ADULTS EXPERIENCING MENTAL HEALTH AND ADDICTION IN PRINCE GEORGE

by

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Abstract

The aim of this practicum was to learn about adult mental health and addiction services available in Prince George, and to gain an in-depth understanding from practitioners on the addiction behaviors unveiled by adults. This practicum report describes the learning experience and the approaches used to familiarize with clinical skills and practice/counseling modalities of the CAST program offered by the Northern Health Authority (NH or NHA). The understanding and development of these clinical skills and counseling modalities has subsequently exposed me to other practice models used within Northern Health and has improved my personal professional practice, and the ability to provide mental health services to adults living with addictions.

This learning experience has not only enhanced my clinical skills, but also equipped the student for future clinical social work practices. The student is confident in her abilities to support patients to strive for emotional and psychological well-being and avert other challenges and disabilities associated with mental illness and substance misuse.
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Chapter One: Introduction

Equitable access for adults experiencing mental health and addictions challenges continues to be central to the health care policy debate in North America regardless of the remarkable efforts by several human rights organizations advocating for equity in care. Finding appropriate services for adults with mental health challenges continue to capture the attention of researchers and academic scholars for the past decade. However, psychologists have done tremendous work assessing both positive and negative outcomes associated with support systems for adults with mental illness (Mackay & Pakenham, 2012; Fitzell, & Pakenham, 2010). Previous research showed some concern over adults with mental health challenges. This concern raises questions regarding addiction, depressions, anxiety, substance use, panic attack, just to mention a few. While numerous studies have assessed people with mental illness, it is very limited to find studies addressing addictive behaviors of adults in Prince George.

Access and retention of mental health services is necessary as it enhances everyone’s well-being and is a critical factor for recovery of people with mental health challenges (Mental Health Commission of Canada, 2014; Mental Health Commission of Canada, 2012). Social and healthcare services directed towards adults faced with mental health and addiction had focused on deinstitutionalization, with an emphasis on independence and interdependence (Prins, 2011). The growing number of adults with addictive behaviors has apparently, however increased the need for social and health care services in Prince George (Public Health Protection, 2015).

With these growing demands, health care professionals including social workers, occupational therapists, nurses, psychologists and life skills workers continue to work with a priority to “assist people with serious and persistent mental illness and/or substance use and those at risk of developing serious mental health problems” (Northern Health, 2015). The goal is
to help their clients “achieve emotional and psychological well-being and prevent other challenges and disabilities associated with mental illness and substance abuse” (Interior Health, 2005). Acknowledging and developing community options and supports for people with mental illnesses and addictions will improve their psychosocial well-being.

As part of the support provided by these health care professionals, cultural sensitivity is required for the plan of care/treatment for people with mental illness (BC Ministry of Health, 2012, First Nations Health Authority, 2012). Cultural sensitivity should include information on gender, age, culture and ethnic background, as these variables will be useful for optimum care. Further, the language used to identify individuals experiencing mental illness and/or addiction disorders should be respectful, and not be indicative of societal stigmatization and discrimination. Yet there is minimal consensus on which term is most appropriate to use (Goldner et al., 2001). In one study, it revealed the term patient was preferred by a majority of the participants, and client was a second preference for both service recipients and providers. Furthermore, consumer and survivor are also terms commonly used by a few respondents in the study (Goldner et al., 2001). In light of this information, this practicum report used the term patient which is also commonly used in the Northern Health Authority (NHA) to refer to people challenged by mental health and addiction. The next section provides a description of my placement practicum.

Description of the Practicum Placement

The primary focus of this practicum was to learn about adults (19 years and older) and mental health and addiction services available in Prince George. This practicum student also gained an in-depth understanding from practitioners on the addiction behaviors unveiled by adults. Through this practicum, the student became familiarized with addiction services
including intake and assessment procedures and contributions to an improved societal and professional understanding of addiction. The student engaged in a supervised practice and gained additional clinical experience in adults' mental health and addiction services, and further engaged on one-on-one and group counselling. The understanding of these clinical skills and counseling modalities has subsequently exposed the student to other practice models used within Northern Health and has improved the student's personal professional practice, and the ability to provide mental health services to adults living with addictions. The next section briefly describes the settings, Prince George.

City of Prince George

The City of Prince George is located near the geographical centre of the province of British Columbia, Canada. To the reader who is not from this area, there may be an assumption that Prince George would be a central versus northern community in the province. However, being that the vast majority of the province's population resides within the Lower Mainland, many British Columbians consider Prince George as a northern city. The City of Prince George is the largest community in the northern half of the province of British Columbia (McGillivray, 2000; Initiatives Prince George Development Corporation and Northern Development Initiative Trust, [IPGDCNDIT], (no date). With over 84,232 residents (Statistics Canada, 2011), Prince George has etched out an identification of being named BC’s northern capital (Halseth, & Halseth, 1998; BC Heritage Branch, 2010). One could argue that Prince George is not only north, but central and south as well. Depending on one's lens, Prince George may also be considered either a rural community or an urban centre. The unique characteristics that make up the flavor of a city such as Prince George have an impact on how its community social services are run. The City of Prince George is the largest community in the northern half of the provinces of
British Columbia (McGillivray, 2000; Initiatives Prince George Development Corporation and Northern Development Initiative Trust, [IPGDCNDIT], (no date). The next section describes the Northern Health Authority, where my practicum was situated.

**Northern Health Authority**

Northern Health provides health services to 300,000 people over an area of 600,000 square kilometers, which is the northern two thirds of the landmass of British Columbia (Northern Health, 2015). The population of this immense region was estimated to be 323,316 in 2008, and grew to 326,566 by 2013 (Island Coastal Economic Trust, 2014). Northern Health promotes an integrated approach to service delivery (Northern Health, 2015). To achieve this aim, a strategic plan was developed in 2008 to incorporate a process for community accountability in a consultation program that helps to shape the operations and strategic direction of Northern Health (Northern Health, 2015; Public Health Protection, 2015). Northern Health’s ideologies are based on a model of excellence in rural health care. Following their mission statement, Northern Health plans to build and strengthen the health of communities, relationships, and all people in northern British Columbia. Its core values are centered towards commitment to improve the health of all the people of northern British Columbia (Northern Health, 2015; Public Health Protection, 2015). Northern Health is committed to providing, and continuously improving, a continuum of services for individuals and their families who are living with addictions and mental illness. The ongoing process of integrating services in keeping with *Every Door is the Right Door* is reflected in the services provided by Northern Health.

**Mental Health & Addiction Services**

Northern Health Authority’s Mental Health and Addiction Program was my area of practicum placement choice. This program provided a wide range of services to assist people
experiencing difficulties with mental health or substance use. The program is known to deliver high quality services in northern British Columbia with the intention to restore, promote and maintain well-being of all northern British Columbians. These programs are also structured to meet the needs of each person through all stages of life, including youth, adult and the elderly (Northern Health, 2015). The Northern Health Authority provides a wide range of Mental Health and Addiction services in a variety of community and residential settings. Services vary from short-term assessment and treatment through long-term programs for those with a serious and persistent mental illness and/or substance abuse problems. Programs are designed to help clients achieve independence and improve their quality of life. Mental Health and Addiction teams work in partnership with many community service providers to offer wrap around services that are client focused and provide a continuum of care. Within the Mental Health and Addiction Program, my placement practicum was situated at Community Acute Stabilization Team (CAST), described in the following.

**Community Acute Stabilization Team (CAST)**

Within mental health and addiction services, CAST provides integrated mental health and addiction services to adults 19 years of age and older who present with a variety of DSM IV (Axis I and II) diagnoses (Northern Health, 2015). Some of the services carried out by CAST address mood disorders, personality disorders, concurrent substance related disorders, bi-polar disorders, grief, adjustment disorders, OCD, PTSD and post-partum depression. These services are provided to individuals who exhibit psychiatric symptoms of sufficient severity to bring about significant impairment in their ability to function on a day-to-day basis (Northern Health, 2015).
Conclusion

Chapter one discussed briefly the growing needs for effective and efficient treatment for patients with mental illness and addiction striving to achieve emotional and psychological well-being. A brief description of City of Prince George, Northern Health Authority, and the student practicum placement were discussed. The next chapter discusses theoretical orientation for this practicum report.
Chapter Two: Theoretical Orientation

The theoretical influences on my practice are many. However, the guiding paradigm for this practicum was the anti-oppressive social work theory (Gil, 2013). This chapter provides an overview of some the theoretical orientation that the practicum site used in terms of mental health and addictions. Some of these discussions include both cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT) commonly used by the community acute stabilization team.

**Cognitive Behavioral Therapy**

Cognitive behavioral therapy (CBT) is known to be effective for many psychological problems; it is easily practiced, and is well received by clients (Parker, Roy & Eyers, 2003; Somers & Queree, 2007). CBT helps clients who are depressed, have anxiety disorder, suffer from substance abuse, and those with personal disorder (a person not able to cope with normal stress, having traits of behavior styles, and cannot establish a relationship with friends, families and co-workers) to achieve recovery (Parker, Roy & Eyers, 2003; Sensky, 2005). Further, CBT is very helpful with clients having emotional troubles, and those who conform that negative feelings are ways of life (Parker, Roy & Eyers, 2003; Sensky, 2005). To achieve the clients goals in a therapeutic alliance, the clinician listens, teaches and encourages clients to put into practice that which has been taught. Further, the expectation is for the client to show positive concern by putting what has been taught into practice (Deacon, & Abramowitz, 2004).

In the field of social work, CBT is a well-known practice theory. Some scholars define Cognitive theory as a “theory about the role (not the ontological exclusivity) of cognition in the interrelationships among variables such as emotions, behavior and interpersonal relationships” (Alford & Beck 1998, p106). This definition entails an entire range of variables of information
processing as well as consciousness of the objects and events that are known (pp.106).

Furthermore, Alford & Beck (1998) as cited in Anczewska, et al (2014), defines Cognitive behavioral therapy “as a psychotherapeutic approach that is designed to influence dysfunctional emotions, behaviors and cognitions through a goal-oriented, systematic procedure (p.2).

Anczewska postulated that CBT is known as an umbrella term used to share both theoretical bases in behavioristic learning theory and in cognitive psychology (p.2). The emphasis in CBT is to change patterns of thinking or behavior that are behind people’s difficulties and their feelings (Martin, 2010, p.1).

**Dialectical Behavioral Therapy (DBT)**

Dialectical behavior therapy treatment is a cognitive-behavioral approach that emphasizes the psychosocial aspects of treatment. DBT is an innovative method of treatment that has been developed specifically to treat difficult groups of patients in a way which is optimistic and which preserves the morale of the therapist (Read, 2013). The theory behind the approach is that some clients are prone to react in a more intense and out-of-the-ordinary manner toward certain emotional situations (Linehan, & Wagner, 2006). Such clients include those primarily found in romantic situations and family and friend relationships (Forbes, & Dahl, 2005). DBT theory suggests that some client’s arousal levels in such situations can increase far more quickly than the average clients, attain a higher level of emotional stimulation, and take a significant amount of time to return to baseline arousal levels (Read, 2013). Clients who are sometimes diagnosed with borderline personality disorder experience extreme swings in their emotions, understand the world in black-and-white shades, and appear to always be jumping from one crisis to another (Linehan, & Wagner, 2006). DBT is a method for teaching skills that help clients in this task. DBT is based on a bio-social theory of borderline personality disorder
(Linehan, & Wagner, 2006). There is an hypothesizes that the disorder is a consequence of an emotionally vulnerable individual growing up within a particular set of environmental circumstances which is referred to as the *Invalidating Environment* (Marsha Linehan (1998), as cited in Read, 2013).

An emotionally vulnerable person is someone whose autonomic nervous system reacts excessively to relatively low levels of stress and takes longer than normal to return to baseline once the stress is removed (Swals, 2010). It is proposed that this is the consequence of a biological diathesis. The term, Invalidating Environment, refers essentially to a situation in which the personal experiences and responses of the growing are disqualified or “invalidated” by the significant others in her life. Furthermore, an Invalidating Environment is characterized by a tendency to place a high value on self-control and self-reliance (Read, 2013). With DBT, the therapist actively teaches and reinforces adaptive behaviors, especially as they occur within the therapeutic relationship. The emphasis is on teaching clients how to manage emotional trauma rather than reducing or taking them out of crises (Swales, 2010). This next section provides an overview of a theoretical framework with an explanation as to why I am adopting an Anti-oppressive Social Work framework.

**Anti-oppressive Social Work Theory**

Anti-oppressive social work theory seeks to identify perceived social inequalities, understand the problems caused by those inequalities, and change or transform the social structures to rectify those inequalities. The means for this change is through the empowerment and emancipation of a group pursuant to increased awareness and critical reflection on the oppressive social structure (Mullaly, 2002). The stigma and oppression faced by adults with mental health and addictions can be viewed as a mode of human relations involving domination...
and exploitation (economic, social, and psychological) between individuals, groups and classes within the globe (Gil, 2013). Within a social work framework, the term “anti-oppressive practice” is commonly understood as an umbrella term that encompasses a variety of practice approaches that include but are not limited to radical, structural, feminist, anti-racist, critical and postmodernist frameworks (Dominelli, 2002; Graham, 2009).

Dominelli (2002) states anti-oppressive social work is a form of social work practice that addresses social divisions and structural inequalities, with a focus on strengthening client/worker relationships in the continuum of providing care. To this end, I will briefly explain my assumptions about the implications of the anti-oppressive theory for guiding the paradigm of this practicum report. Anti-oppressive theory speaks to my desires, and drives my purpose for research, work and life. Anti-oppressive theory, being about a social change, fits well with my desire to empower adults with mental health and addiction, and to make the world a better place for my fellow humans. I see pain and despair, inequalities and meanness, and I want to bring about comfort, happiness and peace to the world.

For example, I see authors demonstrating how and why mental illness and addiction causes cycles of violence and poverty (Carney, 2012; Canadian Mental Health Association, 2007). This fuels my motivation on the use of anti-oppressive social work theory and practice to bring about a change in behavior and attitude, with a better understanding of how to support adults with mental health and addiction. I am adopting the anti-oppressive theory because it challenges me to put into practice what I have learned and collaborate with friends and colleagues in order to make the world a better place for all humanity. Mullaly (2002) cautioned that the societal context is paramount to the understanding of oppression, and how the “psychologizing of what are essentially social problems contributes to oppression” and in this
case contributes to the challenges faced by adults with mental health and addiction... “placing the blame of personal troubles squarely on the shoulder of adults experiencing them” (p.66). This is a contextual understanding of how oppression is embedded in the experiences of adults with mental health and addiction.

Appleby (2001), paraphrasing another author (Pellegrini, 1992), provided an example of what oppression means, noting:

“Oppression is all about power: the power to enforce a particular worldview; the power to deny equal access to housing, employment opportunities, and health care; the power alternatively to define and/or to efface difference; the power to maim, physically, mentally, and emotionally. Racism, classism sexism, and heterosexism together form a system of institutionalized domination. Being oppressed means the absence of choices. Power thus defines the initial point of contact between the oppressed and the oppressor” (p. 37).

Within a social work framework, the term “anti-oppressive practice” is the most ideal model for working and/or supporting adults with mental health and addiction against the multilevels of oppression they live with. The anti-oppressive social work practice model aims to provide more appropriate and sensitive services to mental health and addictive adults by responding to their needs regardless of their social status. Appleby, (2001) also stated that anti-oppressive practice embodies a person-centered philosophy, an egalitarian value system concerned with reducing the deleterious effects of structural inequalities upon people’s lives. Additionally, Dominelli, (2002) and Bishop, (2008) contend that anti-discriminatory practice is a good practice and a approach to social work because it seeks to reduce, undermine, or eliminate discrimination and oppression, specifically in terms of challenging sexism, racism, ageism, and other forms of discrimination encountered in social work practice.
Conclusion

This chapter presented an overview of the meaningful insights of cognitive behavioral therapy and dialectical behavior therapy into the process and treatment for adults with mental health and addiction challenges. The anti-oppressive social work theory was also presented as the theoretical framework for this practicum report. This anti-oppressive social work theory and practice in terms of its ability empower clinicians to share their experiences and understanding of the challenges faced by adults with mental health and addiction. In addition, anti-oppressive social work theory aids the student and clinicians to be culturally sensitive and respectful to the needs and services provided to adults faced with mental health and addiction challenges. The next chapter discusses the literature review for this practicum report.
Chapter Three: Literature Review

This literature review provides the readers with an overview of some of the challenges faced by adults with mental health and addictions. Given that another goal of the practicum is to gain a rich and deep understanding of the addictions services available to adults, the review also provides a review of mental health services available to adults. The rationale for students to include a literature review in their practicum report was to demonstrate their knowledge level on the topic associated with their practicum placement. In Canada, within the last two decades, there have been several Canadian mental health studies conducted. Among these studies, the Mental Health Supplement to the Ontario Health Survey (MHSOHS), and the Canadian Community Health Survey (CCHS) have provided statistics on the prevalence of specific mental health conditions and information about access to mental health services across Canada (Statistics Canada, 2013).

Canadian's Mental Health

Many Canadians are impacted by mental illness at some time in their life. Mental illnesses usually involve alterations in mood, behavior and thinking, as well as other areas of mental functioning (Statistics Canada, 2012). According to Health Canada, mental illness is defined as alterations in thinking, mood or behaviour (or some combination thereof) associated with significant distress and impaired functioning over an extended period of time (Health Canada, 2013). Mental illnesses routinely cause significant impairments in emotional functioning, which may lead to social or physical limitations and may have impact on quality of life (Statistics Canada, 2012). Research indicates that 50% of people who are mentally ill seek professional help at some point in time and the majority of professional help is obtained from general practitioners (Lesage, et al., 2006; Vasiiliadis, et al., 2005). However, 14% of Canadians
who do not have a general practitioner find it difficult to access not only mental health services but general health services as well (Gagnon, 2004).

The prevalence of mental illnesses is greater among females than males and is highest amongst individuals between the ages of 15 and 44 (Statistics Canada, 2012). This latter information was based on hospitalization data only. However, a study by Denton, Prus, and Walters (2004) reviewed the sex ratios reported for mental disorders, and the authors found that almost all social structural and psychosocial determinants of health are generally more important for women, and behavioural determinants are generally more important for men. Therefore, the authors believed that gender differences in exposure to these forces contribute to inequalities in health between men and women. Further, they suggested the need to have a value of models that include a wide range of health and health-determinants in order to determine the importance of gender differences in health. Statistics Canada (2012) also found from the Canadian community health survey that the prevalence of mental illness and substance dependence was about the same between the sexes (11% women, 10% men). Therefore, there is still a great deal of discrepancy surrounding the prevalence of mental illnesses between the sexes.

Considering that the onset of mental illness frequently occurs in adolescence or early adulthood, there is potential for significant impact on the person, particularly in regards to education, career and personal relationships (Ehmann & Hanson, 2004). Not only is the individual experiencing the mental illness affected, family members are also significantly impacted (Health Canada, 2013). Family members often have to make difficult decisions regarding the treatment and course of action for their family member experiencing a mental illness (e.g. perhaps sending the individual away to another community for appropriate treatment), and may also be involved in long-term care for the individual (Public Health Agency
of Canada, 2010). Although, Davis (2003) states that some family circumstances (e.g. other children, employment, and finances) may prevent family members from fulfilling supportive roles.

Currently, most individuals affected with mental illness are treated within a community setting (Pollack & Feldman, 2003). Prior to the 1950s, policies and practices for caring for those with mental illness were vastly different. Individuals were treated primarily within a psychiatric hospital setting, often for an indefinite period of time. During the 1950s and 1960s there was a shift from hospital treatment to treatment in the community, a process referred to as deinstitutionalization or decarceration (Drake, et al, 2003). A number of factors contributed to this transformation in usual methods of care, including the introduction of psychotropic medications (Drake, et al, 2003), campaigns for more humane treatment of the mentally ill, and the fact that many hospitals were in dire need of refurbishment. However, Macnaughton (1991) argued that the deinstitutionalization process commenced “without the existence of adequate, accessible community supports” (p. 4). In Canada, the current method of care for treating people with a mental illness is community-based and, when hospitalization is required, the majority of patients (86%) are placed in general, not psychiatric, hospitals (Health Canada, 2013).

Following the Health Canada report (2002), the focus within the mental health care system was modified. A holistic approach to care is being implemented, including: education for service users and family members, community education, self-help/mutual aid network, primary and specialty care, hospitals, crisis response systems/psychiatric emergency services, case management/community outreach programs, and workplace supports. In BC, a specific mental health plan was developed for children and youth (Maddess, 2006).
Province of British Columbia (BC) Mental Health Reform.

In BC, mental health services are best delivered in an integrated system. Hospital and community services should also be unified to reflect this single system (BC Ministry of Health, 2011). Patients dually diagnosed with both alcohol/drug and mental health challenges should be treated within the Ministry of Health mental health systems (BC Ministry of Health, 2011). This proves that mental health systems work better in a particular geographical area when a centralized intake function is in place with appropriate administrative and high-level clinical support. High level clinical support may include the improved accessibilities such as a decrease in wait list times, and enhanced external scrutiny, resulting from exclusion criteria (BC Ministry of Health, 2011). Further, the shared model of care with family intervention will allow for improvement in the expert support available to family physicians. This shared model of care will establish liaison relationship between psychiatrists/psychiatric services and local family physicians. Furthermore, this shared model of care will integrate psychiatrists or other mental health clinicians in primary care offices. Overall, it is expected that this model will improve communication between the family physicians and psychiatric services designed to improve mental health care for clients (BC Ministry of Health, 2011).

Mental health services delivered in an integrated system are usually viewed as a single body or authority over the spectrum of mental health services across hospital and community for a defined area. This single body may require a single funding envelope for mental health services with a defined area, and resources are redistributed to where they are most needed. Further, referral and intake into mental health services are taken on a central point of entry, and there is always an ongoing collaboration with other ministries/services serving mental health clients (BC Ministry of Health, 2011).
Integrated services within the mental health system, creates an easy access to the mental health system for clients, families, and referring agencies. There is a great improvement in the implementation and coordination of crisis response within such integrated systems, and there is case management across the spectrum of mental health services. In addition, there is an improved continuity of care within a seamless continuum of mental health services and a great decrease in both duplication and fragmentation of services (BC Ministry of Health, 2011). The next section will discuss addiction.

**Addiction**

Addiction is simply defined as compulsive behaviors one is unable to stop despite the desire to do so (Robinson & Berridge, 2008). Addiction becomes a self-destructing relationship to the exclusion of all others. Like an invasive species, addiction moves through the psyche, impacting attachment patterns, drives, instincts and archetypes; undermining the will toward life force and replacing intimate relationships with a seemingly self-sustaining system that is strangled by isolation (Ellenbogen, et al., 2012). Addiction is a condition that reduces, and in a perverse way simplifies, psychic function, diminishing it to a tight, closed system. Paradoxically the treatment and conceptualization of the causes of addiction require a frame of mind that hosts complexity. Gabor Maté (2008), a physician and addiction specialist wrote:

“as we delve into the scientific research, we need to avoid the trap of believing that addiction can be reduced to the actions of brain chemicals or nerve circuits or any other kind of neurobiological, psychological, or sociological data. A multi-level exploration is necessary because it’s impossible to understand addiction fully from any one perspective, no matter how accurate. Addiction is a complex condition, a complex interaction between human beings and their
Neuroscientists and addiction specialists agree that certain traits are universally characteristic in all addictive disorders. For example, addictions to both substances and/or processes occur in gradations, and can be simply defined as the repeated use of a substance, or engagement in a process, despite the negative impact and desire to stop (Carnes et al., 2005). To explore these cross criteria and matching impact, Patrick Carnes (2004) introduced “the model of addiction interaction” (p. 31). Excessive behaviors in activities like gambling, shopping, eating, video games, or sex are behavioral addictions, which are equally as dangerous as chemical addictions because they typically remain hidden, tend to be conducted alone, and have no saturation point (Carnes et al., 2005). The inability to be satiated induces prolonged periods of helplessness and causes a higher suicide risk (Carnes et al., 2005).

Process and chemical addictions are frequently compared for similarities because it is common that one addiction leads to another or multiple addictions exist concurrently (Carnes, 2012). There is evidence on psychological impact across all addictions that manifests in the characteristics of denial, rationalization, depression, mood swings, obsessive preoccupation and attachment problems (Carnes et al., 2005). The conceptualization of various addictions being similar to one another, such as alcoholism and food addiction, took hold when neuroscience perceived the physical process in the brain (Carnes, 2012).

**How addiction occupies the brain.**

Neuroscience research demonstrates that an addictive mode impacts the same areas of the brain to varying degrees depending on the type of addiction (Carnes et al., 2005). This area, the mesolimbic system and brain stem, governs the reward circuitry and the instinctual centers (Carnes et al., 2005; Maté, 2008; Milkman & Sunderwirth, (2009) as cited in Warren, 2011), and
is located physically in the deepest part of the brain, the unconscious. *Meso*, meaning the middle (meso), and *limbic* the Latin word for border or edge (limbic). This part of the brain is associated with survival, “self-preservation and species preservation” (Warren, 2011), which translates to the majority of activity taking place in the instinctual centers.

The limbic system is also known as the emotional brain, and processes feelings. “For all their complexities, emotions exist for a very basic purpose; to initiate and maintain activities necessary for survival. In a nutshell, they modulate two drives that are absolutely essential to animal life, including human life: attachment and aversion” (Maté, 2008, p. 172). Addictions become compelling, ensnarled in someone’s life by engaging the pathways central to seeking and survival. Unfortunately these instinctual processes can become scrambled and imbalanced.

During addictive behaviors, there is usually a release of dopamine and endorphins which initiates and drives the pleasure-seeking behavior, creating a scenario worth repeating over and over again (Warren, 2011). Maté (2008) wrote about the effect of the neurological process on an individual’s psychology. In the process of addiction, the dopamine receptors are flooded, and therefore respond by actually reducing the number of dopamine receptors (p. 152). The low production of dopamine creates a depressed mood, irritability and desire to isolate. As a result, there is a lack of motivation. Depleted, the dopamine generation is now dependent upon an outside substance or process to regain production. “It’s a vicious cycle: [for example] more cocaine use leads to more loss of dopamine receptors. The fewer the receptors, the more the addict needs to supply his brain with an artificial chemical to make up for the lack” (p. 152). A powerful attachment to dopamine and the reward circuit can quickly shift occasional use into habits. Some addicts have low dopamine production to begin with, making them highly susceptible. Even if initially there was not a lack of dopamine production, the motivation system
is thrown off balance by addictive behaviors and the individual must look to substances and processes to restore or create drive (Maté, 2008, p. 152). Things that once seemed important fall to the wayside as the addictive relationship takes precedence.

**Addiction as an extinction archetype.**

An extinction archetype is an instinctual mode of behavior that is expressed through an archetypal manifestation (Dakin, 2010). Archetypes translate and organize affective or chaotic internal states which stem from instincts. The archetypal function is the means by which “the individual brings pattern and process to chaos, and it is the means by which the individual participates in those energies of the cosmos of which we are always a part” (Hollis, 2000, p. 7). As the expression of patterns and chaos, archetypes are distinguishable through a powerful resonance. For example, when one is in the presence of the archetypal field, one is full of terror like the biblical prophet who fears the Lord. “But this fear is more accurately awe” (p. 43). While Hollis’ statement is dramatic it provides a key characteristic, which is a pronouncement of expression when the archetypal level of the psyche is activated.

Like addiction, the forces of the unconscious are profound. This is because addiction is a disorder that originates on an instinctual level, and operates unconsciously, attuning to this deeper level of the psyche is central to treatment. Mate (2008) wrote, “My patients’ addictions make every medical treatment encounter a challenge. Where else do you find people in such poor health and yet so averse to taking care of themselves or even to allowing others to take care of them?” (p. 14). Addiction is an example of the compulsion inherent in instinct, formulated by Jung as the fascination that accompanies the constellation of an archetype (Dundes & Bronner, 2007). Archetypes represent the outward expression of the instincts (Jung, 1936/1975 as cited in Dundes & Bronner, 2007). For example, when someone is acting motherly what is visible is the
external presentation of the mother archetype organizing the maternal instinct. Jung, 1936/1975 as cited in Dundes & Bronner, (2007) wrote:

The instincts are not vague and indefinite by nature, but are specifically formed motive forces, which, long before there is any consciousness, and in spite of any degree of consciousness later on, pursue their inherent goals. Consequently they form very close analogies to the archetypes, so close that there is good reason for supposing that the archetypes are the unconscious images of the instincts themselves, in other words, that they are patterns of instinctual behavior. (pp. 43-44).

Archetypes are noticeable in someone’s presentation and affect. The “affective charge of archetypes, together with their propensity to manifest through portentous imagery, has led to their being turned to as one way to explain the phenomenology of the Spirit” (Beebe, Cambray, & Kirsch, 2001, p. 224). As Beebe et al. suggest, the spirit is powerful and has many faces. These internal patterns and energies can be personal or collective, conscious or unconscious. A conglomerate of memory, feelings and impulses, archetypes are a platform for the personality to express itself from an instinctual foundation (Corbett, 2007). The term extinction archetype emerged from the research of addiction. When engaged, addiction is a walk toward death, a powerful state of archetypal resonance. An extinction archetype encapsulates a mode of being hinged on withdrawal from thriving and an energy of decline. The extinction archetype is the translation of the death instinct (Dakin, 2010) through the mirroring of Freud’s (1920/1989) theory that the death instinct is the desire to return to stasis.
Recovery from Addiction

The term recovery is drawn from the fields of addiction theory and depth psychology, to explore the process of long-term recovery (Carnes, 2009). Addiction psychology examines what happens to the individual in the long-term recovery process, and how their life is rebuilt or developed for the first time (Dakin, 2010). Depth psychology focuses on the deeper, internal, psychic changes (Dakin, 2010). Research shows there have been sixty years of contentious literature in the depth psychology field pertaining to the treatment of addictions (Dakin, 2010; White, 2007). A study shows that depth psychologists have had challenging moments helping alcoholics disengage from the instinctual impulsivity through a rational, analytic approach. A theme of fighting pervaded the description of the treatment in place. If the client was not fighting the treatment, the psychotherapist fought conducting it. And if the psychotherapist agreed to conduct the treatment then there may have been a fight against adjunct programs like Alcoholics Anonymous (Brown, 1985). Therefore a new school of psychology developed known as addiction psychology.

Addiction psychology theory on the subject of recovery

The word “recovery” literally means to cover something that has been exposed, which succinctly fits with the psychoanalytic view that the unconscious drive process, otherwise known as the instinctual process, must be covered up in order for other aspects to be integrated into psychological processes (Solms & Panskepp, 2012). The drive process will outlast every other function of the brain, and become the most pronounced function if given the opportunity (Solms & Panskepp, 2012). Therefore, recovery is not only a covering of drive states and sequestering of the reward system. Further, it is the discovery and re-integration process of other unconscious aspects of the psyche. White (2007) defined recovery in the following way:
Dictionary definitions of recovery convey the process of retrieval—a return to a past state or the process of extracting valuable resources from seemingly unusable sources (Oxford English Dictionary, 2006). Such a definition fits the addiction recovery experience in the sense that something of great value has been drawn from the past addiction experience that potentially transforms those who were once a social problem into a valuable social asset. Recovery can also be depicted as a process of uncovering, or discovery—a movement into new, unexplored dimensions of one’s life (p. 238).

While there is a large behavioral component to recovery work, there is also an interpsychic process. Aspects of the self are discovered and developed. Psychological functions like impulse control, affect regulation, examination of internal states, and interpersonal skills are developed (Reiner, 2004). White (2007) addiction specialist and researcher, writes extensively on the topic of recovery. White’s research is influenced by his work with Native American cultures. In the article Addiction Recovery: White (2007) lays out the criteria for recovery. He stressed that as the epidemic of addiction grows the need for effective treatment models increases.

Inherent in this developmental process is an understanding of the various aspects of recovery, including the stages and types, as well as a standard definition of recovery. The “addiction field’s failure to achieve consensus on a definition of ‘recovery’ from severe and persistent alcohol and other drug problems undermines clinical research, compromises clinical practice, and muddles the field’s communications” (p. 229). White (2007) proposed a definition that focuses not only on the immediate sobriety of an individual but long-term “sustained recovery management” (p. 230). A comprehensive definition of recovery includes both religious
and nonreligious approaches, with or without treatment or medication, and can be applied to both severe and mild substance abuse (p. 231).

There is much to sort through when considering someone’s recovery. For example, is it a total recovery without “secondary” drug use, such as nicotine, or is there a substance substitution once the main substance or behavior is removed (White, 2007, p. 233). Recovery advocates must consider the individual’s overall relationship to addictive patterns. Continuing with secondary or substitute addictions often means engagement with psychological patterns surrounding addiction such as isolation, deceit, or defensive structures. However, “the resolution of addiction is often inseparable from the resolution of problems in which it is nested” (White, 2007, p. 234). This is trading one addiction for another, which can lessen the psychological symptoms but often does not fully restore instinctual balance. Therefore the word recovery implies someone disengaged from using addictive practices and they have begun to address the psychological implications of these processes.

Further, defining recovery in respect to personal character raises an important question: Why are changes of character applied to the definition of addiction recovery when no such changes are included in definitions of recovery from other health conditions? Recovery from any disorder is best measured within the precise areas affected by the disorder. In situations where severe substance use disorders are identified, recovery is defined in characterological terms because distortions in character mark the very essence of the addiction experience (White, 2007, p. 234). Therefore what must be recovered is a sense of values and relating to the self and external world in a respectful way. Recovery models, like Alcoholics Anonymous, encourage abstinence as well as developing relationships with others.
As identified by White (2007), a complete model of recovery should include addressing familial relations, self-care, monetary issues, cultural relations, and overall global functions, “physical, emotional, relational, and ontological (spirituality, meaning, purpose) health” (p. 234). White (2007) advised the process of recovery should be broken down into stages or types, clarifying if the individual is in partial or full recovery. Abstaining is not considered full recovery unless the surrounding global health issues are addressed (p. 234).

The terms full recovery and recovered are best reserved for people who were dependent and have sustained abstinence and enhanced global functioning for five years or more (White, 2007). Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life (White, 2007, p. 236). To do anything to an extreme would seem more a symptom of addiction than dimension of recovery (White, 2004). Recovery is seen as a state of balance. Radical recovery is “the discovery that changing oneself and changing the world are synergistic” (White, 2004, p. 3).

Carnes’ (2009) comprehensive recovery model is based on the posits that both addicts and co-dependents have a brain disease or “complex set of neural networks” that lead them to self-destructive patterns; the behaviors are compulsive and addictive, and eventually biologically habitual; there is addiction creep which leads the patterning to spread to other behaviors; willpower does not work in reversing the behaviors and decision making faculties become impaired. Destructive behavior takes weeks to shift in the brain, months to focus and make changes permanent, and years for the brain to heal; the underlying factors in early childhood,
trauma, genetics, grief, anxiety and brain damage must be addressed in a systematic way (pp. 2-3).

Reiner (2004) stressed that an important area to focus on in the therapeutic treatment of addicts is affect and behavioral regulation. Addicts must learn to experience their feelings in concept and thought rather than in action (p. 315). Carnes (2009) encouraged a model of psychodynamic and behavioral, and exercise the need involve in the development of spiritual practices. Carnes differs from many clinicians and researchers because he openly discussed his own experiences as an addict who supplied his writing with the subjective experience and perspective. Furthermore, Carnes viewed the addict as able to hyper focus like any other goal driven person, only the focus is on the object of the addiction. An essential task of recovery is to direct that ability to hyper focus in a positive direction, rather than addictive behaviors commandeering such a powerful potential of the psyche.

In addition, recovery is frequently initiated by a sudden event, referred to as a quantum change or transformational change (White, 2004). This change is brought on by a “quantum event” that is reported to be startling and outside of everyday mundane occurrences, and imbued with spiritual undertones. Also, it’s worthwhile to know that in recovery the amplified pleasure drive must begin to yield to conscious urgings, but this does not happen through consciousness itself. According to Jung, it happens through unconscious desires and yearnings too. i.e. the person must understand that both destructive and constructive drives exist within them, must assumes unconsciously and automatically that whatever comes out of him/herself—innermost desires, needs and interest—must be wrong or somehow unacceptable. While there are many models of addiction recovery such as solution focus, seeking safety, dialectical behavior therapy, the triad model, the addictions and trauma recovery integration model, cognitive behavior
therapy, 12 step model, but to mention a few. Among the many models used by Northern Health, I will discuss a brief overview of the commonly used model such as CBT, DBT and the 12 steps model in the next section.

**Cognitive Behavioral Therapy**

CBT is a short-term, goal-oriented psychotherapy treatment that takes a hands-on, practical approach to problem-solving (Alford & Beck 1998; Martín, 2012). Its goal is to change patterns of thinking or behavior that are behind people’s difficulties, and help to treat a wide range of issues in a person’s life, from sleeping difficulties or relationship challenges, to drug and alcohol abuse or anxiety and depression (Cuder, et al., 2004). CBT works by changing people’s attitudes and their behavior by focusing on the thoughts, images, beliefs and attitudes that we hold (our cognitive processes) and how this relates to the way we behave, as a way of dealing with emotional problems (Cuder, et al., 2004).

An important advantage of cognitive behavioral therapy is that it tends to be short (Alford & Beck 1998). Clients attend one session per week, each session lasting approximately 50 minutes. With CBT, the client and therapist are working together to understand what the problems are and to develop a new strategy for tackling them. CBT introduces clients to a set of principles which can be applied in a life time (Parker, Roy & Eyers, 2003). CBT can be thought of as a combination of psychotherapy and behavioral therapy. Psychotherapy emphasizes the importance of the personal meaning placed on certain things in life while behavioral therapy pays close attention to the relationship between our problems, our behavior and our thoughts (Somers & Queree, 2007).
History and Development of CBT

The origin of CBT goes back to the early 20th century. Behavior therapeutically approaches appeared as early as 1924, with Mary Cover Jones' work on the unlearning of fears in children. However, it was during the period 1950 to 1970 that the field really emerged, with researchers in the United States, the United Kingdom and South Africa who were inspired by the behaviorist learning theory of Ivan Pavlov, John B. Watson and Clark L. Hull" (Alford & Beck, 1998). In the 1960s, Aaron T. Beck, a psychiatrist, observed that during his analytical sessions, his patients tended to have an internal dialogue going on in their minds, almost as if they were talking to themselves. But they would only report a fraction of this kind of thinking to him (Marchand, et al., 2007). For instance, in a therapeutic alliance, a client might be thinking to him/herself: “He (the therapist) hasn’t said much today. I wonder if he’s annoyed with me?” Such thoughts might make the client feel slightly anxious or perhaps annoyed. The client may also respond to this thought with a further thought: “He’s probably tired, or perhaps I haven’t been talking about the most important things.” This second thought might change how the client was feeling. Beck realized that the link between thoughts and feelings was very important and he invented the term automatic thoughts to describe emotion-filled thoughts that might pop up in the mind (Marchand, et al., 2007). Beck found that people weren’t always fully aware of such thoughts, but could learn to identify and report them. Beck found that identifying these thoughts was the key to the client understanding and overcoming his or her difficulties (Alford & Beck, 1998).

Beck called this modality a cognitive therapy because of the importance it places on thinking. It’s now known as cognitive-behavioral therapy (CBT) because the therapy employs behavioral techniques as well. CBT has since undergone successful scientific trials in many
places by different teams, and has been applied to a wide variety of problems (Mantione, et al., 2014). Amongst all other methods used in treating disturbance disorders, CBT was proven more successful. CBT was able to treat depression, sleeping disorder, abuse disorder, and anxiety disorder (Deacon, & Abramowitz, 2004; Richardson, & Richards, 2006). The therapeutic approaches of Aaron Beck gained popularity among behavior therapists, despite the earlier criticism about their work. The next heading discusses dialectical behavioral therapy.

**Dialectical Behavioral Therapy (DBT)**

Dialectical behavior therapy treatment is a cognitive-behavioral approach that emphasizes the psychosocial aspects of treatment (Giesen-Bloo, et al., 2006). DBT is an innovative method of treatment that has been developed specifically to treat difficult groups of patients in a way which is optimistic and which preserves the morale of the patient (Read, 2013). In addition, DBT has being psychotherapy and a comprehensive program of care (Swales & Heard, 2008). DBT program provide multiple treatment modalities that address the key skills and motivational deficits presented by clients with diagnosis of borderline personality disorder (Forbes, & Dahl, 2005). Further, DBT programs provide skills training for clients, often in a group format; individual DBT psychotherapy, to help clients identify and solve problems in changing their behaviour; and treatment modalities to support generalization of the new skills beyond the treatment environment, most commonly by telephone coaching (Swales & Heard, 2008). DBT programs enhance the skills of therapists on the team and maintain their motivation to treat effectively by providing a mandatory weekly consultation team meeting where therapists receive supervision (Read, 2013).
History and Development of DBT

DBT was developed by Marsha Linehan in the late 1980s and early 1990s (Read, 2013). DBT was originally created for suicidal and actively self-harming patients with a history of multiple psychiatric hospitalizations who met the criteria for borderline personality disorder (Swales, et al., 2012). For about a decade, Linehan had used standard cognitive-behavioral therapy (CBT) approaches with this population but found certain aspects of CBT was unsuitable with clients (Swales, 2008). Further, Linehan noticed that therapists working with this population had a tendency to burn out; due to high demands, frequent stories of suicide attempts, urges to self-harm, and threats by clients to quit treatment (Swales, et al., 2012), as such many therapist were emotionally drained (Read, 2013; Swales, et al., 2012). In addition, Linehan realized that individual therapy was not adequate for treating high-risk clients and developed a multi-faceted approach that includes individual and group therapy, coaching and collateral contact between sessions, and group supervision and support for the therapists treating the clients (Adam, et al., 2014; Read, 2013). In line with a multi-faceted approach, Linehan hypothesized that a comprehensive psychotherapy needed to meet critical functions: a) It must enhance and maintain the client’s motivation to change (clients work collaboratively with therapists and are given a clear set of guidelines and boundaries for their behavior); b) It must enhance the client’s capabilities (through skills groups, phone coaching, in vivo coaching and homework assignments); c) It must encourage the generalization of the client’s newly acquired capabilities); and d) It must enhance the therapist’s motivation to continue therapy and also enhance their skills and abilities (e.g. through group consultation and “cheerleading” among co-therapists) (Linehan, 1998; Linehan, & Wagner, 2006; Swales, et al., 2012). There are four modules used in DBT, these are discussed as follows:
Mindfulness: These are essential parts of all skills taught in skills group. These mindfulness skills involve how to observe, describe, and participate. The questions that may arise are, “what do I do to practice core mindfulness skills?” and “how do I practice core mindfulness skills?” (Lynch, et al., 2007). To enable a therapist answer such questions, he/she must be non-judgmental, one-mindful and be effective in his/her approach (Giesen-Bloo, et al., 2006).

Interpersonal Effectiveness: This module involves the interpersonal response patterns taught in DBT skills training that are similar to those taught in many assertiveness and interpersonal problem-solving classes (Adam, et al., 2014). Interpersonal effectiveness module focuses on situations where the objective is to change something (e.g., requesting someone to do something) or to resist changes someone else is trying to make (e.g., saying no) (Read, 2013).

Distress Tolerance: Most approaches to mental health treatment focus on changing distressing events and circumstances. This module is mainly used by religious, spiritual communities and leaders to tackle mental health challenges. Distress tolerance skills constitute a natural development from mindfulness skills. It deals with the ability to accept a person, in a non-evaluative and non-judgmental fashion (Giesen-Bloo, et al., 2006). Distress tolerance behaviors are concerned with tolerating and surviving crises, and with the acceptance of life as lived (Lynch, et al., 2007).

Emotion Regulation: With emotion regulation, borderline and suicidal individuals are emotionally intense and labile – frequently angry, intensely frustrated, depressed and anxious (Lynch, et al., 2007). DBT borderline clients struggling with challenging emotions will benefit from the following emotional regulation skills: a) Identifying and labeling emotions; b) Identifying obstacles to changing emotions; c) Reducing vulnerability to the “emotion mind”; d)
Increasing positive emotional events; e) Increasing mindfulness to current emotions; and f) Taking opposite action and applying distress tolerance techniques (Adam, et al., 2014). The next heading discusses the 12 steps model.

12 Steps Model

A self-help model that understands substance dependence/addiction as a chronic and deteriorating disease and advocates complete abstinence from substance use as the preferred course of treatment. Developed by the founders of Alcoholics Anonymous (AA) in the 1920s, the model has since become the preferred approach by other addictions self-help groups (e.g., Cocaine Anonymous, Narcotics Anonymous) and the professional treatment community (Ferri, Amato, and Davoli, 2006). Alcoholics Anonymous is a model whose primary purpose is to help members stay sober, and to help other alcoholics. AA is the oldest and founding model of what practitioners commonly referred to as the 12-step program. Alcoholics Anonymous is widely accepted and provides a highly accessible support system and a structured program all over North America and some parts of the world community (Ferri, Amato, and Davoli, 2006).

However, critics of Alcoholics Anonymous argue that emphasis of “keeping what isn’t broken” has resulted in the model’s difficulty in embracing new developments in the field of addiction treatment (Harris, & Bowe, 2008). Some view AA as quasi-religion, while others feel excluded by the model which hasn’t significantly changed since the 1930s, because since inception, it constantly reflects the culture of predominantly white, privileged people, middle- or upper-class male America (White, 2007). Consequently, there have been concerns that incentive policies used to ensure that persons with alcohol problems are indoctrinated into AA are coercive in nature, and AA’s role in Canada’s corrections systems, clearly describing how the model’s culture and rhetoric do not fit First Nations traditions and that the model is viewed as a poor
replacement for traditional healing rituals that, typically continue to be denied (Reed, 2001). The next section will discuss mental health and addiction services in Prince George.

**Mental Health and Addictions Services in Prince George**

The discussions below highlight some of the community mental health and addictions services and program available in Prince George. The majority of the Adult Mental Health Services are offered by Northern Health.

**Intake Services**

This intake process enables a counselor to meet with the child and his/her guardian to determine what, if any, services are appropriate. If services from other service providers are deemed appropriate the client will be assigned a case manager. In some cases clients are informed that they may be put on a waiting list for services (Northern Health, 2015).

**Crisis assessment and management.** In some instances where emergency services are required (e.g. when a client threatens to harm him/herself or others), other service providers like Intersect will do an immediate risk assessment and determine an appropriate course of action (e.g. hospitalization, or referral to other community services) (Northern Health, 2015).

**Short-term counselling.** In such instances, counseling services are usually provided and may consist of six to eight sessions. Counselling may be individually or family based. This form of counselling focuses on the strengths that are present within the child and the family unit.

**Specialized assessment.** If psychological or psychiatric assessment is deemed necessary these services are available (Northern Health, 2015).

**Groups.** A variety of group programs are available in Prince George. For instance, Intersect provides parenting, anger management and social skills (Northern Health, 2015).
**Long-term counselling.** Considering some specific circumstances, counselling services over an extended period of time are required because of concerns surrounding the mental illness or possible environmental risks (Northern Health, 2015).

**Northern Health Mental Health Services**

The programs and services discussed below are based on the information available at the Northern Health website (Northern Health, 2015).

**Youth community outpatient service.** This program provides outreach to youth with co-occurring mental health issues and addictions through assessment, individual and group therapy, case management, life skills training, recreational activities and family support (Northern Health, 2015).

**Early psychosis intervention (EPI).** The EPI program provides assessment, treatment, case management, groups and medication management for individuals experiencing first break psychotic episodes, as well as individual, family and community education (Northern Health, 2015).

**Eating disorders clinic.** This EDC program provides assessments, consultation and treatment, as well as individual and family education and support for children, youth and adults with anorexia nervosa and bulimia nervosa (Northern Health, 2015).

**Community response unit (CRU).** This team acts as a screening unit for adults with mental health and addiction. Also, it can be seen as an entry point for Mental Health and Addiction programs, agencies and supports by facilitating referral and access to services. CRU provides brief assessments, short term supportive counselling and crisis intervention, in a variety of environments to meet the needs of the clients (Northern Health, 2015).
Community acute stabilization team (CAST). Within mental health and addiction services, CAST provides integrated mental health and addiction services to adults 19 years of age and older presented with a variety of DSM IV (Axis I and II) diagnoses (Northern Health, 2015). Some of the services carried out by CAST includes mood disorders, personality disorders, concurrent substance related disorders, bi-polar disorders, grief, adjustment disorders, OCD, PTSD and post-partum depression. These services are provided to individuals who exhibit psychiatric symptoms of sufficient severity to bring about significant impairment in their ability to function on a day-to-day basis (Northern Health, 2015).

Community outreach and assertive services team (COAST). This team provides service for adults living with a serious and persistent mental illness. A comprehensive treatment for adults is based on a Psycho-Social Rehabilitation model with a mental health or addiction diagnoses: Psychosis; Schizophrenia; Schizoaffective disorder; Bipolar I and II; Co-occurring Substance Related disorders; Developmental Disabilities above 70 (Northern Health, 2015).

Assertive community treatment (ACT). This kind of service target complex clients in the greatest need of ACT services. Admissions into this service are based on the program standards for Assertive Community Treatment. The service delivery model of ACT is client centered, recovery-oriented, and provided by groups of multidisciplinary mental health staffs (Northern Health, 2015).

Developmental disabilities mental health (DDMH). The DDMH program provides assessment, treatment planning, caregiver training and life skills groups to individuals with developmental disabilities and who meet diagnostic criteria for mental handicap with an IQ of 70 or below and who have a mental illness and/or a challenging behavior (Northern Health, 2015).
Acquired brain injury (ABI). This program provides neuropsychological assessment, case management, life skills training, consultation, individual and family support and education for people with an acquired brain injury (Northern Health, 2015).

Elderly services. This program provides services for people over 65 (or age related) with a new onset of mental health problems or whose mental health problems are being complicated by aging. Services include case management, substance abuse counselling, life skills program, supportive housing program, and adult protection services (Northern Health, 2015).

Adult addictions day treatment program (AADTP). This program provides a client centered approach to wellness. Further, it focuses on assisting individuals to achieve greater responsibility for their individual recovery, provides access to resources for on-going support and uses the harm reduction model to promote quality health and well-being (Northern Health, 2015).

Methadone program. This program provides methadone treatment services to individuals with drug dependency and offers individual counselling, education, support, and methadone treatment interdisciplinary case management (Northern Health, 2015).

Adolescent psychiatric assessment unit (APAU). This team provides services that include crisis stabilization, comprehensive psychiatric assessment, and brief treatment for youth who are experiencing serious psychiatric symptoms such as psychosis, disorder of mood, suicidal behavior or anxiety states. Usually, services are provided by a multi-disciplinary team which comprises of a psychiatrist, psychologist, nurses, social worker, family liaison, waitlist clinician, recreation therapist and school teachers, as well as other disciplines as needed (Northern Health, 2015).
Youth treatment center mental health and addictions. This program provides substance misuse management, detox and treatment, as well as mental health assessments for youth ages 13 - 18. Individual, family, and group support are also provided (Northern Health, 2015).

Adult psychiatric inpatient units. This program provides care to people certified under the Provincial Mental Health Act. The units offer a multi-disciplinary approach to care, and liaise with community services to ensure continuity of care when patients are discharged to the community (Northern Health, 2015).

Adult withdrawal management unit (AWMU). This program provides substance misuse management for adults through medical detox, integrated case management, family and community care management, education, recreational activities, and individual, family, and group support (Northern Health, 2015). The next section will discuss housing and homelessness.

Conclusion

This literature review offers an overview of the Canadian mental health services and the BC Mental health best practice reform. Additionally, it provided summaries of the mental health and addictions services, recovery, cognitive behavioral therapy, dialectical behavioral therapy, 12 Step Model, and mental health programs available in Prince George. The literature suggests that mental health and addictions clients in recovery desire to live in an environment that is open and non-judgmental. The need for such an environment is crucial for the development, health, and well-being of the adult experiencing mental health issues and recovering from addictions. The next chapter discusses the learning experiences from the practicum.
Chapter Four: Learning Experiences from the Practicum

This chapter describes the student learning objectives, the methods used in achieving these objectives, how these objectives were achieved, what was learned from the objective, and how the student incorporated what was learned into practice. This discussion centered mainly on adults (19 years and older) that are faced with mental health and addiction challenges, and who have come to seek services through the Northern Health Authority in Prince George.

**Learning Objectives**

1) To understand the policies and procedures of Northern Health as its relevance to the CAST Program

2) To develop clinical skills and abilities to competently complete assessments for the CAST program

3) To develop skills and abilities to competently undertake intake independently for the CAST Program

4) To gain a working knowledge of clinical assessment tools commonly used by CAST program

5) To learn about other existing programs within CAST

6) To gain clinical experience in adult mental health and addictions

7) To gain an increased knowledge and skills for effective interdisciplinary collaboration

8) To gain clinical documentation skills and experience

9) To practice and improve upon my one-on-one and group counselling skills
How Practicum Objectives were achieved

Different methods were utilized to achieve these objectives; reading and training, observation, discussion, and consultation. These practicum objectives were covered in the discussions below with no particular order.

**Reading and Training.** During the first few weeks of placement at CAST, the student was trained and reviewed recent reports on CAST, filed and documented clinical materials, and read relevant Northern Health policies and procedures. These documents gave the student an understanding of mental health, addiction services, and the BC Mental Health Act. Knowledge of all these documents has proven to be very useful to the student's practice. The policies and procedures, as well as report documents, guided the student practice within the CAST program. Whenever the student conducted intake and assessment with patients, and with the help of the written reports and CAST program documents, the student was able to do a proper assessment using the clinical skills identified in some of the CAST reports.

As a clinician, the student's role was to conduct intake and conduct assessments using the Mental Status Exam (MSE) to determine the mental state and capabilities of mental health patients. From the assessment conducted by the student, it was identified that these patients required counselling and group supports to help deal with mental health challenges. Also, the student identified the strengths of these patients and provided support (which was requested) to help deal with challenges. Many patients were referred to Adult Day Treatment Program.

Further, during the practicum, the student was self-trained on how to use the Synapse program. This self-directed tutorial program enables students and new employees to learn how to document clients' notes and review all important client documentation with NHA. The synapse program is a computerized charting system of all mental health clients who are being or have
been served by Northern Health. Synapse offers improved dialog between departments, results escalation, emergency department discrepancy tracking, radiologist peer review, and other utilities to enhance radiology workflow (Canadian Mental Health Association, 2006). With the student understanding of the CAST reports and documentation, and the synapse training, the student developed abilities to do the job effectively. This has influenced the student training, learning and clinical experiences in working with patients with mental health and addiction.

**Observation.** Observation as a method was used to understand how clinicians deal with patients in clinical settings. During the first few weeks of the practicum, the student shadowed with clinicians on site, collaborated with the interdisciplinary team within and outside the CAST program, observed their clinical skills in practice, and witnessed how they engaged patients in a therapeutic alliance. The student paid particular attention to their greeting styles, communication styles, self-awareness, use of power, empathy, and attentive listening skills. The student also observed how clinicians related to patients’ challenges within cultural, historical and broader socio-political framework. As the student continued to shadow on a weekly basis, notes were taken on how clinicians and patients involved family in the plan of care. In addition, the student observed how clinicians maintained communication with patients, identified patients’ strengths and barriers in achieving goals, and provided subsequent interventions and referrals. Throughout the student placement, a reflective journal of observations was kept with a view to regularly meet and discuss the student observances with the clinical supervisor.

The student attended clinical sessions where MSE was used severally. During these clinical sessions, the student observed the 10 parts to MSE. These 10 parts to MSE include: general appearance, behavior, speech, mood, affect, thought process, thought content, sensorium cognition, insight and judgment. The student learned how these 10 parts are used to determine
ment of patients. During the practicum, the student used these MSE as a clinical tool to conduct assessments with different patients. These MSE clinical tools ease the student caseload and increased her clinical skills with patients. Upon review of the student records and documentations by the clinical supervisor, feedback showed that the student has gained competency to conduct an intake independently and has become knowledgeable of the assessment tools used by CAST program.

While in training and observing the use of synapse by other clinicians, the student became knowledgeable of the information and records of patients as to why they were referred to CAST. This synapse training and observations have also exposed the student to the rules and regulations pertaining to patients' files and confidentiality matters as well as the expectations from the CAST unit. The student has gained knowledge of how to input patient attendance, waitlist a patient, admit a patient to a unit, chart after therapeutic, discharge and follow-up, no show on appointment, cancellation of appointment, and rebooking of a patient.

Additionally, the student observed, shadowed and eventually co-facilitated a session in Adult Addictions Day Treatment Program (AADTP), where the student collaborated with the interdisciplinary team and asked questions regarding program operations, roles and contributions of every team member. The AADT program was designed for 18 weeks for adults harmfully involved in alcohol, drugs, and/or gambling. The program promoted a safe and supportive treatment environment through relaxed, non-judgemental and conducive environment for individuals and groups to nurture and grow. Upon a completion of the AADT program, patients may be discharge and/or may be referred to Community Based Services in their own community for follow-up. The AADT program was coordinated around respect, patients’ involvement in decision-making and goal settings. The student also attended a self-esteem program that was
coordinated by the clinicians. During this program, the student collaborated with the clinicians and observed how the facilitator communicated respect with patients, how patients were empowered to make decisions regarding their lives, norms, and activities, and how these decisions were taken into consideration. Following all these observations and shadowing, the student gained experience, knowledge and skills for effective interdisciplinary collaboration and clinical documentation.

Based on the clinical skills acquired from shadowing, the student was able to run a self-esteem group session for nine weeks. For example, in one of the sessions the student was able to assist a married couple which had low self-esteem for each other. Based on the skills acquired from shadowing, the student was able to engage in practice wisdom with the idea of helping and/or supporting this couple to improve their self-esteem and positive thoughts. The student empowered the patients to identify times when they had displayed various different positive qualities.

For example, the student asked them to write on a piece of paper about a time they had showed courage, selflessness, love, sacrifice, wisdom, happiness and determination towards each other. The purpose of asking them to do this activity was to help remind them of their positive potentials and being able to compliment each other. The student then sent the couple home with the list they had written down as a sign of a positive reminder. After the group session, the student received a feedback from the multidisciplinary team regarding my approach to the group. From the observation and shadowing process, the student was also able to gain an understanding of one-on-one, group dynamics and clinical skills used in a therapeutic alliance.

**Discussion.** During the practicum, the student held several discussions with the clinical supervisor and other team members in order to familiarize with the counseling modalities and
clinical skills used at CAST. During shadowing with different clinicians, the student asked specific questions to each case, and brainstormed with the clinicians to know possible ways to overcome barriers and triggers that may arise during counselling. This approach best guided the student practice when assigned some caseload.

**Caseload One**

The student had a patient who was addicted to alcohol, worried over her age and was very concerned over her 15-year-old child. This patient came into NH mental health and addiction services through drop-in hours (meet and grief), and was assigned to the student.

The student did initial intake by looking for identifying information. For example, name, age, sex, race/ethnicity, education level, religion, occupation, presenting problems and history of complaints, past medical history, psychiatric history, medication, etc. After the initial intake, the student conducted an assessment to determine the level of risk (low, medium, high) involved with this patient. For example, the patient was given the Burns Inventory Sheet (BIS). The BIS is an assessment tool given to this patient to scale how much she had experienced each symptom during the past week. These symptoms may include thoughts and feelings of self, activities and personal relationships, physical symptoms and suicidal urges. Upon completion of the intake and assessment with this patient, the patient and the student agreed to set a weekly goal in order to address some of the presenting problems. As identified by the patient, the need to stop alcohol usage was a priority. In our therapeutic session, the student asked the patient a few questions; **why is alcohol a concern now? How long is this addiction been a problem? Are you or other family members suffering from what is happening?** The patient stated she was aging and would not want to give up her only daughter to the Ministry of Children and Family Development as a result of her addiction. The student also asked the patient, **what would you do differently to make**
a difference? The purpose for asking these questions was to enable the patient to explore and access her positive assets to make a change. In response, the patient suggested cutting down her alcohol usage, usually she claimed to consume 10 - 12 bottles of beer per day and may use other substances. However, the patient did not identify what kind of substance she uses, but stated that this substance is already in control and has not been used in the last six months.

Following the patient’s suggestion, a weekly goal was set to support her cut down on usage. The goal was to cut down to 6 bottles of beer per day. On the second session, the patient reported some challenges with regards to the goal, and the student appreciated the patient’s effort and encouraged her by identifying her positive strength (“you are a strong woman, I see the strength in you and the love you have for your daughter”) and the courage to seek help. Subsequently, other goals were set to reduce the amount and days of usage. In all these sessions, the student used encouragers (head nodding, positive facial expression, uh-huh); paraphrasing (you feel much better after attending the session); summarizing (from what I am hearing, you stated drinking at your teen age), and avoided judgmental (you are the cause of your addiction) statements. These skills were used to ensure as follows: to prompt or encourage the patient to continue talking; to reflect back to the patient with her important details; and to restate back the patient’s comments as accurately as possible.

At the end of every session, the student provided the patient with the BIS assessment tool for weekly reassessment. This enabled the student to scale and track the current risk level to determine the progress made by the patient during that week. Upon completion of the therapeutic alliance, the patient had reported of the progress made and how she felt about herself and motivation to meet her priorities. A BIS was also administered to track and confirm that the patient has met the priority that brought her to CAST. Upon completion of the therapeutic
sessions and the progress observed through assessment tools and student observations, the student proceeded with a discharge summary. For example, the student logged back into *synapse* to document the presenting problems that brought the patient to CAST, how goals set were met, and current level of patient risk. Afterward, the patient file is closed.

**Caseload Two**

This second caseload discusses a patient who was addicted to alcohol as a result of social phobia or social anxiety. The patient constantly witnessed fear and was unable to visit anywhere there was crowded. The patient depended on alcohol before visiting such places. Upon seeing a physician, the patient was referred to the CAST program for counseling. At the CAST program, the patient was assigned to the student who conducted the intake and assessment in the order that was previously discussed in caseload one. The student and the patient reviewed the confidentiality guideline, attendance policy and collaboratively worked on a treatment plan. In addition, the patient set up goals to achieve during the entire therapeutic sessions.

The student administered to the patient different assessment tools like Burns Inventory Sheet, The Feeling Wheel, and Dairy Card to scale experiences, urges, feelings and thoughts during the initial assessment and weekly follow-up sessions to determine changes that have occurred. After the initial session, the student researched on social anxiety disorder to have a deeper understanding of the disorder. This social anxiety can be described as an intense fear in one or more social situations, which may cause distress and impaire one’s ability to function, at least in some parts of daily life (Deacon, & Abramowitz, 2004).

Goal setting followed the assessment. The student supported the patient to set some *SMART* goals, which can be measurable, achievable and reliable within the time boundry. These goals included: Patient to visit the mall once a day between 12 noon and 2:00 pm; and patient to
visit the Family Resource Centre (FRC) to socialize and engage with new moms (nursing mothers). Within the first few sessions, the patient reported witnessing fear but was able to spend an hour each both at the mall and FRC. The student used clinical skills to empower the client to continue on this great path. Such clinical and empowerment skills included: asking the patient to look at other people and the surroundings (not to focus attention on herself); listening to what was being said at public places visited (not to her own negative thoughts); and that to be silent or not contributing to conversation is okay (let others contribute, it is okay to be an active listener).

The skills really helped this patient to limit all focus from self and negative connotation, and begin to develop new coping skills. As the patient continued to practice these skills, the student provided support and advised the patient to engage in a baby step. For example, it may seem impossible to overcome a feared social situation but encouraging the patient to start with a small situation that she can handle and gradually working her way up to more challenging situations. The rationale behind this was to build the patient’s confidence and coping skills rather than depending on alcohol to overcome fear.

The patient also continued to make progress in her visitation to the Mall and FRC but still complained of fear. The student adapted another skill by asking the patient to identify an outgoing friend who she is comfortable with, and request to go with her to Mall to reduce her fear or anxiety. The student realized that socializing with strangers could cause fear or make one anxious but accompanied by an outgoing friend could make the patient comfortable with the baby steps. The clinical practice with the patient had exposed this student to lots of skills, and experiences that empowered the student to engage in research to meet the needs of the patient. The student understands the need for a relaxation group to teach coping skills like breathing exercises and relaxation techniques to control physical symptoms of anxiety. As explained
above, the student has learned how to support patients to think positively by exploring their unused positive assets to challenge negative and unhelpful thoughts that may cause fear or anxiety. The student has also learned that avoidance and isolation cannot stop fear or anxiety, but facing such situations with a baby step approach can overcome fear. Further, brainstorming with a clinical supervisor helped the student to understand that medications may relieve symptoms of social anxiety but may not cure the disorder. Furthermore, the symptoms may return with the withdrawal from the use of medication, and medication maybe most helpful when used alongside therapy and other self-help techniques to address the causes of the disorder.

Following the effort to brainstorm/debrief with clinical supervisor and other clinicians, the student was able to give specific answers to questions asked by the patient during counseling. Also, this process has taught the student the need to assess the patients’ file (if there are any) before meeting with him/her. The idea of reading up the patients’ file prior to the counselling session exposed the student to the “best practice” approach available to the patient. This process also ensures that the student is knowledgeable of the presenting problems and what was done previously. For example, on the NHA synapse system, the student logged in and reviewed the patient file prior to the session. The student paid attention to the history of the patient, reviewing both past and current details on the file, identifying triggers, cultural issues and concerns, best treatment, support network, family involvement and what worked in the past with the patient. This helped to increase the student knowledge of the patient, their culture, vulnerability, environment, living conditions and how to provide culturally relevant assessments and interventions.

Other discussion arouse from the use of Dialectical Behavior Therapy (DBT) in a group session the student co-facilitated for weeks. This group involved patients that have severe and
persistent mental illness, or patients that have multiple diagnoses that require significant number of services to maintain their current level of functioning in the community. The DBT group was held on a weekly basis with standard clinical topics like: mindfulness, interpersonal effectiveness, radical acceptance, emotion regulation and distress tolerance skills.

**Case load Three**

In a co-facilitation session, the student used mindfulness in working with a patient who was very frustrated about her partner. The patient was made aware of her thoughts, feelings, and body sensations, by asking the patient *how* she was feeling. This was done in a non-judgmental way, i.e. not blaming the patient for having such thoughts and feelings toward her partner. In this situation, the main reason to avoid judgmental statements (Why will you do something of such? Do you have such hatred for your partner?) was to eliminate triggers, behaviors, and feelings that may potentially affect the patient. Further, the student validated the patient's statements by saying, "it is okay to have these feelings, thoughts, and body sensations", as it is much more helpful to notice and/or identify such. Then the student supported the patient to choose where to put her focus and how to cope effectively, even if the stress may not go away. Where to put her focus implies: that the patient needs to reflect back on the good times and happy memories shared in the past years as a couple, and to make positive connections from those moments.

In this group setting, patients were required to complete home practice assignments in which they practice the skills taught during the weekly group. For example, the patients having challenges keeping effective relationship were given a practice guideline as homework to help deal with their challenges. In this guideline, patients were always asked to remember the acronym "GIVE" meaning Gentle, Interested, Validate and Easy Manner. This is further explained below.
Gentle or (be) gentle implies that the patient seeking an effective relationship must be courteous and temperate on his approach to others. The patient stays away from attack either through verbal, physical, clenching fist, and/or expresses direct anger. Also, the patient stays away from threats such as manipulative statements, hidden threats, and "I will kill myself" statements. The patient should avoid blaming or judging others, and should avoid statement like “if you were a good person, you would...,” “…Or you shouldn’t...”

Interested or (act) interested denotes that the patient should listen and be interested in the other person's conversation. See others point of view, opinion, reasons for saying no, or reasons for making a request of you. The patient should not interrupt or talk over the other person, and be sensitive to other person’s desire.

Validate implies that the patient should acknowledge the person’s feelings, wants, difficulties and opinions about the situation. Be non-judgmental out loud, “I can understand how you feel, but…” or “I realize this is hard for you, but…”

Easy Manner or (use an) easy manner indicates that the patient should apply humor in his/her speech, smile, be light-hearted and be polite.

Upon discussion with colleagues, preliminary clinical observations show that the DBT skills training group was effective in reducing symptoms for adults with borderline personality disorder. This was observed from patients’ discussions of their homework successes and struggles. Patients provided both support and constructive feedback to the group. The student, as a co-facilitator also observed change as patients began to experience positive outcomes from the group therapy. Further, the student observed patients developing life skills that improved themselves and their relationships. The student spotted that the patients had gained an understanding and that their prior interactive styles were not healthy. However, using their new
skills they could interpret situations in new ways and react differently. To complement the observation, the facilitator and co-facilitator used Burns Anxiety Inventory Sheet and Diary Card (used for borderline personality disorder) to confirm the current level and changes that have occurred in the lives of the patients. Another discussion between the student and other clinicians was of the observation that some of the patients did not stay in the group long enough to experience these positive changes. On the contrary, it would have been helpful to know their reasons for leaving the group before completion.

**Consultation.** Consultation consists of intervention and supervision during the entire practicum. Consultation was done on a regular basis with the practicum supervisor and some experienced clinicians. Part way into the practicum, the student did some hands on Intake and Assessment work. The student was assigned several patients by the practicum supervisor. The student involvement with the patients included: helping deal with addiction, helping deal with spousal problems, helping to assess clients’ strengths, helping to identify barriers to achieve goals, and helping deal with self-esteem, grief and anxiety. During this practicum, the student often consulted and sought advice and direction from her supervisor, team lead and other experienced clinicians. During these consultations, the student gained a better understanding of the mental health act and clinical skills used within CAST. Further, the student learned that a person with addiction may be experiencing cravings and/or may want to continue using substances.

Apart from the learned and gained experiences from consultations, this entire process has improved the student functioning and interaction with other team members in relation to the prevention, management, and rehabilitation of the mentally challenged person within Northern Health. The essence of consultation as a learning method is that, while help is being given in
relation to solving the current work problem, the student knowledge and clinical skills are being supplemented so that in future practices, the student may be better equipped to handle similar work situations.

**Conclusion**

The primary focus of this practicum was to learn about adult (19 years and older) mental health and addiction services available in Prince George. This practicum student has gained an in-depth understanding from practitioners on the addiction behaviors unveiled by adults. Through this practicum, the student has become familiarized with addiction services including intake and assessment procedures, supervision, documentation and use of *synapse*. This wealth of experience from the CAST program has contributed and improved the student's professional understanding of addiction. The student engaged in a supervised practice and gained additional clinical experience in adults' mental health and addiction services. The understanding of these clinical skills and counseling modalities has subsequently exposed the student to other practice models used within Northern Health and has improved the student's personal professional practice, and the ability to provide mental health services to adults living with addictions.

This chapter discussed the learning contract and methods used to achieve the practicum objectives. These methods consist of four main topics (reading and training, observation, discussion and consultation) that expressed the student readiness, learning, collaboration, experience and passion for the practicum. The next chapter discusses the implications for personal professional practice and the conclusion for the practicum report.
Chapter Five: Implications for Personal Professional Practice and Conclusion.

Chapter five will provide a conclusion to this practicum report. Final areas that will be addressed include the implication for personal professional practice, as well as future practice. The chapter will end with concluding remarks.

**Implications for Personal Professional Practice**

The student has worked with adult mental health and addiction services in Northern Health, Prince George, and has had the honour of learning from this very diverse group and practitioners about what is important in life, as well as about the addiction, recovery and social support for persons with mental health and addiction. As a result, there is potential to have an impact on the personal professional practice, stemming from the student practicum experiences.

The potential implications for practice include making it possible for mental health programs to better understand the point of view of service recipients and to be more inclusive when making decisions about treatments or recovery plans. The patients who access mental health services know what is working and what is not. The voices of these patients should be sought, heard, and ultimately have an impact on the programs that shape practice. The student believes that those patients receiving services should be consulted about the delivery of the services.

Additionally, the impact on practice could be shared among other mental health programs in NH with the potential of a philosophical shift in service delivery, i.e moving towards a recovery-oriented model. With a philosophical shift, the provision of service could look much different for patients living with mental health and addiction, including: improving opportunities to work collaboratively with other mental health programs, and group services provided; bringing individual clinicians with similar experiences together; and focusing on patient’s skills
and abilities, as well as assisting patients to set and achieve realistic goals. The student argues that NH has made a great change in its philosophical model, and advise individual workers to adopt these service provision practices to enhance the care provided to patients with mental health and addiction.

The final idea that the student wishes to address regarding implications for personal professional practice is that of internal and societal stigma. Many sources have highlighted that the best way to challenge stigma is through education (CMHA, 2007; First Nations Health Authority; 2012). The CMHA website gives concrete suggestions about how to fight stigma and discrimination, including: respond to stigmatizing material in the media by way of protest, as well as providing feedback and material containing accurate information to those responsible; speak up about stigma when someone misuses a psychiatric term; talk openly about mental illness, if not talked about, it remains hidden, perpetuating the idea of shame; demand change from elected representatives, including removal of inadequate budgets on mental health services; and support local organizations that fight stigma and discrimination education (CMHA, 2007). These strategies can be achieved through education. Education about mental health and addiction could start with children in a school setting. As well, when practitioners obtain their education, there could be education not only about mental health and addiction, but also about how to combat the stigma and discrimination associated with mental health challenges.

**Post-graduate Employment and Areas for Private/ Professional Growth**

The access and retention of mental health services are necessary as it enhances the well-being of the person living with addiction, and those undergoing recovery (Mental Health Commission of Canada, 2014; Mental Health Commission of Canada, 2012). In future personal and professional practice, the student will continue to lobby and seek for additional funding for
more services and programs for patients living with mental health and addiction. The student will strengthen the collaborative approach among service providers to ensure patients with mental health and addiction can access services offered by NH.

The growing number of adults with addictive behaviors has apparently increased the need for social and health care services in Prince George (Public Health Protection, 2015). In future practice, the student will network with social workers and other collaborators to ensure programs that emerged out of the mental health services are appropriate and effective in meeting the needs of the people who are living with addiction. In addition, as part of the professional growth the student will be registered as a social worker and encourage other colleagues to register with accredited bodies like the College of Social Work or Colleges of Nursing, Canadian Psychological Association, etc. This registration will be renewable and requires a continuous component of cultural competency in all programs. The component of the cultural competency will ensure that the student and/or other healthcare practitioners continuously strive to achieve the ability to effectively support people with mental health and addiction within their cultural context. The rationale for a continuous registration with an accredited body is to improve professional growth in practice, and competency in profession. This is usually achieved through understanding, experience, meaningful contribution, maintenance and enhancement of knowledge and skills (BCCSW, 2014).

For example, if the student works with Aboriginal people, he/she needs to be aware and sensitive to the world of the patient's culture. The student in this case will have to examine his/her biases and prejudices, and how it affects cross-cultural interaction (between the student and her patient). Like some patients, this student also does not keep eye contact and it is a cultural way of showing respect to whomever you are communicating with. If one is not
sensitive to this, the patient’s communication style, behavior, and expectations could be misinterpreted.

With these growing demands for clinicians including social workers, occupational therapists, nurses, psychologists and life skills workers, there is a need to increase consciousness and priority to “assist patients with serious and persistent mental illness and/or substance use. With the exposure in this practicum, the student’s future practice will include drawing the connections between patients with mental health and addiction and their environment, with a focus on the relationship between the patients and public stigma and perceptions, which are core elements that social workers needs to investigate. Understanding and working skillfully in the areas of interpersonal relationships, group dynamics, stigma reduction, and community participation in the development of policy and programs, are skills that other mental health practitioners need to benefit from the future practices of the student.

Specifically, social workers and other healthcare practitioners working with mental health and addiction people should advocate for more funding and programs, to support patients challenged with mental health and addictions. There is a significant opportunity for the student future practices to collaborate and partner with organizations and advocate for housing for this population, since some patients complained to be at risk of homelessness. Social workers and healthcare professionals should advocate for federal and provincial resources to target needs specific to mental health and addiction patients.

In conclusion, social workers should not only engage in a specialized medical model, but also be involved in a generalist approach were practice is integrated with casework, group work, and community organization, with lots of focus on the interaction between persons and their environments (Miller, Tice, and Hall, 2008), while respecting and accepting mental health and
addiction persons in order to provide them with ideal health care services irrespective of their social statues.

**Conclusion**

The aim of this practicum was to learn about adult mental health and addiction services available in Prince George, and to gain an in-depth understanding from practitioners on the addiction behaviors unveiled by adults. Through this means, the student was exposed to clinical modalities and skills necessary to work with patients living with mental health and addiction. This learning experience has not only enhanced my clinical skills, but also equipped me for future clinical social work practices. The student is optimistic that through this means, patients will achieve emotional and psychological well-being, and they will be prevented from other challenges and disabilities that may be associated with mental illness and substance misuse. In this context, the student will continue to advocate for more resources and acknowledge community options and supports for patients with mental illnesses and addictions in order to improve their psychosocial well-being.
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doi:10.3390/brainsci2020147


MSW Practicum II Learning Contract

**Student:** Patricia Okpodi  
**Practicum Supervisor:** Maria Tejero, Jeff Talbot  
**Academic Supervisor:** Bruce Bidgood  
**Agency:** Northern Health, Adults Mental Health and Addiction Dept.  
**Length Placement:** From: January 5th, 2015 To: July 24th, 2015  
**Hours of Placement:** Monday to Friday 08:30-16:30

<table>
<thead>
<tr>
<th>Learning Goals</th>
<th>Objectives and Activities to Reach Goals</th>
<th>Monitoring/Evaluation Criteria</th>
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</table>
| To understand the policies and procedures of Northern Health relevant to the CAST Program | Student reviewed and understood the current policies and procedures of Northern Health.  
Student reviewed recent report on CAST program                                                                 | Kept a written daily journal  
Has reflected on how current policies impact services to adults 19 years and above with mental health and addiction  
Reflected on how this report and clinical experiences may influence my future learning  
Kept records and observances in a reflective journal  
Met on a regular basis with clinical supervisor to discuss observances  
Engaged and periodically requested feedback from other team members regarding progress on the intake process and assessment |
| To develop clinical skills and abilities to competently complete assessments for the CAST program | Student has reviewed and put into practice the clinical modalities used by CAST program  
Student shadowed and observed clinical skills with CAST team members and used the skills in practice |                                                                                                 |
| To develop skills and abilities to competently undertake intake independently for the CAST Program | Student has completed at least two intake processes independently  
Student has conducted assessments using clinical assessment tools |                                                                                                 |
| To gain a working knowledge of clinical assessment tools commonly used BY CAST program |                                                                                                             |                                                                                                 |
| Increased knowledge and skills | Student has spent minimum of one day shadowing staff affiliated Adult Addictions Day Treatment (AADTP)  
Student has met with clinicians at AADTP to discuss its operation  
Student has reflected on mental health and addictions practices and the learning experiences  
Student has shadowed team members to understand their roles and contributions. | Kept a written daily journal.  
Has encouraged feedback from other team members  
Has engaged with multidisciplinary team members and identified the roles  
Has identified and recorded the unique differences between the teams  
Engaged in a continuous reflection on experiences, thoughts, learnings, observations and asked questions |
| **To learn about other existing programs within CAST** | **To gain clinical experience in adult mental health and addictions** | **Has managed a caseload as appropriate and determined by the practicum supervisor**  
**Has met with clients as assigned throughout the semester**  
**Student has learned from the perspective of the adult client by spending time hearing their stories**  
**Student has developed an understanding of the bio/psycho/social and spiritual needs of culturally diverse adult clients**  
**Has participated in consultation with rural and remote communities**  
**Has created opportunities to exchange knowledge with community stakeholders**  
**Has appreciated the right for people to live at risk**  
**Has participated in consultation with rural and remote communities**  
**Has created opportunities to exchange knowledge with community stakeholders**  
**Has appreciated the right for people to live at risk** |
| Student has attend and participated in meetings and clinical team sessions |  |  |

| Student has demonstrated the |  |  |

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<tr>
<th>for effective interdisciplinary collaboration</th>
<th>ability to engage and communicate with the team members</th>
<th>Has participated in a weekly multidisciplinary meeting to review schedule and weekly plans</th>
</tr>
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<tbody>
<tr>
<td>To gain clinical documentation skills and experience</td>
<td>Student has learned the system of documentation used at the site. Such as <em>synapse</em>: mental health system documentations</td>
<td>Kept a written daily journal.</td>
</tr>
<tr>
<td></td>
<td>Student has accurately documented chart notes</td>
<td>Has reviewed <em>Synapse</em> documentation with clinical supervisor</td>
</tr>
<tr>
<td>To practice and improve upon one-on-one and group counselling skills.</td>
<td>Student co-facilitated and facilitated weekly addictions group</td>
<td>Kept a written daily journal.</td>
</tr>
<tr>
<td></td>
<td>Student attended other therapeutic groups within CAST</td>
<td>Received positive feedback from other team members.</td>
</tr>
<tr>
<td></td>
<td>Student has documented her learning process and did self-reflection during this practicum</td>
<td>Has engage in discussions with clinical supervisor about counselling skills</td>
</tr>
</tbody>
</table>

**Signatures:**

Student: ____________________________  Date: ____________________________

Practicum Supervisor: ____________________________  Date: ____________________________

Academic Supervisor: ____________________________  Date: ____________________________