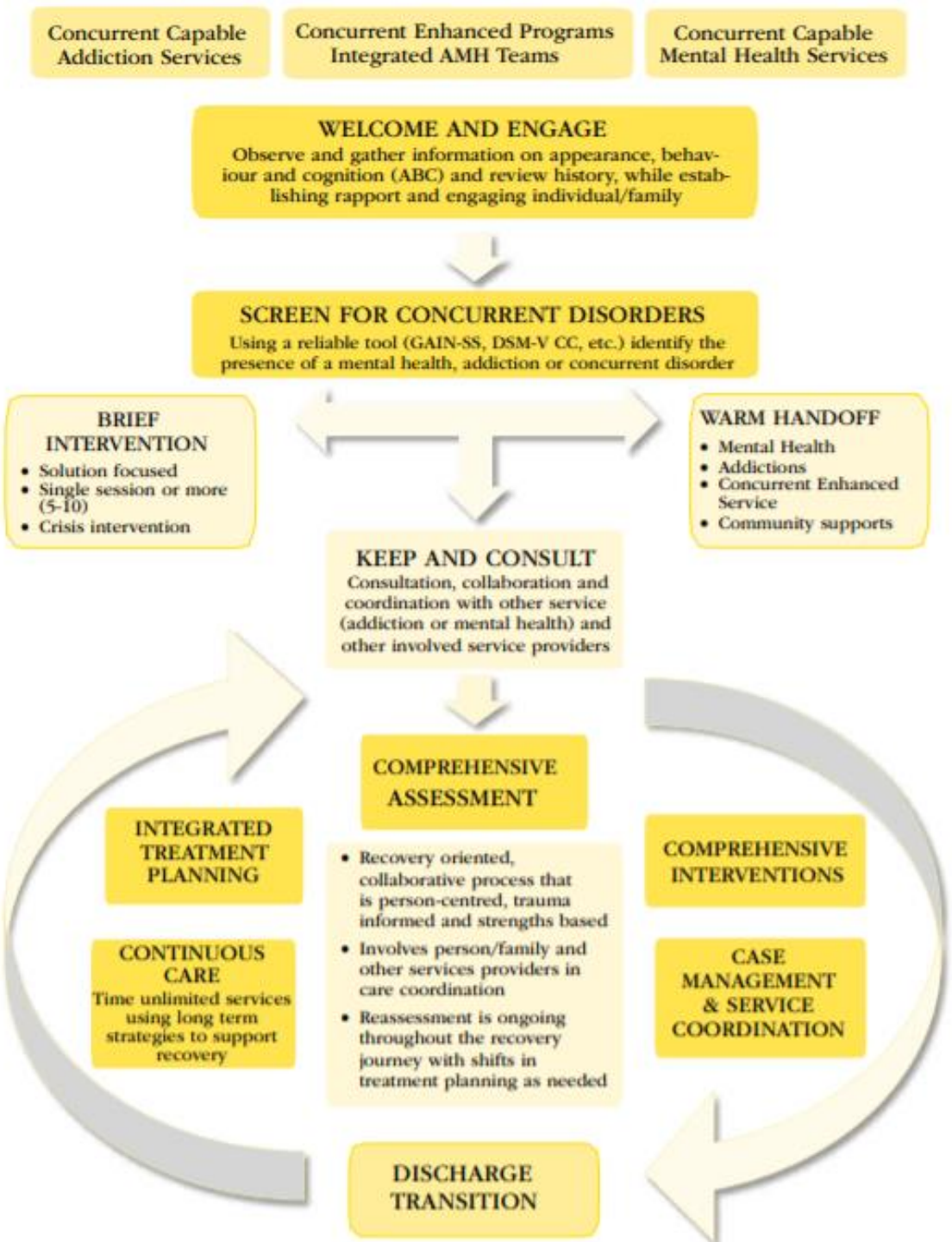
(Alberta Health Services, 2016/2020/2021; WHO 2016)

- **What has been your experience moving from one service to another, or accessing additional services/resources?**
  - Once I stopped “bouncing” between individual services [. . .] I found I could focus on my recovery and knowing that I have a team dedicated to helping me during the most difficult time in your life, empowers you.

- **Was there anything or anyone that made this transition easier?**
  - [The Doctor] never gave up on me, convinced me **I was worth saving**. [The therapist] has been a constant, which exactly what I needed in order to maintain my recovery. Ultimately a **TEAM** effort.

- *MJW, CODI Outreach participant*

Tying it All Together: An Algorithm for Concurrent Capable Practice



(Enhancing Concurrent Capability, Alberta Health Services, 2016)

Barriers to Coordination

1. Inequities in access and availability of key services
2. Lack of clear communication between services.
3. Lack of clarity regarding roles and responsibilities (what do each of the services offer and who does what/who is responsible for what).
4. Time constraints.
5. Lack of familiarity with evidence-based practice in this area.
6. Lack of belief or confidence in the value to be added by collaboration to coordinate care.
7. Attitudes, stigma and discrimination working with people with mental health and addiction problems.
8. Change management and policy/leadership support

(SAMHSA, Tip 42, 2020 and Collaboration for Addiction and Mental Health Care, 2014)

Ideas for Addressing Barriers to Coordination

For Participants (and providers!)

1. Including of relevant external service providers in case meetings.
2. Continuity, communication and partnership across providers. (including warm hand offs, information sharing)
3. Shared respect for individual and all their health needs (holistic).
4. Awareness and appreciation of barriers to coordination and the impact on individuals seeking services.

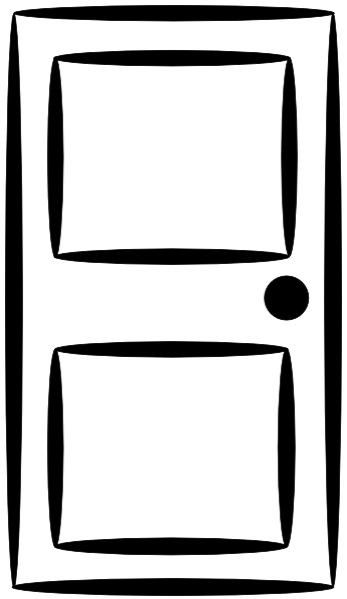
For Providers

1. Engaging in cross-disciplinary training and education
2. Build capacity for collaborative partnerships between services to provide integrated care.
3. Workplace that values and promotes service coordination
4. Engagement in leadership and system advocacy
5. Trying new ideas to improve care

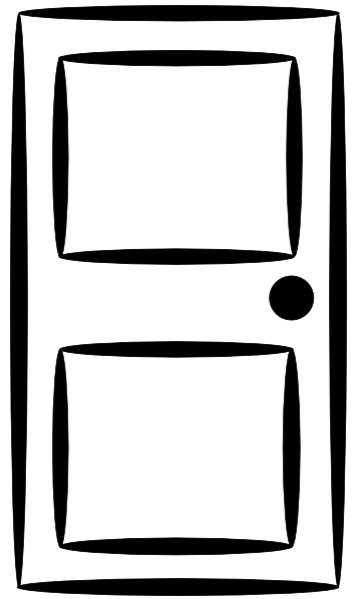
Final Thoughts on Coordination

A “no wrong door” policy should be applied to the full range of individuals with co-occurring disorders. Clinicians and programs can address obstacles that prevent entry to treatment for those with either a mental health disorder or a substance use disorder.

Mental Health



Addictions



(Manitoba Health-CODI, 2005 and SAMHSA, 2020)

Questions?

Wrap Up: Next Steps

- Thank you for your participation!
- Please provide feedback via the survey codes ---->
- To complete the course you must log back onto LMS and complete the **"Co-occurring Disorders Educational Curriculum (CODEC) Post-Training Knowledge Check - LMS-2079"**. If you successfully pass the quiz you'll be marked as attended and receive a certificate of completion