EMPOWERING PEOPLE WITH CONCURRENT DISORDER IN A CLINICAL CONTEXT: A STRUCTURAL PERSPECTIVE

by

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Abstract

Concurrent Disorder (CD) is a nascent area of study relative to mental health and addiction. Conceptions of effective treatment and desirable outcomes in the field remain contested. In my examination of CD literature, most researchers concluded the preferable outcomes of treatment to be a reduction or cessation of mental health symptoms and abstinence from substance use. The preferences of people with CD were largely absent in the literature review I conducted. The dissonance between CD literature and my structural social work values prompted me to adopt an empowerment lens for my practicum.

Empowerment is defined in this report from a structural perspective. Structurally informed empowerment acknowledges that systematic discrimination is a factor precluding people with CD from living as they desire. In a clinical setting, the reduction of adverse effects from CD and oppression are the most prevalent forms of empowerment. Empowerment in a clinical context is aided by utilizing the recovery movement in determining what people define as a meaningful life; recovery from CD is possible with the continued presence of mental health symptoms and substance use. Shared decision making (SDM), harm reduction, personal medicine, and treatment modalities are possible empowering clinical methods to enact a person’s vision of recovery.

Common needs for the increased well-being of people with CD were ascertained through dialogue and observation at the practicum site. Resources to contribute to fulfilling many of the needs were available in Prince George, British Columbia, yet knowledge of their existence is often esoteric. Social workers in the clinical context are able to address many of the needs in micro and mezzo capacities.
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I am greatly appreciative to all the people whom allowed me to participate in a therapeutic relationship with them during my practicum. Without their participation, I would have been unable to improve my clinical skills and learn further about empowerment.

I would also like to thank all the professionals at the Community Acute Stabilization Team and other Northern Health Authority programs that assisted me in my learning journey through allowing me to participate in professional activities with them and sharing their wisdom with me.
Dedication

I am dedicating the writing of this practicum report to my mother Zenovia, my father Wayne, my brother Erik, and my sister Vanessa. You have provided me with a safe, supportive, loving environment which encouraged engagement with ideas and instilled me with a sense of social responsibility. You have all contributed greatly to my development and to any success that I have had and will experience. I love you all very much.
Chapter One: Description of Practicum, Agency, and Theoretical Orientation

This chapter will provide a description of my practicum objectives, the practicum learning environment, target population and service provision, learning goals, theoretical orientation, theory guiding clinical interventions, and a synthesis of the theories guiding my practicum experience and report.

Practicum Objectives

The selection of CD and clinical social work as areas of interest for my practicum was a continuation of the curiosity piqued from previous employment and academic pursuits. Witnessing difficulties experienced by people in addressing mental health and addiction simultaneously left me with an enduring impression. Clinical work was an aptitude that I had observed in myself and wanted to develop further. Securing a placement working with people experiencing mental health difficulties and/or addiction in a clinical context provided an opportunity to learn more about an area of interest and further develop my counselling abilities.

After securing a practicum comprised of 560 hours with the Community Acute Stabilization Team (CAST), I performed a literature review as part of my practicum proposal to become better acquainted with the different dimensions of CD. It appeared that most research on CD involved the treatment of the condition. Successful treatment of CD was narrowly defined as achieving outcomes such as: reduction of or abstinence from substance use, medication compliance, and psychiatric symptom reduction or elimination. These parochial definitions of treatment success conflicted with my structural social work theoretical orientation. I wanted to know what people with CD defined as treatment success.

After learning how the CD research community prioritizes outcomes for people with CD and being aware of the discrimination encountered by those with mental illness and addiction, I
decided to utilize an empowerment framework in providing a focus and a lens for my practicum experience. I wanted to learn how to empower people with CD individually and structurally.

**Practicum Learning Environment**

The setting for my field placement was with the CAST at the Northern Interior Health Unit located in Prince George, British Columbia. The program, operated under the auspices of the Northern Health Authority, is comprised of mental health and addiction clinicians primarily from the disciplines of social work and nursing. Psychiatrists are attached to the program to provide services to people who would benefit from their expertise. A mental health and addiction clinician with a MSW provided consistent, direct, agency based supervision for the duration of the practicum.

**Target Population and Service Provision**

The CAST program provides therapeutic, outpatient services for people aged 19 and older presenting with a variety of *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnoses and/or a substance abuse disorder (SUD). The CAST contrasts with many contemporary programs that deliver mental health and addiction services separately. Once vetted by the Community Response Unit (CRU) and referred to the CAST, people can utilize services for as long as required. Services are delivered to people who exhibit debilitating psychiatric symptoms and/or addiction issues that impair their day to day functioning. The CAST provides assessment, treatment, and emergency counselling; operates from a multidisciplinary approach; utilizes a variety of treatment approaches based upon individual needs; delivers treatment primarily through personal counselling and group work; and has transition protocols with the Ministry of Children and Family Development for young adults entering services.

**Learning Goals**
Three learning goals directed the activities performed in my practicum placement. First, I wanted to further develop my skills as a clinical social worker in the setting of treating people with mental health and/or substance use disorders. Through my practicum experience I learned how to initiate, develop, and terminate the therapeutic relationship in a clinical context. I developed greater familiarity with the role and tasks of the clinician. I became better at using and more knowledgeable of the treatment modalities utilized at the CAST. I also gained greater competency in identifying and addressing the needs of people in counselling. My practicum experience helped to express and cultivate my strengths as a clinician and set a future agenda for further development.

Second, I desired to learn more about empowering people with CD. I came to adopt a nuanced definition of empowerment that incorporated the structural approach after interacting with people with CD, speaking with my practicum supervisor and other professionals, and further reviewing academic literature. From my practicum experience I discovered that empowering people with CD involves sharing power in the therapeutic relationship, allowing people to define desired treatment outcomes, and being flexible in treatment approaches to accomplish agreed upon goals.

Third, I aspired to learn more about the resources available to people with CD in Prince George. In speaking to people with CD and other clinicians and continuing to perform research on the subject, I increased my knowledge of the needs of people with CD. From the greater understanding of needs, consulting the aforementioned groups, and performing additional research, I was able to construct a directory of resources likely pertinent to those with the condition in Prince George. A detailed record of practicum activities is included in Appendix 1.

Theoretical Orientation
My orientation is influenced by my beliefs about what relationships between each other should be like in society. John Rawls in his book *A Theory of Justice* provocatively asks what kind of society we would want if it could be remade (1971). He devises a thought experiment where individuals are placed in the 'original position,' before the creation of society, and act under a 'veil of ignorance,' where they do not know their abilities or what position they will hold in society, to develop a just society. Rawls develops two principles of fundamental justice to guide the creation of society. The first principle states that all people have a right to basic liberties such as freedom of thought and conscience, political liberty, and freedom of association, among others. These are inviolable rights that cannot be infringed upon for the needs of society. The second principle of fundamental justice states that inequalities are acceptable as long as they are of the greatest benefit to the most disadvantaged members of society and positions in society are allocated on the basis of just equality of opportunity where all members of society are able to develop the skills and possess the chance to meaningfully pursue their definition of a desirable life.

I believe that some amount of income disparity is tolerable in society and I do not adhere to equality of outcome, where all people receive the same income regardless of their role in society (Rabe, 2001). A certain amount of income inequality will be an impetus for motivation and achievement, yet allowed disparities should be small, for success can be largely attributed to factors outside of the control of individuals such as genetics, access to opportunities, and environment.

I believe in negative and positive freedom as articulated by Isaiah Berlin (1969). The concept of negative freedom states that individuals should be free from government or others interfering in the performance of activities that do not harm others. Positive freedom occurs
when the actions of others allow us to become closer to being our ideal self. The provision of education is an example of positive freedom. Negative and positive freedom is imperative to the conception of empowerment through helping people gain more control over their lives. People should be free from unnecessary interference and have access to resources to help actualize their goals.

Structural social work is a theory which influences my theoretical orientation and practice. “Structural social work views social problems as arising from a specific societal context, liberal/neoconservative capitalism, rather than from the failings of individuals” (Mullaly, 2007, p. 244). Since social problems are largely the result of a defective societal construction, Mullaly advises social workers to “alleviate the effects on people of an exploitative and alienating social order; and to transform the conditions and social structures that cause these negative effects” (p. 244). Other helping professions seek to treat the individual and often neglect the broader context in which social problems occur. Structural social work seeks to extirpate sources of social dysfunction in addition to assisting individuals with immediate difficulties. A systemic view of social problems allows structural social workers to avoid resocializing people to fit into the existing societal paradigm.

An effective method of bridging the micro context of individual difficulties and the macro goal of structural change is working with people from an ecological systems perspective (Germain & Gitterman, 1980). People are seen as being changed by and changing their social environment (Payne, 1997). Social problems, such as poverty, discrimination, and stigma, pollute the social environment, thereby reducing the person’s ability to maintain a healthy fit with their milieu. Until we can change the hierarchal and exploitative structure of society, helping people to identify things in their environment that are in their power to change and
raising consciousness about the things they cannot will allow us to practice social work in a structural way (Payne). We need to expose the structural root causes of people's problems so that work can be done to build a new society based upon principles of social justice (Olivier, 2010).

**Theory Guiding Clinical Interventions**

Treatment of CD is still an emerging field. People with dual diagnosis are a heterogeneous population with different types of substance abuse and mental health disorders with varying severity and complexity (McDonell et al., 2012). While there are modalities that have shown some success in treating people with CD, people require interventions based on their individual needs. This philosophy is reflected in the use of treatment approaches at the CAST. In a meta-analysis of 26 studies, Drake, Mueser, Brunette, and McHugo found that people who participated fully in a variety of dual disorder treatments tended to do well (2004). There is presently not sufficient evidence to support any approach as the definitive treatment for CD, yet there is tentative support of some treatments for them to emerge as preferred practice.

**Cognitive Behavioral Therapy.**

Cognitive Behavioral Therapy (CBT) has been found to be effective treating SUD and various mental health disorders. Meta-analyses have demonstrated a tentative relationship between the use of CBT and decreases in psychiatric symptoms and substance use in people with CD (Dixon et al, 2010; Tiet & Mausbach, 2007). The authors of these meta-analyses observed methodological problems of the studies they examined noting: a general lack of standardization, an absence of fidelity testing of intervention methods, varying lengths of treatment, numerous outcome measures, inconsistent staffing models, and diverse training approaches. The disparate approaches of researchers toward the study of CD have undermined the ability to make more confident claims about the efficacy of CBT and other psychosocial treatments.
The cognitive behavioral approach was created through an integration of cognitive and behavioral techniques into a unified approach (Hazlett-Stevens & Craske, 2002). Challenging automatic thoughts, cognitions that occur involuntarily in an individual’s stream of consciousness, is an essential task of CBT practitioners (Curwen, Palmer, & Ruddel, 2000). Automatic thoughts are formed from underlying and intermediate beliefs. Underlying beliefs are the ingrained views and assumptions which give structure to automatic thoughts and intermediate beliefs are composed of attitudes, rules, and expectations (Curwen et al.). When a situation occurs, we experience automatic thoughts that are informed by underlying and intermediate beliefs (Beck, 1995).

A central principle of CBT is that thoughts, emotions, behaviour, and physiology are part of a connected system in which a change in any one realm affects the other components of the system (Curwen et al., 2000). Positive, realistic thoughts lead to healthy emotions and behaviours (Maguire, 2002). Conversely, negative, spurious thoughts lead to maladaptive feelings and actions. The way we react to a situation is not inherently caused by the circumstance, but our response is largely determined by how we perceive it (Curwen et al.). CBT practitioners can choose to intervene in distorted thought processes, maladaptive emotional responses, and/or inappropriate behaviour (Maguire, 2002). An effective treatment plan can access the problem from multiple perspectives concurrently, yet the behavioral and cognitive aspects of the approach are the most focused upon to initiate change.

CBT for people with CD involves identifying maladaptive cognitions; generating alternative, realistic, positive thoughts; and practicing techniques for challenging thoughts in situations that have a propensity to exacerbate mental health symptoms and/or precipitate substance use (Brown et al., 2006). Part of the CBT process for people with CD is to help them
understand the interaction between their mental health disorder and substance use (Chan-Osilla et al., 2009). Psycho education is a method to help people develop more insight into their mental health issues and substance use.

**Motivational Interviewing.**

People with CD often have difficulty initiating and sustaining motivation to engage in treatment (Drake et al., 2004). Motivational Interviewing (MI) has been used successfully to help people begin and maintain constructive changes for many different types of maladaptive behaviours. The meta-analyses that gave tentative support for the use of CBT in the treatment of CD extend that endorsement to MI (Dixon et al., 2010; Tiet & Mausbach, 2007). The same methodological concerns also apply to studies examining the efficacy of MI in treating people with CD.

MI is an intervention approach designed to help people work through ambivalence to change or strengthen their commitment to transformation (Glasner-Edwards, 2011). Klag, O'Callaghan, and Creed believe that all people engaging in substance use are somewhat ambivalent about it, for there are invariably negative consequences to drug and alcohol addiction (2005). MI seeks to extricate and explore the incongruity between a person's actions and goals. MI provides an empathetic, non-judgemental environment in which people often reach the conclusion that cessation from substance use is in their best interest.

The spirit of motivational interviewing consists of collaboration, evocation, and autonomy (Miller & Rollnick, 2002). Collaboration posits that the counsellor is a partner with the person; a positive, therapeutic environment is created that is conducive to change and allows the person to explore their motivation for transformation; and the counsellor needs to be attuned to their personal motivations, so they do not act authoritatively or persuade the person to seek a
certain outcome. Evocation asks us to help the person articulate their feelings on substance use through open ended questions. Autonomy acknowledges that the responsibility for change is with the client.

The four general principles of MI are to express empathy, develop discrepancy, roll with resistance, and support self-efficacy (Miller & Rollnick, 2002). Empathy is enhanced and conveyed through performing reflective listening and seeking to understand a person’s feelings without judgment. Through practicing empathy we are building a therapeutic alliance that increases self-esteem and permits change.

Developing discrepancy seeks to broach ambivalence about substance use by having the person articulate the incongruity between their goals and behaviour (Miller & Rollnick, 2002). In making the person conscious of the divergence between their aspirations and present actions, the person has to reconcile the discrepancy to reduce the unpleasantness of cognitive dissonance. The counsellor can facilitate the change process by amplifying ambivalence, so that the current situation is no longer seen as tenable. MI can be a powerful catalyst for change because it draws upon internal motivators.

Rolling with resistance entails reframing opposition to the constructive reduction of ambivalence to provide momentum for change (Miller & Rollnick, 2002). The counsellor should avoid arguing for cessation of substance use while the person gives opposing reasons, for this will likely entrench them in their position. Resistance from the person is a signal to change approach. The person can be offered new information and perspectives which may serve as an impetus for re-evaluating how substance use relates to their values and goals.

Supporting self-efficacy refers to the person’s belief that they are able to perform tasks integral to the change process (Miller & Rollnick, 2002). Even though people may want to
change, for sustained action to occur, they must believe that they can change. Increasing confidence is part of the MI process. A person that feels supported will likely have increased confidence and thus greater self-efficacy. Prompting people to discuss past personal successes or sharing those of others in similar situations are methods of bolstering self-efficacy.

MI complements the Transtheoretical Model developed by Prochaska and DiClemente (1983). The five stages involved in the change process are precontemplation, contemplation, preparation, action, and maintenance. MI is particularly helpful in the contemplation, preparation and action stages. In the contemplation stage of the model, a person is ambivalent about changing behaviour, for they have reasons of similar strength for continuing and stopping the behaviour. MI can help the person resolve ambivalence and seek constructive change. In the preparation and action stages, the person’s resolution for change may falter; MI can help the person remember what galvanized the change process.

MI can be adapted for the needs of people with CD. The interplay between substance use and mental health, adherence to a prescribed pharmacological regimen, and ambivalence of seeking help for dual disorders are topics that should be broached when contrasting the present situation to goals and values (Glasner-Edwards, 2011). Adjustments in MI techniques should be made to help those with cognitive impairments such as using repetition, avoiding verbose language, using visual aids, and having breaks within sessions (Glasner-Edwards). Ample time should be allowed for the person to reflect upon and process the content of a session. Writing a list of reasons not to engage in substance use on a card for the person to carry can provide ongoing reinforcement (Handmaker, Packard, & Conforti, 2002).

Acceptance and Commitment Therapy.

Acceptance and Commitment Therapy (ACT) is a counselling modality utilized at the
CAST. There is a dearth of literature examining ACT in the treatment of CD, yet in analyzing the efficacy of ACT the American Psychological Association found that it is a component of an effective treatment regimen for a variety of difficulties (2013). Specifically, ACT demonstrated strong research support in the treatment of chronic pain and modest support in the treatment of depression, mixed anxiety, obsessive-compulsive disorder, and psychosis. Inadequate research exists on the use of ACT in the treatment of substance use to make even tentative statements on efficacy, yet the strength of ACT in the treatment of various mental health conditions makes its use likely beneficial for people with CD.

ACT posits that a primary cause of psychological problems relates to how language and cognitions interact with perceived personal possibilities and interpretation of memories to produce the inability to sustain behaviour in pursuit of long term goals informed by values (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). The outcome of the aforementioned process is termed psychological inflexibility. The six components of psychological inflexibility are: dominance of the conceptualized past; lack of values clarity; inaction, impulsivity, and avoidance persistence; attachment to the conceptualized self; cognitive fusion; and experiential avoidance.

People who are attached to the verbally constructed past and future do so at the expense of contact with, and effective behaviour in, the present moment (Bach & Moran, 2008). Lack of value clarity results in the person becoming focused on feeling good and avoiding pain as opposed to endeavouring to achieve long term, personal goals. Inaction, impulsivity, and avoidance persistence occurs when the person is hampered by language and cognitive constructions combined with a lack of expressed values. Behavioral techniques are often used to document this phenomenon. The conceptualized self refers to the verbal content that the person uses to describe and define her or him. Defense of this constructed self often guides the person’s
actions and the verbal labels they ascribe to him or her can be detrimental to a positive self-image. Cognitive fusion refers to behaviour that is inflexible and is influenced more by verbal networks than by experienced environmental consequences. Experiential avoidance is attempting to eradicate or resist one’s unwanted thoughts, feelings, sensations, and other personal events. Efforts to remove the undesirable experience often fail and enhance the unpleasantness of the event. Strategies successful at achieving experiential avoidance are often deleterious to personal well-being, i.e. substance use.

Psychological flexibility is established through six ACT processes: acceptance, cognitive defusion, being present, self as context, values, and committed action (Hayes et al., 2006). Acceptance refers to actively embracing personal experiences without seeking to alter them when doing so would precipitate psychological harm. Cognitive defusion attempts to change the undesirable functions of thoughts or personal events rather than alter their form, frequency, or context association. Cognitive defusion endeavours to make thoughts harmless by removing ascribed meaning from them. Being present involves experiencing psychological and environmental events in a non-judgemental way, so that behaviour is more flexible and actions can be more consistent with values. Language should describe events and not be used to evaluate and predict them. Self as context encourages people to be aware of one’s experiences without being attached to them. Values are chosen qualities that manifest in how a person lives moment to moment. Committed action refers to the development of effective patterns of behaviour to live in accordance with chosen values.

**Theoretical Synthesis**

The treatment modalities used at the CAST and structural social work are complementary. This would seem counterintuitive since CBT, MI, and ACT operate primarily on
the level of the individual and group while structural social work directs much of its focus to macro change, yet the use of treatment modalities for structural social workers is a component of a social justice framework. Treatment modalities can be used to alleviate the effects of oppression experienced by people with CD as members of a minimum of two outgroups through increasing their functioning and well-being (Mullaly, 2002). Part of the difficulties encountered by people with CD is structural in nature. People cannot effectively engage in structural change when they are debilitated by oppression and CD. The use of treatment modalities is an initial step in the process of creating a just society. In my analysis of CD, treatment modalities and structural social work can have a synergistic effect on empowering those with mental health difficulties and an addiction.
Chapter Two: Literature Review

The literature reviewed in this section relates to the empowerment of people with CD in a clinical setting. The definition of CD, the demographics of people with the condition, and their prognosis for recovery are broached to provide increased context. Empowerment is then defined from a structural social work perspective. In the discussion of empowerment, the societal structure, its effects, how it could be deposed, and specific actions social workers could enact are presented. The recovery movement is examined as a practical conceptual framework for operationalizing empowerment in the therapeutic relationship. Harm reduction, SDM, and personal medicine are studied as ways of facilitating potential expressions of desired treatment preferences and outcomes that may not be able to be accommodated within the traditional abstinence from substance use and psychiatric medication treatment model. As a fixture in CD treatment, psychosocial modalities CBT, MI, and ACT are examined for their impact on empowerment.

Little has been written on my practicum report topic as it is framed, so the areas of study I have chosen to research were determined after a preliminary examination of CD and empowerment. The subjects in the literature review represent an evolution of my understanding of empowering people with CD.

Definition

CD refers to the co-occurrence of drug and alcohol addiction and mental health difficulties and their mutual impact upon each other (Kimberley & Osmond, 2003). Clinically meeting the definition of CD requires satisfying DSM V criteria for a SUD of an enumerated psychotropic substance including alcohol and a mental health disorder.

DSM V classifies SUDs by the specific substance used (American Psychiatric
Empowering People with Concurrent Disorder (Association, 2013). Different disorders include: alcohol; cannabis; phencyclidine; other hallucinogen; inhalant; opioid; sedative, hypnotic, or anxiolytic; stimulant; and other. A person is said to have a SUD if they have experienced at least two of the following in the past year: taking the substance in larger amounts or over a longer period than was intended; there is persistent desire or unsuccessful efforts to reduce use; significant time is spent in obtaining, using, and recovering from the substance; craving or a strong desire to use the substance is present; substance use has resulted in a failure to fulfill obligations at work, school, or home; substance use continues despite recurrent social or interpersonal problems caused or exacerbated by the substance; participation in activities of importance are reduced; use in situations that are physically dangerous; continued use despite knowledge that ongoing physical and/or psychological problems are caused or exacerbated by the substance; has exhibited tolerance; and has displayed withdrawal symptoms. Severity of SUD is characterized by the number of symptoms present; the presence of two to three is rated as mild, four to five is moderate, and six and above is severe. The mental health component of a formal diagnosis of CD requires meeting the criteria for a mental health disorder as enumerated in the DSM V.

Demographics

People with CD are a heterogeneous group, for they use a variety of substances, experience different mental disorders, encounter addiction and mental health problems with varying severity, have different interactions between their mental health difficulties and substance abuse, and are unique people with individual life experiences (McDonell et al., 2012). Yet there are also similarities among people with CD.

People with CD experience increased psychotic symptoms, poorer treatment retention, reduced medication adherence, more housing insecurity, increased rates of HIV infection, and
higher usage of emergency room services, relative to those affected by only addiction or mental health issues (McDonell et al., 2012). Rush et al. found that substance abuse problems and mood or anxiety disorders were present in 1.4% of Canadian females and 2.1% of men (2008).

Extrapolating the data to the Canadian population, approximately 435,000 people had these forms of CD in the country at a given time. A Canadian study at the Burnaby Treatment Center for Mental Health and Addiction (BCMHA) found that people with CD in the program had a mean age of 40.2 years old; 65.2% were male and 34.8% female; 29.3% had completed high school and 70.7% had not graduated high school; 12.0% were employed; 31.5% had a fixed address and 68.5% were experiencing some degree of homelessness; 69.6% were White, 21.7% were Aboriginal, and 8.7% are other; 68.0% experienced moderate to severe childhood emotional abuse; 65.3% had experienced childhood physical abuse; and 56.0% had experienced childhood sexual abuse (Schutz et al., 2013). The most used substances of people with CD in the program were crack or powder cocaine at 65.2%, alcohol at 48.9%, and heroin at 33.7%. Rush and Koegl found that of the people with CD they studied, 33.9% had a personality disorder, 19.2% had schizophrenia, 17.1% had an anxiety disorder, and 18.1% had a mood disorder (2008).

**Prognosis**

Drake et al. discovered in a study of 130 people recruited from outpatient CD treatment settings with schizophrenia or schizoaffective disorder and SUD that most people achieved 4 out of 6, participant consulted, recovery based outcomes over the 10 year period of examination (2006). People received three years of treatment and were contacted yearly by researchers for follow up. At the end of the study period 62.7% had psychiatric symptoms below clinically significant levels; 62.5% were in remission from substance use as defined by attaining a late active stage of recovery or better; 56.8% were in independent living situations 80% of their days
or more; 41.4% were employed in an integrated setting, receiving at least the minimum wage, and working directly for the employer rather than through an agency; 48.9% had regular contact with friends who did not abuse substances as a measure of social recovery; and 58.3% expressed overall life satisfaction. Recovery outcomes were relatively independent from each other with the exception of high psychiatric symptoms and low life satisfaction, which were highly correlated. All six measures of recovery showed improvement with employment, active control of substance use, and regular contact with non-substance abusers as the greatest areas of change. The proportion of people achieving the recovery outcomes, with the exception of housing, continued to progress throughout the 10 years in a positive trajectory demonstrating that recovery is a long term, ongoing process.

A study by Xie, Drake, McHugo, Xie, and Mohandas examined 116 people accessing treatment who had been diagnosed with an alcohol use disorder and a mental illness for a period of 10 years to monitor outcomes from the same data set as the previous study (2010). 86% of people attained at least a single six month remission during the study; remission was defined as not meeting DSM IV criteria for alcohol abuse or dependence. 66% of remissions were achieved through reducing alcohol use and 34% of remissions involved abstaining from alcohol consumption. The average remission time was 3 years and whether people abstained from alcohol or reduced consumption did not appear to affect remission length. Although a minority of people in the study sample abused other substances in addition to alcohol, primarily marijuana and cocaine, use of these other substances tended to diminish in parallel with decreasing alcohol use. These results display a trend of decreasing long term substance use for people with CD.

It should be noted that each of these studies was part of the data collected from the New Hampshire Dual Diagnosis Study that began in the late 1980s. People were recruited from
outpatient settings as opposed to a hospital psychiatric context. Koegel and Rush categorized treatment care levels for people with CD with 1 being the least intensive and 5 being the most intensive (2012). Level 2 was weekly outpatient counselling and level 3 was receiving services with an Assertive Community Treatment team. The people in the aforementioned studies utilized lower levels of treatment intensity. People with CD requiring residential treatment in levels 4 and 5 may have a different prognosis than those studied, so these results should not be generalized broadly.

Empowerment and Structural Social Work

Defining Empowerment.

In my theoretical orientation I stated that structural social work is a perspective through which I view the world. I have applied this framework to the conception of empowerment. Fook and Morley state that empowerment needs to be complemented by another theory to help articulate what is to be realized and guide the development of effective methods for its implementation (2005). Structural social work is descriptive, in that it articulates the process through which people are marginalized, yet it is also prescriptive, for it sets out actions that liberate people individually and collectively. I will now elucidate empowerment informed by structural social work to present the lens utilized in my practicum and in the writing of this report.

There are many definitions of empowerment. Mullaly (2007) states it is an essentially contested concept with no definitive meaning, yet some descriptions are better than others and more pertinent for people with CD. Mullaly, in his structural social work infused definition, describes empowerment as "a process through which members of subordinate groups reduce their alienation and sense of powerlessness and gain greater control over all aspects of their lives..."
and their social environment” (p. 298). In this definition of empowerment Mullaly draws attention to oppression and the adverse effects it has on marginalized groups. Through emancipation, people are able to express their free will individually and collectively.

MacDonald and MacDonald assert that all conceptions of empowerment have an understanding of what power may be (1999). The definition used in this report is power as capacity. It refers to the ability of people to pursue courses of action that they deem appropriate (Hindress, 1996). This conception of power and my use of empowerment both emphasize people exercising more control over their lives. This characterization of power is consonant with social work practice, for it promotes section 1.3.1, self-determination and autonomy, of the Canadian Association of Social Workers Guidelines for Ethical Practice (2005).

Fook and Morley express that empowerment will look different depending on the context (2005). Given the setting of my practicum in a clinical context with a unique population with particular manifestations of oppression, empowerment methods and areas requiring intervention are distinct, yet the broad empowerment objectives of increasing equality, equity, and autonomy apply. Empowerment is a difficult concept to enact and measure in most settings. This endeavour seeks to help articulate empowerment as it relates to people with CD in clinical context.

**A Description of Oppressive Social Structures.**

Canadian society is structured so that some individuals and groups are able to achieve their objectives, i.e. exercise power, better than others. Mullaly (2002) said that oppression occurs when a person is denied opportunities at self-development, precluded from full participation in society, denied rights possessed by the privileged class, or is regarded as subordinate due to membership in an undesirable group. Carniol (1992) states that primary structures such as patriarchy, racism, capitalism, heterosexuality, ableism, and ageism are
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Oppressive and inhibit people from expressing reasonable self-determination.

Within structures are ingroups and outgroups (Carniol, 1992). Those in outgroups are adversely affected in their ability to effectively engage with their world. Goffman (1963) categorizes mental illness and addiction as 'blemishes of character' for which people are stigmatized for the perceived personal failings associated with each condition. Consequently, people with CD have membership in a minimum of two outgroups. Moreau (1989) opines that ingroup status greatly affects the allotment of rights, resources, and rewards. All Canadian citizens are equal before the law; laws are purportedly applied uniformly to all people, yet socially distributed opportunities disproportionately benefit those from ingroups. Gil (2013) states that people from outgroups are more likely to encounter difficulties in such domains as employment, relative poverty, housing, education, and health care. People in outgroups often encounter intergenerational trauma from previous incarnations of oppression that continue to affect their environment and the people in it.

Harmful social structures not only affect people adversely though precluding the expression of reasonable self-determination and materially, there is also a psychological element of oppression. Freire (1968/2000) espouses that when people are subjected to negative valuations by the dominant group some people internalize and give credence to those judgements. The result is a negative self-concept where people attribute their lack of success to personal failings and perceive the overarching structure asacceptable. Moreau (1989) hypothesizes that oppressive social structures change the way people treat each other. When some people are perceived as lesser, privileged individuals may find it onerous to identify with marginalized people as full human beings and, subsequently, deny them essential rights. The alienation experienced by the privileged toward the oppressed can result in subordinate people being
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treated as objects to suite the purposes of the former. Saleeby, in his work on the strengths
approach, observes that subjugated people will often identify with the dominant class in an
attempt to avoid the negative consequences and connotations that come from membership in an
outgroup (2002). In this effort to align themselves with the privileged class, people often become
estranged from their internal resources, external supports, history, and traditions.

**Undermining Oppressive Societal Structures.**

There is uncertainty about how an equitable social structure would arise. Karl Marx
(1867/1993) espouses that capitalism can only be profitable through paying workers enough to
subsist and taking most of the ‘surplus value,’ the difference between the cost to produce a good
or service and the price for which it sells, for themselves as revenue. Marx posits that businesses
buy machinery to give themselves a temporary efficiency boost, and hence a profit advantage,
over their competitors; yet as all companies in the industry adopt the technology the advantage
dissipates. As industries become more automated, profits decline, for surplus value only can be
earned from labour. A ‘capitalist crisis’ eventually ensues; this is also known as a recession.
Weaker businesses become insolvent or get acquired by larger firms. Numerous crises results in
larger and fewer businesses, more mechanization, and a greater proportion of workers to owners.
The bargaining position of workers diminishes as many people are competing against each other
for employment in oligopolistic industries and results in poor wages and labour conditions. Marx
expounds that harsh treatment of workers by capitalists unites the proletariat to overthrow the
capitalist order in favour of socialism and eventually communism.

Imbrogno (1999) muses that perhaps if there is a social crisis and the dominant class feels
that existing power structures will collapse, values and norms that govern social relations may
change. Gil (2013) believes that for structural change to transpire, large numbers of people
would need to acknowledge that the current structure fails to meet their needs economically, socially, psychologically, spiritually, and in ensuring safety. Moreau (1989) postulates that even though the structures of society are coercive towards outgroups, the operation of societal institutions requires the cooperation of large numbers of oppressed people. Without marginalized people performing their prescribed roles in the system, the viability of oppressive social structures rapidly deteriorates. Freire (1968/2000) perceives the struggle against oppressive social structures as inevitable as people seek to regain their denied humanity.

An oppressive social structure is difficult to displace, for the people who benefit from it seek to preserve their privilege. Bishop (2005) suggests that focus is often placed upon ‘good’ and ‘bad’ people and away from the structures that affect people and outcomes. Resources are often expended in assisting oppressed people to adapt to prevailing structures. The better oppressed people can fulfill their prescribed role, the easier they can be dominated. Freire (1968/2000) posits that the dominant group is not capable of conceding their advantage even though there are some advantaged people who desire to help the oppressed and alleviate their suffering. The change to an equitable social structure goes beyond generosity. Freire also believes that some marginalized people have a simultaneous attraction and aversion to oppressors. People may not want to reject the unjust social order, but, rather, they seek to acquire the privileges and status of oppressors.

**Interventions to Empower.**

Mullaly (2002) states the empowerment must occur at personal, cultural, and structural levels. From a micro perspective, social work helps people increase control over their lives through engaging in work to reverse the damage inflicted by oppressive social structures. Work at the personal level can take many configurations depending upon how structures have impacted
the individual. Ameliorating poor self-concept, connecting people to resources to bolster material and psychological well-being, and helping people achieve increased functioning are examples of potential interventions. At the cultural level, assumptions and stereotypes about outgroups and ingroups are challenged. Alternate narratives about privileged and oppressed groups help to liberate people through perpetuating a more realistic identity and engendering increased misgivings toward societal structures that perpetuate falsehoods. Discarding specious perceptions of group and personal attributes could act as an impetus for consciousness raising. At the structural level, institutions that are responsible for promoting oppressive relations are actively resisted and challenged. Mullaly (2007) added that social workers are not able to empower people directly. They can only help to establish the conditions through which empowerment is possible.

Moreau (1989) enumerates four and posthumously five (Carnoil, 1992) objectives for structural social work. First, client empowerment: increasing personal power within the helping relationship. Second, materialization of social problems: a component of people’s difficulties relate to access to resources. Third, collectivization of social problems: cultivate understanding that social problems are primarily structural in their cause and solution. Fourth, defense of the client: maximizing access to rights and resources for persons served. Fifth, enhancing the client’s power through personal change: helping people to change thoughts, feelings, and behaviours that are not beneficial to them. People are acted upon by oppressive structures as objects, yet marginalized people retain their ability to act as subjects in pursuit of their own goals.

Freire (1968/2000) describes his pedagogy of the oppressed as a two stage process. In the first stage, people become familiar with the structures and characteristics of oppression and through praxis seek their transformation into a social order that allows people to live with dignity
and their full humanity. Freire terms this combination of awareness and action as conscientization. He believes that people cannot be empowered individually, it is a collective process. In the second stage, oppression is dispelled and the pedagogy belongs to all in establishment of permanent liberation.

Lee (2001) theorizes that empowerment in a clinical context refers to removing indirect and direct power blocks. Indirect power blocks are a negative self-concept initiated by notions emanating from the dominant class. Direct power blocks are oppressive measures applied by social structures and their agents. Social workers should seek to eliminate the negative effects from indirect power blocks and to reduce the effectiveness of direct power blocks with the aspiration of eventually eradicating them. Social workers are concurrently concerned with people and environments.

The Recovery Movement

White and Kurtz (2006) described the contributions of the addiction and mental health communities toward the concept of recovery. The addiction community developed a concept of recovery as abstinence from substance use, yet they had more difficulty articulating and embracing a concept of recovery where substance use continued to occur. The mental health community, informed by consumer narratives, constructed a concept of recovery where people can lead lives of personal significance despite ongoing mental health difficulties, but it has been onerous to displace the pervasiveness of the medical model in setting treatment priorities and defining mental illness for people.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is an agency within the United States Department of Health and Human Services committed to reducing the impact of substance abuse and mental illness. The organization defines recovery for
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mental health and addiction as “a process of change which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (2011). SAMHSA describes four dimensions needed to support a person with CD in recovery. (1) Health: managing or overcoming one’s conditions. (2) Home: having a safe and stable place to engage in recovery. (3) Purpose: participating regularly in meaningful activities and having the ability to engage in society. (4) Community: experiencing mutually beneficial relationships.

SAMHSA enumerates 10 guiding principles of recovery (2011). (1) Recovery emerges from hope. It helps to galvanize and sustain recovery efforts. (2) Recovery is person driven. Self-determination is a foundational value of recovery. (3) Recovery occurs via many pathways. People have unique experiences and require services, formal and non-formal, that can facilitate individual journeys. (4) Recovery is holistic. The person is viewed mentally, spiritually, emotionally, physically, and relationally. (5) Recovery is supported by peers and allies. It is a communal process in which people receive and give support. (6) Recovery is supported through relationships and social networks. Healthy relationships provide a context conducive to personal growth. (7) Recovery is culturally based and influenced. The recovery pathway will be affected by a person’s beliefs and values and they should be reflected in CD services. (8) Recovery is supported by addressing trauma. Services should be trauma informed to effectively address the influence of trauma in mental health difficulties and substance use. (9) Recovery involves individual, family, and community strengths and responsibilities. People and their environments possess the strengths required for growth and have responsibilities in facilitating recovery. (10) Recovery is based upon respect. People with CD need to be acknowledged as possessing inherent value and they demonstrate courage for engaging in recovery.

Davidson and White (2007) believe that recovery is a potential unifying principle for the
mental health and addiction fields. They define recovery as the “ways in which persons with or impacted by a mental illness and/or addiction experience and actively manage the disorders and their residual effects in the process of reclaiming full, meaningful lives in the community” (p. 113). The authors then articulate a vision for recovery within an integrated framework. Recovery is primarily the responsibility of the person with CD. The role of the clinician, within the recovery model, is to provide access to opportunities (e.g. provide treatment, impart skills, and facilitate the expression and pursuit of meaningful goals). Beyond formal treatment, people need access to community based resources to augment and maintain their progress, for some people this could entail supported housing, peer mentoring, employment assistance, or social opportunities. The majority of recovery occurs in the community. Recovery does not intend to restore the person to their state of being previous to CD, for that would negate the strengths the person has acquired through experiencing CD. The process of recovery indelibly changes people as they overcome CD and the stigma associated with the condition. Recovery occurs within a variety of religious, spiritual, and secular frameworks.

Davidson et al. (2008) sought to provide a recovery framework for CD through trying to coalesce addiction and mental health recovery paradigms. The researchers performed a literature review and consulted people with mental health difficulties or an addiction to articulate recovery for each framework before amalgamating them into a six stage unified model of the recovery process. First stage (two simultaneous steps): initiating recovery and assuming control and establishing and maintaining mutual relationships. Second stage: renewing hope, confidence, and commitment. Third stage (two simultaneous steps): understanding, accepting, and redefining self and community involvement and finding a niche. Fourth stage: incorporating illness and maintaining recovery (including managing symptoms and triggers). Fifth stage (two
simultaneous steps): overcoming stigma and promoting positive views of recovery and assuming control. Sixth stage: becoming an empowered citizen.

Initiating recovery and assuming control: the beginning of the recovery journey in addiction appeared to be initiated by an epiphany moment for many people (Davidson et al., 2008). Similar narratives are not typical in mental health recovery. Both forms of recovery involved people asserting control over their recovery. Establishing and maintaining mutual relationships: both forms of recovery encouraged people to participate in mutually beneficial relationships. Renewing hope, confidence, and commitment: hope provided motivation for action. People needed to believe their life situation could improve and possess sufficient self-efficacy to take the requisite actions to achieve personal goals. Understanding, accepting, and refining self: increased self-worth appeared to be a necessary condition for recovery. From recovery narratives, improved self-worth seemed to precede significant recovery as opposed to following it. Community involvement and finding a niche: well-being appeared to be enhanced through performing personally and socially valued tasks in the community. Incorporating illness and maintaining recovery (including managing symptoms and triggers): people in each form of recovery spoke of it as an ongoing process rather than something with a defined end. Overcoming stigma and promoting positive views of recovery: surmounting self-imposed and societal stigma and countering negative messages was part of creating a personal and collective environment conducive to recovery. Assuming control: people are responsibility for their recovery. Becoming an empowered citizen: people in mental health and addiction often desired to contribute positively to society and exercise greater autonomy.

Hipolito, Carpenter-Song, and Whitely (2011) conducted a study on the meanings of recovery from the perspective of people with CD. Focus groups were conducted with residents of
small housing communities for people with CD in Washington, D.C. Three dimensions of recovery emerged from the analysis of the transcripts: acknowledgement, present orientation, and transformation and growth. Acknowledgement: recognized that mental health and substance use had adversely affected their life, gained self-knowledge about their experiences with CD, and confronted events that are exacerbating their condition. Present orientation: entailed not dwelling on experiences that the person is unable to change. People tried to stay in the moment through immersing themselves in the present task or grounding themselves through a religious worldview. Transformation and growth: participants identified personal capacity for change and manifested that belief in action.

McHugo, Drake, Xie, and Bond (2012) conducted a study that interviewed 130 people with CD, yearly for 10 years, to evaluate the relationship between employment and five non-vocational outcomes frequently associated with recovery: independent living, psychiatric symptoms, substance use, non-substance abusing relationships, and life satisfaction. Participants were separated into groups of workers and non-workers for analysis. Both groups made significant improvements in psychiatric symptom control, substance use remission, regular contact with non-users, and general life satisfaction. Over the first five years of follow up, workers gained independent housing and improved life satisfaction more rapidly than non-workers, yet these differences disappeared by 10 years as the non-workers attained outcomes similar to steady workers. These findings occurred in the context of both groups receiving treatment and improving progressively over 10 years. Steady workers found that employment helped to manage their CD, but non-workers reported that it exacerbated them. The non-workers utilized, on average, $150,000 more per person in services than workers over 10 years. Workers and non-workers were on different paths to recovery based upon their coping strengths.
Roberts (2010) examines recovery from CD in relation to language, clinical expertise, and empowerment. People with CD are identified as possessing two conditions that have been deemed problematic by medical authorities. In accepting that people are experiencing mental health and addiction difficulties, we need to be circumspect not to exclude other important components of the person and their experience. Diagnosing people with CD is an example of clinician power, yet a diagnosis does not require a predetermined course of treatment. Clinicians can diminish the power disparity through working with people to address the issues and outcomes most important to them. Clinicians in a recovery based relationship cease being experts and become partners with the person on their recovery journey. Clinicians have the knowledge of techniques and resources to assist the person in actualizing their version of a meaningful life despite the possible presence of continuing mental health and/or substance use issues.

Laudet, Magura, Vogel, and Knight (2000) conducted a study on the recovery challenges encountered by people with CD. The sample was comprised of 310 participants recruited from CD self-help groups in New York City. Recovery challenges rated as 'very difficult' were: dealing with feelings (anger, pain, shame, guilt, etc.) by 46% of participants; working, finding, or keeping a job at 46%; fear of using substances at 44%; having money problems at 41%; dealing with inner conflicts at 39%; not being understood at 37%; change not happening fast enough at 37%; and being bored at 36%. It is interesting to note that 25% of people rated coping with a mental health disorder as very difficult. For many people with CD it appeared that the addiction component of recovery is more onerous than the mental health aspect. The authors speculated this difference may relate to people with CD having access to psychiatric medication and developing coping mechanisms for mental health difficulties through previous experience. Conversely, the difficulties from abstinence or substance use reduction are relatively novel and
additional strategies may need to be acquired. All the functions that addiction was previously serving, like diminishing negative feelings and social/personal enhancement, need to be fulfilled elsewhere.

O’Grady and Skinner (2012) conducted a qualitative study on the recovery experiences of 38 concerned family members (CFMs). CFMs included blood relatives, spouses/partners, or close friends of someone with CD. The majority of CFMs were women (80%) and were parents of the person with CD (55%). Three themes emerged from the analysis of the transcripts: journey into illness, journey through illness, and journeying on. In journeying into illness, CFMs made the disquieting realization that their loved one suffered from more than one diagnosis, grieved the loss of the person they knew before the onset of CD, and tried to assist the person with CD within the family and through informal means. In journeying through illness, the complexities of the person’s condition became more evident and CFMs were often unable to obtain effective treatment for their family member. Consequently, CFMs felt intensified pressure to provide care. In journeying on, CFMs developed a renewed appreciation of life events including the small victories of the family member, acquired hope for the person with CD despite the vacillations of the condition, increased their knowledge of CD which facilitated feeling more confident and able to cope, and improved their self-care which was referred to as essential for wellness. The authors posited that assisting CFMs improves their well-being and is likely to benefit the people they care for with CD. Recovery applies to the entire support network of the person with CD. CFMs are typically integral to the progress of people with CD and should be involved in treatment planning where appropriate.

Davidson, Tondora, and Ridgway (2010) survey recovery as a process and an outcome. For recovery as a process to be understood in an empowering manner, it needs to be
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disassociated from exclusively achieving traditional outcomes. Meaningful outcomes are determined by the individual. Recovery is available to every person with CD despite the continued presence of substance use and/or psychiatric symptoms. Although implementing someone’s vision of the good life could be difficult in active addiction and with ongoing mental health difficulties, it would be unjust to ask people to indefinitely postpone embracing life until substance use and psychiatric symptoms abate entirely.

In responding to claims that recovery may be rendered hollow if it is so broadly defined that everyone with CD could potentially be in recovery, Davidson et al. (2010) contend that if someone claims to be in recovery, on what basis would we disagree? What would be the purpose in denying recovery to someone? People are encouraged to resist the adverse aspects of CD and to the extent that they are successful, they are considered to be in recovery. Recovery is not an ideal state of being; it is doing as well as possible with the present circumstances.

Davidson, Drake, Schmutte, Dinzeo, and Andres-Hyman (2009) contrast evidence based medicine with recovery. Both of these concepts accept the premise that people have the right to make informed decisions regarding their treatment, suggesting that there is a degree of compatibility between them. Few studies utilize recovery oriented outcomes in their analysis, so little is known about the efficacy of recovery oriented practices. Autonomy of people with CD supersedes effectiveness of interventions when choosing treatments. It is likely that treatments selected by people with CD will be effective as they are meaningful to the person seeking change. It is assumed that reducing psychiatric symptoms and substance use are positive outcomes, yet we should avoid conflating minimizing illness with enhancing life. These concepts may often align with each other, but they should not be viewed as indistinguishable. Clinicians need to be aware of the person’s values, needs, preferences, and choices when formulating a
treatment plan. Recovery provides an overarching structure that promotes empowerment in the therapeutic relationship through incorporating the requirements and desires of people receiving treatment. In determining which recovery oriented practices facilitate people achieving their desired outcomes, we should expand the scope of what constitutes evidence beyond academic treatise to include personal accounts of people with CD.

Min, Whitecraft, Rothbard, and Salzer (2007) examined the effect of participation in a peer support program for people with CD on three year hospitalization patterns. People in the peer support group had longer periods without rehospitalisation and more total days in the community. 73% of the control group were rehospitalized in the three year period compared to 62% of people receiving peer support. All participants had received intensive case management services.

**Harm Reduction**

Marlatt (1998) outlines the five principles informing the harm reduction approach. First, harm reduction is a public health alternative to the moral/criminal and disease models of substance use and addiction. Harm reduction focuses on the effects of drug and alcohol use on the person and society. It accepts that many people engage in substance use and that abstinence based strategies are not appropriate for all people. Second, harm reduction recognizes abstinence as an ideal outcome, but it accepts alternatives that reduce harm. Harm reduction is not anti-abstinence; it views substance use primarily in terms of excessive and minimal risk. Any reduction in substance related harm is movement in the right direction. It is contested in the addiction field whether harm reduction, while a valid goal, should be presented as an equally worthy option compared to abstinence. Third, harm reduction has emerged primarily as a ‘bottom up’ approach based on the advocacy of people with addiction, rather than a ‘top down’
strategy. Fourth, harm reduction promotes low threshold access to services as an alternative to traditional, high threshold approaches. Harm reduction services are a treatment option available to people who are still actively using substances. Mandating abstinence to receive services precludes access for many people who could potentially benefit from them. Fifth, harm reduction is based upon the tenets of compassionate pragmatism versus moralistic idealism. When people are suffering adverse consequences from substance use, it is of little value to examine the probity of their actions. Seeking to facilitate the reduction of harm from substance use should not be conflated as endorsement for substance use.

Denning (2012) writes about the necessity to adapt treatments for CD to reflect the principles of harm reduction. She believes that the creation of a form of counselling that integrates harm reduction is an apt framework to help accomplish this. Harm reduction psychotherapy has 11 guiding principles. (1) Harm reduction is any action that attempts to reduce the harm of drug abuse. (2) There can be no punitive sanctions for what a person puts in their body or refuses to put in their body. (3) People use substances for many reasons and not all drug use is abuse. (4) People can and do make rational decisions about important life issues while still using. (5) Denial is not denial. It is a product of shame and punitive sanctions and is usually quite unconscious. (6) Ambivalence and resistance to change are human. It is our job to work with someone’s ambivalence and explore it, not confront it. (7) Addiction is not a disease, but a biopsychosocial phenomenon in which the weight of biological, psychological, and sociocultural aspects are different in each person. (8) Substance abuse represents a relationship that offers significant support to the person. Treatment must offer support, as well as acknowledge that the positive benefits of substance use may not be able to be fully replaced. (9) Motivation toward change is the mutual job of the treatment provider and the client. (10) Success
is any positive change or any step in the right direction. (11) Change is slow and incremental with many setbacks. Relapse is the rule, not the exception. Planning for it should occur. The therapist should help people stay alive and healthy and connected to treatment during their process of change and through any relapses.

Phillips (1998) and Phillips and Labrow (2000) scrutinize the viability of harm reduction approaches as a complementary option to abstinence only treatment. Harm reduction frameworks have a good understanding of the benefits people derive from substance use. For some people, drug use provides a community where they experience acceptance, friendship, and an alternate identity that does not occur elsewhere in their lives. Drug use may be, for some people, the only area where they feel that they have some degree of control. Harm reduction may be inappropriate for people with substantial cognitive impairments or those lacking insight while experiencing acute CD. Harm reduction can be modified to adapt to the needs and reality of each individual.

Tsemberis, Gulcar, and Nakae (2004) examined perceived control in housing choice, time spent homeless, and housing tenure with 255 people who had CD and were homeless. 126 people were assigned to the control group which required treatment and abstinence from substances to retain housing and 99 were placed in low barriers housing without prerequisites. Follow ups were conducted at 6, 12, 18, and 24 months. People in low barriers housing experienced significantly more perceived control in their housing choice; spent less time homeless; and were more stably housed, with approximately 80% still in low barrier housing at the completion of the study compared to approximately 30% in the control group. Levels of drug and alcohol use were similar between the control and experimental groups.

Mancini, Hardiman, and Eversman (2008) review the compatibility of harm reduction and recovery oriented practices for people with CD. Harm reduction is an adaptable approach
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that is compatible with best practices, CD treatment. It often manifests as minimizing the negative physical, social, or legal consequences of use through encouraging people to engage in safer substance use patterns and behaviours such as: reducing the frequency and intensity of use, using in a secure environment with trusted others, and utilizing clean needles and condoms. Low threshold services tend to increase retention rates in CD services and reduce the likelihood of people being in hospitals, correctional facilities, homeless shelters, and living on the streets. They also provide housing, food, clothing, health care, and social support without requiring abstinence. Low threshold programs attempt to help people develop skills to reduce or eliminate substance use while cultivating empowerment and autonomy. They provide an engaging forum to prompt people to consider how substance use affects their life and the interaction between psychiatric symptoms, substance use, and medication. Harm reduction services can be complementary to abstinence based treatment.

Little, Hodari, Lavander, and Berg (2008) chronicled the operation of a harm reduction drop in group for people with CD. The authors posited that the low threshold format embraced people that may otherwise not have contact with services and it encouraged them to examine their substance use and its position in their lives. The drop-in structure was welcoming of all people with CD and provided an accessible form of group treatment.

The Little et al. enumerated the seven principles of the low threshold, harm reduction group they studied (2008). (1) People in drop in groups were accepted as they were, including their substance use. (2) Members were experts on their lives. People were encouraged to explore their narratives. (3) Members chose discussion topics. People talked about what was meaningful to them. (4) The facilitator did not seek a specific outcome for group members. The facilitator remained neutral and explored members’ experiences of substance use through tools like the
decisional balance. (5) Facilitators respected member resistance to change. People had the right to continue using substances if they chose. (6) Conflict was minimized in the group. The authors observed that conflict seldom was beneficial to the treatment process. (7) Facilitators fostered a therapeutic environment. People needed to feel safe and accepted to maximize the benefit from group participation.

**Shared Decision Making**

When people engage in clinical treatment they enter into a relationship. The therapeutic relationship contains power dynamics and individual values, preferences, fears, and desired outcomes. It is imperative that the autonomy of people with CD is respected in the treatment process. SDM is a framework, that I have adapted from the medical discipline, which seeks to achieve a mutually agreeable structure for treatment. I believe that it can be applied successfully to the counselling relationship to facilitate the empowerment of people with CD.

Moulton & King (2010) examine SDM from an ethical perspective. They define SDM as “a process of communication in which the physician and patient use unbiased and complete information on the risks and benefits associated with all treatment alternatives and information from the patient on personal factors that might make one treatment more preferable than others to come to a treatment decision” (p. 84). The authors postulate that SDM promotes autonomy while allowing space for beneficence (professional obligation to act in the best interest of the client). To make decisions in accordance with SDM principles, people need access to relevant information, the advice of the physician, and the autonomy to incorporate their goals and values.

Charles, Gafni, & Whelan (1997) outline the essential components of SDM. The authors identify four characteristics of SDM. (1) SDM involves at least two people, the clinician and the patient. (2) Each party takes steps to participate in the process of treatment decision making. (3)
Information sharing is a prerequisite for SDM. Both parties bring values and knowledge to the relationship. (4) A treatment decision is made and both parties agree to the decision. The treatment plan may not be the best course of action in the opinion of the clinician, but it is within the acceptable range of treatments. Both clinician and patient share responsibility for the final treatment decision.

Drake, Deegan, & Rapp (2010) advocate for the use of SDM in the mental health field. The authors state that the adoption of a SDM framework would contribute to diminishing power disparities between medical staff and people with psychiatric disabilities through the provision of information about treatment and recovery. Mental health treatment usually involves complex trade-offs and the people experiencing the effects of treatment decisions are in the best position to evaluate compromises in regard to treatment efficacy, goals, and side effects. SDM creates a space for communication which facilitates people being able to pursue outcomes that are congruent with their values and beliefs. People with serious mental illness have the capacity to understand the potential benefits and harms of different treatments and are able to make rational decisions based upon their interests.

Woltmann & Whitley (2010) conducted a study on the decision making styles of 16 people utilizing mental health services. Two prominent themes emerged from the study. First, people tended to define their decision making preferences somewhat differently as envisioned in SDM literature. People expressed a preference for autonomous decision making or SDM in interviews, but further exploration revealed a desire to confirm their decision with their case managers. No one in the study stated a preference for a paternalistic decision making style. Second, people had an ambivalent decision making relationship with their case manager. People did not want to disclose some information to their case manager due to mistrust, primarily
stemming from a lack of experience with them. When discord arose over a decision, people would often defer to the judgement of the case manager, for they doubted their own decision making abilities. When people agreed with their case manager, they focussed on the relational and affective aspects of decision making and not on the deliberative features or the content of their decision. The authors postulated that having been denied agency and self-efficacy in previous encounters with the mental health system, people may need assistance in developing assertiveness in encounters with health professionals.

**Personal Medicine**

Deegan (2005) conducted a qualitative study on resilience with 29 people with serious mental illness. When people described their use of psychiatric medicines, they also explained personal medicine. Personal medicine was defined as “self-initiated, non-pharmaceutical, self-care activities that served to decrease symptoms, avoid undesirable outcomes such as hospitalization, and improve mood, thoughts, behavior, and overall sense of well-being” (p. 31). Participants expressed two types of personal medicine: activities that gave meaning and purpose to life and coping strategies. Many people described using a combination of psychiatric medication and personal medicine to manage mental illness. Participants often did not share their personal medicine strategies with health care staff. Four participants in the sample reported medical practitioners inquiring about their personal medicine strategies. When psychiatric medication interfered with meaningful activities, many people reported discontinuing the responsible pharmaceutical.

Deegan (2007) describes her experience with psychiatric medications as a person diagnosed with schizophrenia to advocate for the use of personal medicine within a SDM framework. When Deegan was first diagnosed with schizophrenia, it was presented to her as a
chronic condition for which there was no recovery. For Deegan, not taking her medication represented a rejection of the hopelessness of her diagnosis. Deegan states that medication should support the things that help to make a person’s life meaningful and not be a question of obedience. Clinicians can help elicit a recovery vision and personal medicine techniques from people with mental illness. A combination of scientific and personal knowledge should inform mutual agreement on problem definition, determine how the condition will be treated, and decide what the desired outcomes will be. The mixture of psychiatric medication and personal medicine should be optimized to promote recovery.

MacDonald-Watson, Deegan, Hutchinson, Parrotta, and Schuster (2013) outlined an endeavour to operationalize personal autonomy and well-being in the medical encounter with the assistance of an internet based application called Commonground. The devised process had three stages: identification and communication of personal medicine, development of a power statement, and generation of a summary health report. Peer support specialists helped each person articulate their personal medicine. The top three strategies for each person were entered into Commonground and at every appointment the person reported their personal medicine use. The power statement described how the person would like psychiatric medicine to help them. A shared decision was then made about the use of personal and psychiatric medicine between the person and the prescriber at the end of each appointment. The use of personal medicine increased from 74.9% at the initial report to 82.6% at the last report. People who used personal medicine were significantly more likely to communicate no concern about medication side effects and express that medication was aiding their recovery. Personal medicine use was significantly associated with better health functioning, symptom improvement, and decreased belief in their mental health recovery lacking progress.
Empowerment and Treatment Modalities

CBT, MI, and ACT are the primary treatment modalities at the CAST. Glassman, Kottsieper, Zuckoff, and Gosch (2013) conducted a study that explored the effect of MI on hope, meaning, empowerment, and service participation for six people with CD enrolled in an outpatient program. Study participants had been identified as difficult to engage by clinicians based on inconsistent attendance and/or low involvement in sessions. After four sessions of MI, all study participants expressed increased levels of hope, meaning, and empowerment.

Keegan-Eamon (2008) examines empowering vulnerable populations through cognitive behavioral interventions. The most frequent criticisms of CBT, in regards to empowerment, state that it is an expert driven and controlled process, it is used to identify individual deficits and facilitate people in adapting to unjust circumstances, and CBT lacks social relevance through changing narrowly defined behaviours, establishing quantitative intervention goals, and standardizing procedures.

Keegan-Eamon counters each claim individually (2008). First, CBT as an expert driven technique may constrain freedom by directing individual behaviour. Additionally, defining the target behaviour and dictating assessment, intervention, and evaluation procedures may increase feelings of powerlessness. However, assisting people to counter behaviour and thoughts that are experienced as disempowering can enhance individual freedom. Second, CBT can be used to empower or oppress, for it does not possess an inherent value stance. Treatment goals should be important, desirable, acceptable, and viable from the perspective of those receiving services. Practitioners should possess cultural competence to develop solutions consistent with a person’s experience. Third, problem and goal selection, assessment and intervention procedures, and tracking progress are individualized, described, negotiated, and agreed upon with the person.
receiving treatment. The above process allows people the opportunity to make informed choices. When we validate people’s strengths and adaptive responses to difficult situations, we are engaging in empowering practice.

**Summary of Literature Review**

CD is defined as having a diagnosis of a SUD and a mental health disorder as outlined by DSM V. People with CD are a heterogeneous group who have a multiplicity of mental health disorders, use a variety of substances, and are unique individuals, yet there are tendencies among this group. Most people with CD are male, are experiencing some degree of homelessness, have not graduated high school, are unemployed, identify as Caucasian, and have suffered childhood emotional, physical, and sexual abuse.

The prognosis studies I examined had a large number of participants, observed them over an extended time frame, and recruited people from outpatient settings. Most people with CD whom initially engaged in outpatient treatment at the end of 10 years of study had psychiatric symptoms below clinically significant levels, were in remission from substance use, were living in independent housing, and expressed general life satisfaction. A substantial number of people were employed and had regular contact with friends who did not engage in substance use. These results may have been less sanguine if study participants had been recruited from inpatient settings.

The definition of empowerment used during my practicum and in the writing of this report incorporates structural social work. People with CD are adversely affected as members of outgroups in satisfying their material and psychological needs. Empowerment theorists are hopeful that societal structures can be changed to reflect justice and equity, yet there is uncertainty how this transformation would emerge. Social workers can increase empowerment
by helping people with CD alleviate the adverse effects of oppression they experience, improving control of their lives through treatment, and attempting to modify societal structures.

Conceptions of recovery initially emerged from the addiction and mental health communities. Efforts have been made to articulate recovery as it pertains to people with CD. Recovery is unique for each individual and is manifested in seeking to achieve a self-defined, meaningful life. It is a process and an outcome that is available to all people with CD, including those with ongoing psychiatric symptoms and/or substance use. Recovery and the effects of CD extend to those who care about people with the condition. Recovery is an organizing framework for the therapeutic relationship between clinicians and people with CD.

Harm reduction is an additional treatment option available to people with CD. Abstinence from substance use is not the preferred outcome for many people with CD. In a harm reduction paradigm, substance use is examined by the damage inflicted upon the person using substances and society. Subsequently, harm reduction informed practice seeks to reduce the destruction related to substance use. Low threshold services, not requiring abstinence from substance use, provide an opportunity to engage with a population that has traditionally been underserved. Harm reduction can be complementary to abstinence based treatment, not antithetical.

SDM is a framework that decreases power disparities through clarifying the positions of people in the therapeutic relationship, providing information on treatment options, and reaching mutually agreed treatment decisions. It promotes the autonomy of people with CD. Clinicians should be receptive to pursuing various treatment outcomes and exhibit flexibility on the methods to realize goals as a component of creating an equitable relationship.

Personal medicine refers to non-pharmaceutical strategies used by people with mental health difficulties to improve their well-being. Types of personal medicine are engaging in
meaningful activities and using coping strategies. Patricia Deegan, who initially articulated the concept, gives personal examples in relation to schizophrenia such as: using earplugs or headphones in the din of large crowds to diminish the prevalence of distressing voices prompted by these situations, exercising to dispel tension, praying and meditating to quiet thoughts, and having the goal of attending and completing university. Psychiatric medication can complement or contradict personal medicine. The inclusion of personal medicine into CD treatment is consonant with empowerment and recovery.

Of the treatment modalities in use at the CAST, literature was found contrasting MI and CBT with empowerment. Empowering use of MI increases the ability of people to exert control over their lives. CBT can be empowering when it helps people challenge thoughts and behaviours that are encountered as oppressive and when the practitioner includes the person in defining problems, customizing treatment, and choosing outcomes. MI and CBT are not inherently empowering or disempowering.
Chapter Three: The Practicum Learning Experience

The purpose of this chapter is to describe the accomplishment of the learning goals guiding my practicum. First, I will discuss the development of my clinical social work skills through performing individual counselling and co-facilitating psycho educational and support groups. Second, I will examine my perception of empowering people with CD in a clinical context as informed by my practicum experience and the literature review. Lastly, I will review the resources available to people with CD in Prince George.

Learning Goals and Questions Guiding the Practicum Placement

I completed a practicum of 560 hours with the CAST through the Northern Health Authority in Prince George. The practicum involved the completion of three tasks. (1) Develop my skills as a clinical social worker within the setting of treating people with mental health and/or substance abuse disorders. (2) Learn more about empowering people with CD. (3) Become more aware of resources available for people with CD in Prince George. My practicum experience was guided by three questions. (1) What are the common needs to improve the well-being of people with CD? (2) From my vantage point as a practicum student with the CAST, how are the needs of people with CD being met? (3) What can clinical social workers do to facilitate the needs of people with CD being met at micro, mezzo, and macro levels?

Development of Clinical Social Work Skills

Development of Clinical Skills through Individual Counselling.

I was fortunate to have been able to provide seven people experiencing mental health and/or addiction difficulties with individual counselling during my practicum. People were vetted with my practicum supervisor to ensure that the difficulties they exhibited were within my skill set to address. These people displayed trust and kindness to engage in a therapeutic
relationship with me knowing that I was a student, with less experience than staff clinicians, and
that I would be with the CAST for a limited duration of time and they would be transferred to
another clinician at the end of my practicum. I greatly appreciate their willingness to participate
in my learning experience.

A common occurrence that I encountered at intake at the CAST was people being
overwhelmed with mental health and/or addiction difficulties. The problems they experienced
were beyond their coping capacity. People often presented as feeling powerless, out of control,
and despondent. Intake was an opportunity to collect information to guide the therapeutic
relationship and screen for imminent danger to themselves or others, yet I discovered it was also
an occasion for instilling hope. It did not involve making assurances that things would improve,
but it entailed acknowledging that they had taken a courageous step in seeking counselling,
imparting that people with their condition had been able to lead personally defined, meaningful
lives, and talking with the person about what positive change would look like in their life. My
practicum experience taught me the importance of conveying realistic hope.

Most people seemed to be apprehensive at the intake session. Feelings that people may
have had included: unease about disclosing intimate details of their life, doubts about whether I
was able to effectively assist them, internalized stigma from societal attitudes that often
accompany seeking counselling and acknowledging the presence of mental illness and/or
addiction, and discomfort about the prospect of changing aspects of their life. I tried to facilitate
an environment that conveyed safety and comfort to allow the person to explore difficulties,
strengths, possibilities, preferences, the self, relationships, and their physical, social, mental, and
spiritual milieu. I attempted to build rapport through showing friendliness, empathy, compassion,
a caring attitude, and unconditional positive regard. My practicum experience improved my
ability to create an atmosphere conducive to therapeutic engagement.

I prepared session plans to provide structure in the counselling relationship. My session plans began with homework from the previous meeting and ended with possible activities to be completed between then and the next time we convened. Homework was individualized and often consisted of practicing a skill, accessing a resource, or completing a worksheet. Most of the session plan consisted of topics and activities that I wanted to broach in the upcoming session based upon the content of the previous meeting and the achievement of the person’s goals. Often, my session plan was completely abandoned as the person’s circumstances had changed significantly, rendering my therapeutic interventions irrelevant, or they were in crisis and I needed to address present concerns. The times when I discarded the treatment plan hastened my development as a clinical social worker, for I was compelled to utilize the range of my skill set to assist the person. Additionally, I perceived that I was more attuned to the present moment without my session plan, for I needed to comprehend and analyze the person’s current situation more intently. As my therapeutic abilities were enhanced, my session plans became less detailed and I was more comfortable and better able to adapt my clinical focus. My practicum experience helped me to adopt a flexible counseling disposition to meet the needs of people.

My practicum experience allowed me to use treatment modalities such as CBT, MI, and ACT in therapeutic interventions. Prior to being with the CAST, I had limited experience employing the former two and had not used the latter. The clinical practice I received provided an opportunity to expand my knowledge of these treatment modalities. Clinical experience provided insights of when to employ a particular modality and their respective strengths and limitations. I also discovered that my knowledge of these modalities required further development to apply them to situations such as pain management, trauma, post-traumatic stress
disorder, and borderline personality disorder. The inclusion of additional therapeutic paradigms would benefit my clinical practice. This practicum experience allowed me to increase my familiarity with the aforementioned modalities and establish learning objectives that include applying these psychosocial treatments to specific conditions and becoming familiarized with additional paradigms such as Prolonged Exposure Therapy.

Many of the people with whom I engaged in clinical interventions were consuming prescribed psychiatric medications. They would often want to discuss the effects and efficacy of their medication. I found my knowledge of psychotropic medications to be deficient, so my learning contract was amended to include collecting information on common psychiatric medications and the condition(s) which the drug was intended to treat. After assembling the material on pharmacological interventions for mental health diagnoses, I found that I was able to engage in conversations on medication more competently.

Prior to commencing my practicum I had some experience in the addiction field, yet my understanding of many mental health conditions and CD was nascent. During my time with the CAST, I gained a better understanding in all the aforementioned areas. My knowledge of mental health and CD increased the most, for I received significant clinical exposure to these areas to build upon my underdeveloped understanding. Specifically, my knowledge of anxiety, depression, obsessive compulsive disorder, post-traumatic stress disorder, bipolar disorder, borderline personality disorder, and CD were enhanced through clinical experience, utilizing supervision, and performing additional research.

**Development of Clinical Skills through Group Experience.**

**Changeways Core.**

During my tenure with the CAST I participated in three therapeutic groups: Changeways
Core, Anxiety and Panic, and Relapse Prevention. Each of them greatly contributed to my clinical knowledge base. The Changeways Core Program: Practical Strategies for Personal Change was first initiated by psychologists Peter McLean, Lynn Alden, and William Koch in 1991 to target people experiencing depression using CBT principles. In a trial of the initial program, people in the Changeways Core group experienced an 8.1% hospital readmission rate after six months compared to the control group at 30% (Paterson, 2006). Additionally, those in the experimental group had an average 39% shorter hospital stay than the control group.

Changeways Core is primarily a psycho educational group. The group I co-facilitated at the CAST consisted of people with non-acute depression and it was held weekly for 8 sessions that were 2 hours each in length. The program, as constructed by Paterson (2006), consisted of five modules: triangle and goals; stress, depression, and lifestyle; thinking about thinking; the role of your social life; and the road ahead. The triangle and goals module introduced the CBT concept of the connection between thoughts, feelings, and actions and people set attainable goals to accomplish. The stress, depression, and lifestyle module educated people on stress and depression and discussed lifestyles to help people achieve better coping. The thinking about thinking module addressed the cognitive side of CBT through conducting exercises in thought monitoring, exploring styles of distorted thinking, and broaching strategies for overcoming negative thinking. The role of your social life module examined the importance of personal relationships to mental health, how to improve and expand social networks, and assertiveness. The road ahead module provided a review of course material and addressed relapse prevention.

Participants set a personally meaningful goal during the first session that was specific, their own, action oriented, realistic, and time limited. Goals were divided into attainable weekly tasks that contributed to people accomplishing their objectives. Setting expectations at current
capacity appeared to help create a positive spiral where successes created an autocatalytic effect. The program’s design facilitated people gaining momentum in achieving their chosen goal and recovering from depression. A woman in the group stated that the tidiness of her home had declined after she experienced an acute episode of depression which had since reduced in severity. She set the goal of increasing the cleanliness of her home. In the group session we would discuss the room, days, and amount of time she would clean along with any foreseen obstacles. The next session we would discuss how successful she had been in accomplishing her weekly goal. From pursuing her goal the woman stated that she had a much cleaner home, an increased sense of accomplishment, improved physical fitness, and a bolstered sense of well-being.

I had moderated psycho educational groups in the past, yet their duration had been an hour at most. The material from the program engaged the group directly for approximately an hour; the remainder was spent facilitating discussion. The presentation of material was interspersed with discussion. Initially, I was apprehensive about the format. To counter this, I prepared thorough notes on the material to ensure sessions would reach full time. While sessions did not end early, I found that I was excessively relying upon my notes and this stifled discussion, for I was doing much of the speaking. In subsequent sessions, I still prepared comprehensive notes, yet I wrote them with an intention of facilitating discussion. My new approach was successful and people seemed to connect better with the program material and each other. I realized that my initial apprehension had been based on uncertainty of my own skills as a facilitator in a group format. I had sought to compensate for my lack of confidence through control. Generating more participant interaction with the program material helped me to increase my confidence and become more comfortable in sharing space with others. In co-
facilitating this group I learned more about how to effectively moderate therapeutic groups; particularly how to present material and facilitate discussion.

**Anxiety and Panic Group.**

Another psycho educational group I co-facilitated was Anxiety and Panic. It is a program designed for people who are experiencing panic attacks and anxiety that are adversely affecting their well-being and quality of life. Developed by clinicians at the CAST, it is a CBT based program that specifically targets behaviours and thought patterns that contribute to anxiety. The program has five components: education about anxiety and panic, relaxation training, CBT, Behavioral Exposure Therapy, and assessments. The program is comprised of 10 weekly sessions that are two hours in length.

Former University of Northern British Columbia student Lani Ho analyzed the Anxiety and Panic group for her Master of Social Work thesis conducted at the CAST in Prince George (2010). She performed a mixed methods study consisting of semi-structured interviews with three participants and analyzed pre and post intervention assessments collected from 34 people from 2006 to 2009.

Seven themes emerged from the qualitative interviews (Ho, 2010). (1) Joining the group and expectations of the group. (2) The group experience. (3) Coping strategies. (4) Strengths, likes, and highlights of the group. (5) Weaknesses, dislikes, and low points of the group. (6) Suggestions. (7) The interviewee’s environment. The most frequently stated reason for joining the group was to learn coping strategies. People found the group experience to be supportive and it helped normalize their experience with anxiety and panic. The coping strategies introduced by facilitators and group members resonated with participants, with different strategies proving effective with different people. People particularly enjoyed group discussions and the sharing of
personal experience, yet it was expressed that some participants spoke disproportionately and discussed topics irrelevant to the subject matter. Follow up inquiries were suggested as a method to improve the program.

In examining the pre and post assessments, Ho (2010) found that the average participant: experienced less general anxiety, moving from severe anxiety to minimal to moderate anxiety; gained a threshold of functioning pertaining to the fear of anxiety and related symptoms; had a similar number of panic attacks, but experienced them less intensely; while alone and when accompanied practiced less avoidance in common anxiety provoking situations; was less depressed; and had less fearful, anxiety related thoughts. These results are remarkable considering Anxiety and Panic encourages people to confront anxiety provoking situations. Ho’s research gives credence to the skills and perspective acquired in the group.

I had read the aforementioned thesis prior to co-facilitating Anxiety and Panic. As a co-facilitator, I found it to be a valuable resource in how I conducted myself during the group. I attempted to increase elements that people in the thesis had identified as positive and diminish those that had detracted from the experience of participants. The features of an effective Anxiety and Panic group, as noted by Ho, appeared to apply to the embodiment of the group I co-facilitated. Access to this resource likely increased my effectiveness as a co-facilitator in Anxiety and Panic.

Through the group, I was privileged to be given access to personal accounts of anxiety and panic. Participants’ narratives and methods of coping provided me with a better understanding of the mechanisms of anxiety and panic and ways to alleviate it. For example, people reported noting the location of bathrooms and seeking refuge in them when experiencing panic attacks in public places until it subsided as a method of coping.
Prior to my practicum, I had much more experience with the cognitive aspect of CBT. This group, along with my individual counselling experience, helped me become better acquainted with behavioral interventions. I was able to apply the knowledge I gained in this group to counsel individuals with anxiety disorders. After involvement in a motor vehicle accident, one person I counselled had severe anxiety about travelling in an automobile. Once we had talked about his stressors and reduced them in his life, examined his thoughts about motor vehicle travel, and practiced and became skilled at using coping strategies, he was able to drive with much less distress as evidenced by his anxiety scaling.

All group based programming at the practicum site had multiple facilitators. This system helped to distribute teaching and moderating responsibilities, allowed for different perspectives on the same topic, provided an opportunity for facilitators to gather their thoughts, and contributed positively to the mental well-being of group members by allowing a facilitator to observe demeanour and assist those in distress while being able to continue the group. This last point was particularly significant in Anxiety and Panic, for the difficulties in joining a new group were magnified by their condition. Extra care needed to be taken in assessing how people were feeling and appropriate measures enacted with the individual or group. In the second session, after the assessments were completed in the first meeting, my practicum supervisor ascertained that many members of the group were quite anxious. Fears of participants were alleviated through discussing curriculum and expectations of group members. The anxiety was not conveyed through discussion, but with non-verbal communication. My supervisor was conscious of group members discomfort before I became aware of it. At the beginning of Anxiety and Panic it was imperative to create a non-threatening environment; this meant being more active as facilitators to set group norms. When participants established that the group was safe, facilitators
were able to take a less active role. My practicum supervisor was very skilled at evaluating how people were feeling and helping to ameliorate their emotional state. Through observing her in Anxiety and Panic, I gained a better understanding of how to manage groups emotionally.

**Relapse Prevention.**

The Relapse Prevention group differed in audience, content, and format from the two other groups in which I participated. Core Changeways and Anxiety and Panic were directed toward people that were primarily experiencing mental health problems, depression and anxiety disorders respectively. Most people attending Relapse Prevention were having difficulties predominately with addiction issues. Despite the principal focus of the group, when a participant broached mental health, it was addressed in the group. More comprehensive CD work was done with the person in individual counselling.

Relapse Prevention, unlike other programs at the CAST, was an open group, for there did not need to be a referral by a counsellor with the agency and the person did not even need to be receiving other services from the organization; it was open to all people seeking assistance in their recovery journey. A safe and therapeutic dynamic needed to be continually reaffirmed, for with the open format, there were people new to the group attending most sessions along with the regular attendees. People seemed to be more reticent at the beginning of the session, yet as time progressed, and the comfort of participants improved, people would increasingly express what they were experiencing and respond to material presented by the facilitators.

SAMHSA and the Center for Substance Abuse Treatment (2005) outlined the functions of relapse prevention groups as skill development, CBT, support, and psycho education. Relapse Prevention in operation was a fascinating mix of these components. The clinicians were adept at alternating between the different functions of the group, for the needs of groups members.
required them to switch from one role to another. Being a good facilitator in this environment necessitated having good judgement of group needs and how to respond appropriately, such as whether to be active or passive and what function to employ.

One instance that was particularly remarkable occurred when a group member shared his difficult relationship with his adult children. He related how his parenting had been affected when he had an active addiction. My initial impulse was to respond to him with the support, CBT, and skill development functions, yet I restrained the impulse and allowed the group to address the issue. People related their experiences with similar circumstances and how they initiated healing. Afterwards, I stated that his intense guilt for past actions was not beneficial and reiterated the actions suggested by the group to repair the relationship with his children. The group provided the man with valuable guidance in a difficult situation.

Of all the groups I participated in, I found Relapse Prevention the most onerous in which to be a facilitator. With my previous experience in the addiction field, I thought I would adapt quickly, but the group format, though effective, was unfamiliar for me. In joining Relapse Prevention, I was initially unsure about my role. I was uncertain when to be active, when to allow the group to process issues, and what function to fulfill when I acted. Through the guidance of the other facilitators and my practicum supervisor, I adapted to this group paradigm. Participating in Relapse Prevention allowed me to become acquainted with an additional therapeutic group process. I feel prepared after participating in this group to be able to create a supportive environment in a variety of group treatment settings.

My previous experience in the addiction field was at a youth drug and alcohol detoxification centre. The youth I worked with tended to be in the earlier stages of change: precontemplation, contemplation, and preparation (Prochaska & DiClemente, 1983). People
attending the Relapse Prevention group were in the action and maintenance phases. Prior to
Relapse Prevention, I had little understanding of how people with addiction navigated recovery.
Through my experience with this group, I gained knowledge about the challenges and benefits
encountered by people in recovery. I also found this group to be helpful for contrasting the
experiences of adults and youth with addiction to better my understanding of the factors
contributing to addiction, relapse, and recovery across the life span. My experience with Relapse
Prevention taught me how to better assist people in reducing or eliminating their substance use
through knowing the common causes of relapse and successful strategies to navigate recovery.

One person I counselled was recovering from a crack cocaine addiction. We identified his
primary stressors that may endanger his recovery as suppressing negative emotions, family
conflict, and chronic pain. Strategies for maintaining his sobriety consisted of using existing and
learning additional coping mechanisms, reducing excessive stress from his life, accessing
treatment to manage pain, utilizing his support network, and continuing to have awareness of his
desire to act as a good uncle which served as an initial and ongoing impetus for abstinence.

**Other Practicum Activities that Enhanced Clinical Skills.**

At my practicum placement I experienced a range of learning opportunities which
contributed to my skills as a clinician. I attended a presentation by Glen Schmidt outlining the
modifications to the 5th edition of the DSM. In addition to the stated purpose of the discussion, I
gained a greater understanding of the benefits and limitations of the DSM. DSM provides a
common language when conversing about mental health conditions and it assists in informing
clinical impressions, yet the inclusion and exclusion of various diagnoses in the manual is a
contentious process and its continued expansion could be construed as pathologizing routine
human behaviour. This presentation helped me to use the DSM with more effectiveness and
I participated in a conflict resolution seminar presented by the Northern Health Authority. Many different perspectives were presented by the facilitator. The most enduring aspect of the seminar for me was the section on conflict styles (Thomas & Kilmann, 1974). The five styles of conflict were: competing, collaborating, compromising, avoidance, and accommodating. I was galvanized by the material to consider my emotional response to situations, what conflict strategy I employed, and whether it was beneficial. This seminar helped me to clarify how I confront conflict, examine my motivations in disputes, and scrutinize conflict in the therapeutic relationship.

I attended a countertransference in group settings seminar at the CAST hosted by John Sherry as a representative of the Canadian Group Therapy Association. It was an illuminating experience to examine my feelings that have been elicited by group work with a clinician skilled in the subject. I found it liberating to accept that I am occasionally triggered by people in the therapeutic relationship. I learned that what is imperative in countertransference is not that there are feelings elicited, but that we are able to work through them effectively without them impinging upon the best interests of those we serve.

During my practicum I had the opportunity to accompany the Adult Addictions Day Treatment Program (AADTP). It is an 8 week non-residential program for people aged 19 and older with addiction or CD and abstinence based recovery goals. The program follows a module format with components such as: morning process group, Seeking Safety, health and wellness, self-esteem, social skills, activity group, Self-Management and Recovery Training (SMART Recovery), and afternoon process group.

My experience with AADTP allowed me to learn more about the continuum of treatment
for addiction. The people attending tended to be commencing drug and alcohol cessation. The content overlapped with much of the material I have encountered in detoxification and Relapse Prevention environments, but the planning with program participants was much more detailed. At the beginning of each day, people were asked about their previous evening in regards to encountering triggers, desire to use substances, activities undertaken, stressful situations, and lapses; people were not discharged from the program for lapses. The day ended with people telling the group their plan to abstain from substance use for the evening, including how they would confront any foreseen difficult situations. Participation in this program conveyed the fragility of early recovery and the steps clinicians can take to maximize the likelihood of continued abstinence from substance use.

I was fortunate to have been able to accompany a person with the Community Outreach and Assertive Services Team (COAST). Based on the Psycho-Social Rehabilitation Model, COAST serves people aged 19 and above with serious mental illness, CD, and those with higher levels of functioning and a developmental disorder. Multi-disciplinary staff provides in vivo and agency based services to help people attain the skills to successfully navigate tasks of daily living, maintain good mental health, and accomplish their personal goals.

Prior to my introduction to the COAST, I had notions of what people with mental illness and CD required to flourish. Accompanying the COAST member to the homes of program participants, resources in the community, and agency based interventions, I gained a better sense of the material, social, emotional, and physical requirements for people with mental illness and CD to live a life they deem meaningful. I developed a more holistic and practical conception of how the process of self-actualization manifests in the community for people with mental illness and CD. I met one woman at her home, Connections Clubhouse, and at the Activity Centre for
Empowerment. These contacts allowed me to witness her negotiate physical and mental health difficulties and financial pressures while attempting to have fulfilling relationships and pursue meaningful activities. I observed how the COAST and other service providers helped her to reduce her stressors and assisted her in endeavouring to achieve her aspirations. My experience with the COAST combined pragmatic realities for people with mental illness and CD and clinical conceptions of well-being for a more nuanced understanding of their needs.

**Perspectives on Empowering People with CD from my Practicum Experience**

**Empowerment in Individual Counselling.**

At intake I met with people that wanted to improve their well-being, but they had been unable to achieve sufficient, sustained improvement hitherto through their own efforts and those of others. Thus, some people appeared skeptical about whether an effective intervention for their situation existed. I tried to instil realistic hope that emphasized recovery as a gradual, incremental process that was available to all. Hope can be an impetus for people to exert more control over their lives.

During my practicum I utilized SDM to construct empowering treatment plans. I engaged in a dialogue with people to articulate their difficulties and strengths, provided information on the treatments available to address their condition(s), and elicited beliefs and values toward the construction of goals and a definition of a meaningful life. It is imperative that the person agree to the problem definition, methods, and outcomes stated in the treatment plan for it to be considered consonant with empowerment. The treatment plan did not have to be optimal in my opinion for me to enact it, but I did have an ethical and professional responsibility for it to be an acceptable course of action. To be empowered in counselling, the person receiving treatment must be the creator of their own recovery. In my experience, a treatment plan harmonious with
the desires of the person for whom it is intended is likely to encourage therapeutic engagement.

In constructing one treatment plan with a person during my practicum, I did not agree with how she defined the difficulties she was experiencing. She construed her problems as relating to poor self-esteem. From her narrative, it appeared to me that low self-esteem was an effect originating from harmful experiences that were still adversely affecting her. I could see how my conception of the problem and hers were related. I believed it was tenable to adopt her version for the treatment plan. As the therapeutic relationship progressed and we explored low self-esteem, the events that had produced low self-esteem were broached. Had I insisted on implementing my definition of the problem, the therapeutic relationship may not have advanced past the joining phase and our subsequent discussions would not have occurred. She was able to express her autonomy and I was able to use my professional discretion.

I encountered several instances in my practicum where people wanted to address mental health and/or addiction issues, but did not want to significantly alter problematic relationships. We discussed how these relationships, as currently manifested, were adversely affecting their ability to live their definition of a meaningful life and address their mental health and/or addiction issues. Practising empowerment based clinical practice compelled me to respect what the person was willing to confront. Increased well-being can still occur with the presence of problematic relationship dynamics and people may determine in the future that they want to address unhealthy relationships. Particularly, two individuals came to understand more about the origins of their anxiety and learned coping mechanisms to reduce it although they never significantly altered problematic relationships during treatment. Empowerment entails people gaining more control over their lives and this includes determining the direction of the therapeutic relationship.
One person whom I was counselling was in the action phase of the Transtheoretical Model of Behaviour Change in addressing mental health issues and in the contemplation stage for substance use. Therefore, clinical interventions involved the use of CBT and ACT for mental health difficulties and harm reduction and MI for substance use. I was apprehensive in initially adopting a harm reduction treatment plan for her addiction for I believed that her continued substance use would exacerbate her mental health symptoms. Interestingly, as her mental health improved, the frequency with which she engaged in substance use decreased. Her substance use appeared to function as a coping mechanism to decrease the impacts of her mental health condition. In retrospect, I believe this person knew the function of substance use in her life and did not want to reduce it without first diminishing negative mental health impacts. Over the course of my practicum she became more cognizant of the situations and feelings that made her inclined to use substances, started exercising regularly with friends, made her home and life more conducive to reducing stress and facilitating personal growth, increased her coping abilities, and worked toward improving her self-esteem and lowering her anxiety. Her commitment to achieving greater wellness and control over her life was astonishing to witness. People with CD are well positioned to judge how to achieve recovery.

Counselling people with CD can be conducted from a variety of perspectives: medical, social control, empowerment, etc. Wakefield (1988a) espouses what differentiates clinical social workers from therapists from other disciplines is the intent with which they perform interventions. Methods and outcomes may be similar between clinicians, yet social workers, according to Wakefield, seek to promote social justice through treatment. In my practice at the CAST, I performed clinical activities with the intention of empowering people with mental health and/or addiction difficulties. Improving functioning contributes to empowerment when an
intention of the counselling relationship is to liberate people from oppression.

In my clinical practice at the CAST I broached consciousness raising when it appeared appropriate. People often possessed negative valuations of themselves in multiple domains. When we explored the origin of these attitudes there was often a structural element. Discrimination related to mental illness, addiction, physical appearance, poverty, gender, and sexual orientation are topics that I discussed in therapeutic relationships during the span of my practicum. People often appeared to feel relieved that their anguish in these areas was acknowledged as unjust and galvanized in the knowledge that the type(s) of discrimination they experienced were widespread and systematic.

ACT, CBT, and MI were integral in providing treatment that corresponded with empowerment during my practicum. An empowerment based treatment plan was enacted through the use of various psychosocial modalities. I found them to be instrumental for people to increase control over their conditions and lives. I adapted to people’s needs through shifting and adjusting treatment modalities during the session, for different approaches were required to appropriately address the issues present in their lives. For example, one man I was counselling experienced severe anxiety. When our therapeutic relationship began I employed CBT and ACT to explore and attempt to reduce his anxiety. As our discussions progressed, it became evident that family conflict was exacerbating his distress and impeding him from achieving his goals. While he acknowledged that it was a source of stress for him, he did not want to alter these relationships. After consulting other clinicians, I conducted a cost benefit analysis with him, which is typically employed in MI, to prompt a productive discussion.

After counselling sessions I would evaluate with myself and other clinicians whether the modalities I had utilized and how I used them were apt in achieving the desired recovery goals
and encouraging empowerment. My use of modalities usually promoted empowerment, yet sometimes I did not possess sufficient clinical tools to adapt to the evolving needs of the therapeutic relationship. I was able to expand my knowledge of known clinical paradigms and gain exposure to some unknown to me through additional research and conferring with my practicum supervisor and others. Clinical paradigms facilitate empowerment through providing therapeutic instruments to help people gain more control.

Some people that I counseled in my practicum were passive in expressing inclinations about how treatment was conducted and provided minimal input toward a broader definition of recovery. I thought that perhaps some people preferred that others make treatment decisions to reduce stress and/or they trusted in my clinical judgement to act in their best interests. Unsure of whether delegation of decision making represented a preference or social conditioning, I would inform them of what I was doing, why I was doing it, and asked their thoughts about the direction of treatment. To bolster self-esteem, I employed the strengths approach to acknowledge the abilities and skills they possessed in addressing the treatment objective. I recognized and respected their basic goal to improve mental health and/or diminish/eliminate substance use, yet I provided continued opportunities to direct treatment and express a vision of a personally meaningful life. Empowering practice respects the choice not to take control, but views it as possibly a product of oppression and social conditioning.

One man expressed a desire to reduce his discomfort precipitated by a fear of contamination as part of an obsessive compulsive disorder. He had difficulty providing instances that activated his disorder or activities he would like to engage in as part of Exposure and Response Prevention, yet he assiduously completed exposure exercises at home and at appointments. One of the exercises we did together was holding a washed utensil and being near
a garbage can. His unease about being contaminated decreased and he was able to become more socially active.

**Empowerment in Group Treatment.**

The groups I participated in through my practicum at the CAST were devised with the primary intention of treating people with mental illness and/or addiction, yet I believe that empowerment occurred in them. Judging by pre and post-tests, feedback from group participants, and my clinical observations, most people appeared to improve their functioning and made positive movement toward their definition of the good life. As discussed previously, helping people improve control over their condition(s) is an initial form of empowerment.

As a co-facilitator, I would sometimes initiate a discussion on systematic discrimination based upon a comment from a participant or it would occur spontaneously from group members. Consciousness raising was employed in these instances to discuss structural issues. It appeared to have a more powerful impact in a group where people had similar difficulties and experiences than in a discussion in individual counselling. I could acknowledge people’s experiences and provide a forum for conversing about oppression in individual counselling, yet the validation group members provided each other through sharing common experiences of discrimination appeared to resonate more profoundly with participants. Once people have more control over their CD, forming or joining groups that take action against systematic discrimination and raise consciousness may be part of their recovery. The consciousness raising that occurred in the groups I participated in at the CAST may have presented a novel way for participants to view their experiences or it may have reinforced a perspective with which people already had familiarity.

For some people in Relapse Prevention, recovery included surmounting mental illness as
well as addiction. Some people with CD have experienced stigma, a lack of empathy and acceptance, feeling unable to talk about mental health issues, and hostility toward psychiatric medications in traditional, mutual help, addiction support groups (Bellamy, Rowe, Benedict, & Davidson, 2012). Relapse Prevention established an environment where people with CD could share a holistic account of their experience and receive acceptance and support from their peers and the facilitators. With the absence of mutual help support groups for people with CD in Prince George, it is imperative that there are therapeutic group environments where this population can be supported as holistic individuals.

The sharing of personal medicine between participants occurred in every therapeutic group I participated. The methods utilized by people to cope better were numerous and diverse. Often, people reported their experience utilizing a strategy divulged by another group member. No single coping method was beneficial for every person that tried it, yet a technique effective for one person was often useful for others. Personal medicine sharing served as an effective process for people with CD to better control their conditions and lives.

People shared their experience with psychiatric medications in therapeutic groups, particularly the Core Changeways and Anxiety and Panic groups. Dialogue with other group members would often help people articulate what was beneficial and detrimental about their current medication regimen and how they would like medication to assist them. These discussions helped people express to their physician what they wanted from medication and hopefully resulted in a medication regimen that assisted their recovery. Therapeutic groups provided an opportunity to process experiences with medication and use the increased comprehension to support empowerment.

**Resources for People with CD in Prince George**
With the assistance of my practicum supervisor, other clinicians at the CAST, people with CD, and the Community Resource Directory published by the Crisis Prevention, Intervention, and Information Centre for Northern B.C., I developed a resource inventory for people with CD in Prince George (2013).

The Northern Health Authority has adapted their mental health and addiction programs to address the needs of people with CD. These are the only locally available services that acknowledge CD. Provincially, the BCMHA exclusively treats people with CD. Access protocols to the BCMHA for the five regional health authorities, including Northern Health, dictate that for people to be granted admission, they must have significant issues in mental health, substance use, physical health, and behaviour and have been unable to adequately engage with, receive services from, or benefit from services at a regional level (Schutz et al., 2013).

In developing my resource list, I maintained an awareness of the common characteristics of people with CD and the challenges they are likely to encounter as informed by the demographic information listed in the literature review. There are many non CD specific resources in Prince George that would likely benefit people with CD.

Summary of the Practicum Learning Experience

From my experience at the CAST I achieved the following clinical competencies: acquired greater understanding of the importance of conveying realistic hope; enhanced my ability to create a comfortable environment at intake; became better at adapting session plans; achieved more familiarity with various treatment modalities; attained increased comprehension of pharmacological interventions; gained more knowledge of mental health, addiction, and CD; learned to present psycho educational material more effectively; improved my ability to monitor and manage the emotions elicited in a group intervention; fulfilled multiple facilitator roles in a
Relapse Prevention group format; expanded my understanding of recovering from addiction; updated my knowledge of DSM; discovered and analyzed my conflict style; developed more competence at managing countertransference; augmented my knowledge of the treatment continuum for addiction; and increased my understanding of the context of recovery.

At the CAST I gained the following insights about empowering people with CD: provision of realistic hope is an initial stage in becoming empowered; treatment plans should incorporate the principles of SDM and the recovery movement; only address issues people are willing to confront; people choose treatment plans that are consonant with their recovery vision; helping people gain more control over mental illness and addiction is a form of empowerment; consciousness raising in individual or group treatment contributes to personal and societal transformation; using treatment modalities suitable to the needs of people can increase well-being and control; declining to direct one’s treatment may be a preference or a consequence of oppression; people need therapeutic space where they are viewed holistically; personal medicine can help people have more control over mental illness and addiction; and groups can present opportunities for processing experiences with medication and facilitate planning to have medicine complement recovery.

The Northern Health Authority has resources for the treatment of people with CD in Prince George. For people that have not responded well to these treatments, BCMHA provides intensive, voluntary, inpatient treatment specifically for people with CD. Many local agencies, not specifically focused on assisting people with CD, offer services that would likely benefit this population.
Chapter Four: Acquired Learning and Implications for Social Work Practice

In this chapter I will address the three questions guiding my placement with knowledge gleaned from my practicum experience. (1) What are the common needs to improve the well-being of people with CD? (2) From my vantage point as a practicum student with the CAST, how are the needs of people with CD being satisfied in Prince George? (3) What can social workers do in a clinical context to facilitate the needs of people with CD being met at micro, mezzo, and macro levels? I will also address the implications of my practicum experience on social work practice.

What are the Common Needs to Improve the Well-Being of People with CD?

I chose to investigate common needs to improve well-being because I believe it would increase my clinical skills, expand my understanding of empowering people with CD, and help me learn more about resources available in the community. The needs I have enumerated were problems I observed in my clinical interactions with people with CD. A primary intention of structural clinical social work is to increase well-being through reducing the effects of oppression and increasing functioning; through better comprehending the needs to improve the well-being of people with CD, we can engage in empowerment and treatment more successfully.

Often, people with whom I was engaged in a therapeutic relationship at the CAST had financial instability as an ambient component of their life situation. The consequences of poverty appeared in some instances to contribute to the continuation of mental health and/or addiction difficulties. Maslow’s hierarchy of needs asserts that people must satisfy physiological requirements before they can effectively address higher order needs (1943). Often people who seek treatment at the CAST are debilitated by their condition to the extent that they are unable to participate in the labour market. Financial security allows people with CD to focus on recovery
from their condition.

As stated in the previous chapter, hope is important as a clinical skill and an element of empowerment. People seeking treatment at the CAST have been unable to consistently and effectively reduce the severity of their condition in an adaptive manner; participating in counselling is often an action taken out of desperation for many people. In my practicum I observed that hope is an impetus for people to engage in the therapeutic relationship and take more control over their life. Hope can improve well-being and facilitate the conditions to bolster it further.

Many of the people attending the CAST that I encountered had experienced the violation of their security in an egregious, sometimes chronic, manner. Consequently, they perceived the world as replete with threats and danger. People would often report feeling acute distress in attempting to navigate the world safely. For a woman who had been sexually assaulted, increasing her feeling of safety entailed talking about thoughts she had when encountering anxiety in the presence of men and having interactions with men in safe, low anxiety provoking circumstances to attempt to create positive experiences to counter past harmful events. Improved psychological well-being entails possessing a sufficient sense of security to conduct life activities without fear and to not avoid desired behaviours because of safety concerns.

My practicum experience confirmed the finding in my literature review that people with CD often have limited control over their lives. Restrictions in personal power appeared to emanate from the limitations imposed by mental health problems and addiction, through structural means, and from harmful relationships. It is onerous for people with CD to exert more control over their life direction when they are debilitated by their condition. Systematic discrimination affects people with CD due to their membership in a minimum of two outgroups.
Noxious relationships often involve power discrepancies and are influenced by systematic discrimination. People with CD require increased control over their lives to substantially improve well-being.

Experiencing CD was isolating for many people I encountered at my practicum. The adversity of CD and the stigma associated with the condition appeared to distance some people from their social support system. Support needs varied based on the preferred level of social interaction and the size and strength of existing networks. Social support appeared to promote convalescence through mitigating difficulties, facilitating personal growth, and helping people achieve goals, along with other benefits. Social support increases the well-being for many people with CD.

Although people may have differing concepts of how to operationalize their definition of recovery, some sort of treatment, either informal or formal, is required to overcome CD. People may want to address their CD through utilizing personal medicine, the mutual assistance of peers with a similar condition, and/or employing the help of other people in their support system. It is likely with more acute forms of CD, people will need formal treatment to complement informal resources. People with CD require some form of treatment to address their condition.

Many people with CD with whom I spoke during my practicum did not feel that they were in a position to contribute to others and society due to their condition. Some of this sentiment appeared to emanate from the perceived limitations engendered by their condition and the negative messages they had received from others. Part of the healing process for many involved meeting the needs of other people and fulfilling a personally and socially valued role in the community. These actions appeared to boost self-esteem, self-efficacy, and a sense of belonging. People with CD often gain substantial benefit from helping others and fulfilling
personally and socially valued roles.

Some people with CD thought that their condition adversely affected how other people perceived them. Initially many attempted to conceal it, yet as their difficulties become more acute, it became increasingly onerous to obscure it from other people. When it was discovered by others that they had CD, additional negative conceptions of mental illness and addiction were frequently foisted upon them. Often people internalized these messages which resulted in a decrease of self-esteem and self-efficacy. Consequently, some people felt that they did not deserve to be treated well by others. Self-acceptance and realistic self-esteem is integral to increasing well-being in people with CD.

Are the Needs of People with CD being Satisfied in Prince George?

Acute CD often does not permit people with the condition to retain employment. The availability of resources through concerned loved ones varies with each individual. Many people with acute CD will be unable to accrue sufficient resources to avoid absolute poverty without assistance from outside their social network.

In British Columbia, through the Ministry of Social Development and Social Innovation (MSDSI), single adults that are deemed employable receive $235 in income assistance and a shelter benefit maximum of $375 (2014a). Persons with Persistent Multiple Barriers (PPMB) are eligible for increased income assistance; single adults receive $283 in income assistance and a shelter benefit maximum of $375. One of the criteria for PPMB is that the person has an ongoing medical condition that has persisted for at least a year and is likely to continue or frequently reoccur for at least another two years and impedes or precludes employment. Addiction is specifically defined as not being a disease, yet the presence of mental illness would appear to make people with CD eligible for PPMB. A person applying for PPMB needs to have their
physician complete a medical report. The Persons with Disabilities (PWD) designation from MSDSI appears to apply to more enduring and debilitating conditions than those to qualify people for PPMB and could include some forms of CD. To be eligible for this distinction, a person with a physical or mental impairment must be evaluated as being “significantly restricted in his or her ability to perform daily living activities either continuously or periodically for extended periods” (MSDSI, 2014b) by a physician and an assessor, who could be social worker. The rates for PWD are $531.42 in income assistance and a shelter benefit maximum of $375 for a single adult. The government of British Columbia provides no-cost psychiatric medication through Plan G for people with mental illness and limited income.

Analysis of the assistance offered through MSDSI to unemployed people with CD would benefit from examining the cost of living in Prince George. The Canadian Mortgage and Housing Corporation states that in October 2014 the average rent for a privately owned bachelor suite in Prince George is $567 per month. The government of British Columbia, through the cost of living calculator at WelcomeBC, estimates that a single adult in Prince George residing in a 500 square foot apartment, utilizing transit, and earning $21,320, the lowest amount permitted as an input, would have yearly expenses of $16,566 (2015). A person with CD able to obtain PWD status qualifies for $10,877.04 a year in assistance from MSDSI. There is a large disparity in the provincial government’s assessment of the expenditures necessary to live in Prince George and the income it provides people with CD.

Through compiling a list of resources for people with CD, I have become more familiar with the services available in the Prince George area. The Northern Health Authority has residences for people with complex mental health problems or CD. Other local agencies provide varying types of supports to help people needing assistance meet their physiological needs. A
network of programs and services to prevent absolute poverty exists for people with CD in Prince George, yet it provides insufficient assistance to allow people to engage in convalescence without experiencing financial stress. Someone unfamiliar with this network would have difficulty navigating it successfully due to its fragmentation. A person with knowledge of local resources and the ability to act as an advocate would be an asset for many people with CD.

Stress contributes to and exacerbates mental health difficulties and addiction. Alleviating stress is an initial step of treatment. Many people whom I counselled at the CAST were too ill to retain long term employment, but the income allotted by MSDSI and the support provided by other programs was insufficient to create an environment free from financial strain. Consequently, several people returned to the workforce before they were capable and were unable to remain employed. The time people contend with poor mental health and addiction is protracted by providing those afflicted with deficient financial resources. A government committed to the recovery of people with mental illness and addiction would provide adequate resources to foster an environment conducive to bolstering well-being.

There are many treatment options available to people with CD in Prince George. Services available for people with CD include: CAST, COAST, CRU, AADTP, Youth Community Outpatient Service, Youth Treatment Centre Mental Health and Addictions, Adult Withdrawal Management Unit, and Adult Residential Services. These resources serve people with mental health diagnoses or addiction, yet they also have the capacity to provide CD services. BCMHA provides treatment that specifically serves people with acute CD. There would appear to be sufficient treatment available in Prince George for people with moderate CD and provincially for those with a severe manifestation. These programs are financially accessible for people with CD as they are within the scope of the Medical Services Plan. At the CAST there are no waiting lists
to access treatment or a predetermined number of sessions. I cannot address accessibility for the other programs enumerated due to insufficient knowledge, yet from my experience, substantial barriers to entry and inadequate duration of services are prevalent in the social services sector and are likely an issue in CD treatment.

In examining the needs I observed that if met contribute positively to the well-being of people with CD, it could be argued that many of these are personal concerns outside of the purview of government and society, yet in contemplating them from a structural empowerment paradigm, I considered the effect of being in an outgroup. Wakefield, (1988b) in studying John Rawls model of distributive justice, determined that there are non-material social goods that are largely disseminated by the societal structure. The needs I enumerated in the previous section would appear to be affected by the social order. Oppressed people are more likely to experience diminished: hope, real and perceived security, control, social support, ability to fulfill personally and socially valued roles, and self-acceptance and self-esteem than those in privileged groups. People with CD have membership in a minimum of two stigmatized groups that negatively impact their ability to satisfy the aforementioned needs. I would contest that the societal structure is inadequately distributing the attributes for high well-being to people with CD.

What can Social Workers do in a Clinical Context to Facilitate the Needs of People with CD being Met at Micro, Mezzo, and Macro Levels?

Micro level interventions can be performed by clinical social workers to contribute to meeting the observed enumerated needs of people with CD through individual and group treatment. Individual counselling is the most personalized form of satisfying needs. Group treatment allows people with similar experiences to provide insights and mutual support as another method of fulfilling needs. Micro level interventions are a strategy to facilitate meeting
the non-material social goods that have been poorly distributed by the social order and impede well-being from increasing. Structurally informed, empowerment based clinical practice within a partnership committed to growth and guided by a skilled practitioner with ample treatment modalities is a powerful agent to bolster the well-being of people with CD in micro contexts.

Working with the families and concerned others of people with CD is a micro level intervention that can be conducted, if desired by the person receiving treatment, to meet their needs. The proximity of CFMs to the person with CD allows them to articulate needs for well-being that may not have been expressed. CFMs can also be instrumental in the implementation of the treatment plan.

A mezzo level clinical social work intervention for meeting the enumerated needs of people with CD is advocating at agencies, where people with CD are treated and clinical social workers are employed, for the provision of adequate resources to help those seeking assistance.

Macro endeavours at satisfying the needs that contribute to increased well-being occur principally outside the purview of the clinician’s agency role, although some clinical activities have macro implications. Clinical social work attempts to influence the societal structure primarily through the people engaged in the therapeutic relationship. Alleviating the effects of mental illness and addiction allows people more control over their life to implement consciousness raising and alternative cultural narratives about ingroups and outgroups discussed in treatment. Clinical social workers facilitate the conditions for people to support structural change. All of the enumerated needs to improve the well-being of people with CD, in my judgment, have a component of structural discrimination. Increased well-being for people with CD involves a macro level element that requires actions to instill an equitable social structure.

There is some contention about how an alternate order based upon social justice would
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arise. If a strategy to engender a new equitable social order is non-violent, empowering, and takes the Kantian position (1785/1969) that people are ends in themselves and should not be treated exclusively as means to achieve the aims of others, it seems unnecessary and fruitless to condemn any strategy to realize a just society, yet it would be sagacious to note which methods appear to be the most efficacious. Possible specific actions social workers could take to induce macro change are: supporting the actions of a group of people with CD or another outgroup, engaging in the organized labour movement, or participating in the democratic process and civil society. The creation of an equitable social order would help to ameliorate the position of many people with CD by negating the noxious influences that harm the enumerated needs that contribute to their well-being.

Implications for Social Work Practice

This practicum experience and report will have lasting effects on my professional practice and perspectives. One motivation to obtain a Masters of Social Work degree was to enhance my clinical social work skills. My time at the CAST provided me the opportunity to become a better counsellor through engaging in therapeutic interventions with the guidance of my knowledgeable, supportive supervisor. I learned more about treatment modalities and their use and gained skills and insights about how to make the therapeutic relationship more responsive to the needs of people with mental illness and/or addiction. As well as increasing my clinical knowledge, my practicum experience helped to set priorities for medium and longer term learning through presenting areas which require further development such as the treatment of some mental illnesses and studying additional treatment modalities.

When I began researching CD, I did so as someone unacquainted with the subject and with no preconceptions. In the studies I accessed, outcomes were often narrowly defined by
researchers. Through my practicum experience, I sought to understand what people with CD defined as desired outcomes. By performing the literature review, speaking with my practicum supervisor and other clinicians at the CAST, and in my discussions with people with CD, I came to understand that there is no universally preferred outcome for those with CD, yet there appear to be some commonly desired results. What seems to be paramount is that people with CD have the opportunity to articulate and endeavour to achieve their chosen treatment objectives.

I have articulated in this practicum report a framework for empowering people with CD in the counselling relationship. The clinician possesses an outlook of empowerment that incorporates structural social work and utilizes the recovery movement to define treatment outcomes. SDM, harm reduction, personal medicine, and using treatment modalities with an intention of empowerment are methods that can support people in pursuing their own definition of success. Psychiatric medications and abstinence from substance use are conventional treatment approaches that may align with the preferred outcomes of many people with CD. My clinical experience during the practicum reinforced this framework through my observation of the extent people engaged in treatment when it involved achieving their outcomes and how I perceived it in meeting the needs of people with CD. I will continue to utilize this approach in my future clinical practice.

The empowerment framework that developed as a result of my practicum experience is limited in that, at this stage, it is not supported by any qualitative or quantitative research measuring its effectiveness in bolstering treatment engagement, producing outcomes desired by people in the therapeutic relationship, or increasing well-being. The CAST serving people with mental health and/or addiction and my incipient counselling capabilities restricted the therapeutic interactions I had with people with CD, yet I feel that I had sufficient clinical experience with
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people with milder manifestations of CD to confidently make statements about empowerment and common needs to improve well-being. The process for empowering people in a clinical context and the common needs for well-being, I discovered in my practicum experience, are similar whether a person has mental illness, addiction, or CD.

My synthesis of various approaches and applying them to counselling people with CD to promote empowerment could be helpful for other clinicians and a subject for future research. I believe this framework is not restricted to the treatment of people with CD and could be applied to those with a mental illness or an addiction.
Chapter Five: Conclusion

I began my practicum experience at the CAST with the desire to achieve three learning goals. (1) To increase my clinical skills. (2) Learn more about empowering people with CD. (3) Become more familiar with the resources available for people in Prince George afflicted with the condition. Through my actions and in the writing of this practicum report, I believe that I have demonstrated increased competency in the areas I sought to improve.

Clinically, I gained skills in providing a therapeutic environment, utilizing treatment modalities, and administering structurally informed, empowerment based counselling. Through consulting people with CD, the clinicians at the CAST, and the literature review, I achieved a more nuanced understanding of empowerment that incorporated structural social work and utilized the recovery movement to establish the person directed priorities of the therapeutic relationship. Empowering practice requires utilizing an array of therapeutic interventions. In compiling my resource list, I feel that I would be well positioned to direct a person with CD to appropriate services in Prince George.

I had three questions that I wanted to answer through my practicum at the CAST. (1) What are the common needs to improve the well-being of people with CD? (2) From my vantage point as a practicum student with the CAST, how are the needs of people with CD being satisfied in Prince George? (3) What can social workers do in a clinical context to facilitate the needs of people with CD being met at micro, mezzo, and macro levels?

Through research, dialogue, and analyzing my interactions with people with CD at the CAST, I feel that I was able to identify some common needs integral for high well-being. There are many potentially beneficial services for people with CD in Prince George, yet sparse financial resources exist for this population. The ability to fulfill common needs for high well-
being is connected to the structural composition of society. There are accessible and effective options for social workers in a clinical context to act at micro and mezzo levels to address the needs of people with CD. Macro actions to fulfill needs occur outside of the clinical context.
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Appendices

Appendix One: Practicum Activities

The following activities were derived from the practicum learning goals contained in the learning contract:

1. To develop my skills as a clinical social worker within the setting of treating people with mental health and/or substance abuse disorders through completion of the following tasks:
   
   a. Utilize Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), Acceptance and Commitment Therapy (ACT), and group therapy, among others, in the treatment of mental health and/or substance abuse disorders.
   
   b. Consult written, taped, and/or digitized materials to inform clinical interventions based on CBT, MI and ACT.
   
   c. Review resources to assist in the development of effective treatment plans.
   
   d. Develop treatments plans for participants in the Community Acute Stabilization Team (CAST) program.
   
   e. Perform intake with people seeking entrance into the CAST program.
   
   f. Conduct assessments.
   
   g. Provide therapeutic support to people enrolled at the CAST.
   
   h. Act as a referral agent when program members require resources outside of the purview of CAST.
   
   i. Perform crisis intervention services.
   
   j. Facilitate psycho educational and support groups.
k. Maintain charts and other documentation pertinent to the functioning of the CAST.

l. Attend agency, community based, and/or out of town professional development activities for the purpose of gaining knowledge and enhancing skills relevant to performing mental health and/or addiction therapeutic interventions.

m. Observe clinical activities performed by Brigitte Loiselle and others in their role as clinicians at the CAST.

n. Use the Diagnostic and Statistical Manual of Mental Disorders (DSM) V as a tool for forming clinical impressions.

o. Engage in individual counselling with six to ten people with variance allowed for availability of clients and complexity of cases.

p. Observe interventions conducted by the Adult Addictions Day Treatment Program (AADTP).

q. Accompany a member of the Community Outreach and Assertive Services Team (COAST) as they provide services consonant with the Psycho-Social Rehabilitation Model.

r. Review pharmacological interventions for mental health conditions.

2. Learn more about empowering people with Concurrent Disorder (CD) through the completion of the following tasks:

   a. Become more familiar with the experiences of people with CD through dialogue and observation.

   b. In my interactions with people with CD in the CAST program, ask questions relating to empowerment such as: how would their life/CD differ if they had more
control, what is preventing them from gaining more control over their life/CD, what would help them have more control over their life/CD, and what would they describe as successful treatment of their CD?

c. Continue to perform research regarding empowerment with people with CD through a structural social work lens.

3. Learn more about the resources available to help people afflicted with CD in Prince George through the completion of the following tasks:

   a. Compile a list of resources relevant to people with CD in Prince George.

   b. Dialogue with colleagues about their knowledge of supports specifically for CD and those for difficulties often encountered by people experiencing it.

   c. Speak to people with CD about resources relevant to ameliorating their condition and fulfilling their needs.