OBSERVATIONS:
INTEGRATING SERVICES FOR THE COMPLEX INDIVIDUAL

About this Presentation

- Background of CDSS providing access to concurrent disorder and complex need. Assumes that the combination of ABI & addiction may include mental health or other issues.
- Provides observations on complexity and integration of service.
- Explores clinical approaches to ABI clients considering or wanting addiction services.
- Explains addictions sector services to ABI clients wanting either abstinence or harm reduction approaches.

Background in Access: Concurrent Disorders Support Services

- Mainly an access centre of 45 partnerships (43 organizations), funded by the Ministry of Health.
- A range of services focused on concurrent disorder (co-occurring mental health and addiction) **and** complex need, including ABI.
- The service is CD-capable or sometimes specialized, relatively quick in most cases, but transitional, depending on the service.
- We also have some unusual direct services for marginalized clientele such as addictions medicine and psychotherapy, MHA therapy, trauma groups for women and DBT-style coed groups.

What is complexity?

- Complex individuals are expected to be the most difficult to serve, due to the large variety of personal issues and the limitations of the social service system.
- In preparation for a system of coordinating care, the health system has been disputing this term for years now.
- A survey of agencies resulted in a paper listing 25 indicators that put adults in Toronto at risk, e.g.:

Social Determinants	Psychiatric Disorders	Addiction Disorders	Medical & Physical
Justice System	Impact of High Risk Background	Limited Family & Social Support	Inability to Access Services

What are we measuring in complexity?

- Health system → the cumulative number of personal issues.
- Agency → the services needed or the urgency of need.
- Worker → the particularities of who is to do what and where.
- Study → shows that persons who are seen as complex may not have as many needs because they are stabilized. CDSS tracked clients' number of issues for years & found that young people with fewer issues are more likely to have complex situations than older people because: → they have not had the opportunity to receive services.

What is integration?

Integration is a priority of health and other funding bodies, but the term is confusing. There are (at least) three levels of integration:

1. Systems level: Coordination of care of complex individuals through existing local resources and, as necessary, use of the Health Links Coordinated Care Program.

1. Agency level: Coordination of major issues - basic needs, ABI, mental health and addictions - internally through different workers or externally through interagency connection.

2. Individual practice level: Combination of concurrent issues within an individual or group practice (e.g. SUBI).

Integration on an Agency Level

Two options:

1. One worker takes the primary role and conferences or coordinates the care with other workers who are in close contact, because:
   - They all work in the same agency
   - They all work in an interagency partnership or
   - They are committed to keeping connected.
2. A team of individual workers with different roles can coordinate different aspects of care, e.g. ACT Team. In either case, integrated care may consist of:
   - Parallel approaches to ABI and substance use, that is, at the same time.
   - Sequential approaches, that is, one after the other.

Upcoming!!

Changes in Addictions Services

1. Coordinated Access for Addictions will be integrated into Access Point. The Central Access to detox beds will remain separate.
2. The Health Links are now piloting Care Plan tools for complex MHA individuals. All health-funded programs will be expected to have a Care Plan for every complex client. Workers will be expected to :
   - Identify a lead Care Coordinator.
   - Describe the indicators of complexity.
   - Name the primary care provider and date contacted.
   - Hold a case conference and identify participants, including any physicians, psychiatrist and non-service supports.
   - Note what worked well, what presented challenges.
   - Note the client's experience of the Plan, i.e. their sense of inclusion and degree to which it reflected their goals.

The Complicated Assessment of the Complex Client

Cognitive/ Behavioural:
- ABI
- Developmental
- Cognitive/learng impair
- Issues with ADL's

Substance Use:
- Alcohol
- Cannabis
- Crack/ cocaine
- Opiates

Mental Health Diagnoses:
- SMI
- Mood Disorder
- Dementia
- PTSD

Medical Issues:
- Injuries
- Chronic illnesses
- Physical disability

Legal Issues

Income & Budgeting

Stable Housing

Primary Care

Intake and Assessment with Complex Risk Factors

- Including ABI and Substance Use -

1. Deal with crisis first!
2. Note all current providers. What can you and others do?
3. For the basic issues of income, housing, medical or justice, determine
   - If appropriate applications have been made (OW, ODSP, CASH, CHC)
   - If there are any requirements (probation)
   - If other sectors could be involved (developmental, MHJ)
4. Of MH and SU, note the prominent issue to you and to the client.
   - The client's motivation to seek assistance (Stage of Change, experiences).
   - The formats of service that are most consistent with the client's ABI issues.
5. Consider internal capacity and external referrals. Think outside the box!
6. If there are barriers (including the client's attitude) to any needed service, make potentially do-able suggestions or take steps to reduce or eliminate them.
7. Determine a potential service plan.
8. Consider a way to engage and motivate the client.

Approaches to Change: Motivational Interviewing

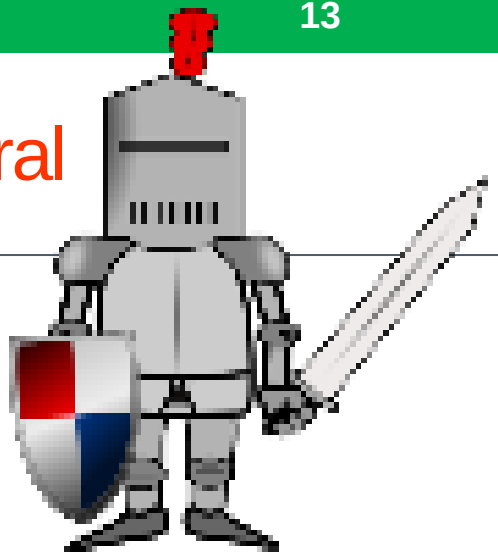
Motivational Interviewing is the traditional route to assisting individuals to progress from pre-contemplation to contemplation to other stages of change in substance use.

- It is an active, goal-oriented collaboration of client and worker to strengthen motivation & develop a plan.
- The worker asserts the client's right to choose goals.
- The worker does not tell the client why s/he should change, but continually **evokes** or **elicits** client's reasons.
- The worker avoids any statements that would provoke resistance, but shapes the interview in such a way that the client states "Something has to change!"

Approaches to Change: Modified CBT Approaches

1. Cognitive Behavioural Therapy is a “family” of treatments and practices that focus on change in how we think, feel and behave rather than change on outward circumstances such as people, situations and events.
2. CBT is based on the idea that thought influences behaviour and that people with complex issues have restricted their thought processes and coping abilities.
3. CBT is individual, time-limited, focused on current problems and manualized. It follows a structured style of intervention.
4. CBT is well-researched for many for many MH or SU disorders, but aside from SUBI there are few examples of combined treatment.

Some Comments on External Referral



1. It is assumed that the Case Manager will need assistance from external mental health and addiction services.
2. Workers of external services may be accustomed to dealing with various types of cognitive impairment, including ABI, but they will probably not be able to distinguish them. Some workers may make unfounded (negative) assumptions.
3. You will need to be an ambassador for your field - that is, communicate the best ways of working with the individual client and offer your continuing assistance.

Comments on Abstinence vs. Harm Reduction

- First - does your client have the right to use? “Yes”
- Substance use with a condition of ABI is currently or potentially harmful. Also SU may jeopardize a person’s housing or bring them into conflict with the law.
- While your job as worker is to take your opportunities to address the issue, to assist in minimizing or eliminating harm, the client will always have the last word.
- You as worker may wish the client to become abstinent, go “cold turkey” as it seems controllable and clear-cut. It has measurable outcomes and does not present the problem of mixing abstinent & controlled use clients, e.g. in housing.
- However, the client may want to continue using to some extent. This would entail a harm reduction approach.

Harm Reduction or “Warm Turkey”

Harm reduction refers to public health policies, practices & programs that aim to reduce the harmful consequences of alcohol and drug use by persons who do not wish to stop.

Its defining features are:

1. Prevention of harm rather than prevention of drug use.
2. Non-coercive assistance to people who continue to use rather than those who abstain from use.
3. Reference to all psychoactive drugs, including controlled drugs (e.g. methadone and suboxone), alcohol, tobacco and pharmaceutical drugs.

It is not: An “either-or” between continued use and abstinence. Harm reduction can be used with persons who are temporarily abstaining, modifying their use with the intention of becoming abstinent or controlling their use.

Warm Turkey Updated : Controlled or Moderate Drinking (Brown 2009)

- 30 years research has shown that:
  - Controlled use is as successful as abstinence-based treatment.
  - Most users in treatment do not have long-term goals of abstinence.
  - Most frequent motivation to drink is unpleasant emotions.
- Many users have a painful past and drink to self-medicate. When finding other methods of coping, a paced approach, integrated with MH counselling, may be helpful.
- Treatment should be a process of negotiation, reflecting the most realistic & appropriate goal for client.

"Warm Turkey": Reducing Use of Alcohol as a Route to Eventual Abstinence (Miller 1991)

Method	Process	Advantages
Trial period of abstinence	Usually 3 months abstinence, with assurance that the client can return to old pattern of drinking.	• Breaks current pattern. • Gives clear indication of success or needed areas of change (coping skills)
Gradual tapering down	Progressively lower limits each week over a period of many months with a goal of complete abstinence. Carefully documented.	• Can be used as an alternative after a failed attempt at abstinence. • Slips expected, can be used as motivation for increased abstinence.
Trial moderation	Recommended a minimum of 6 months, with restriction to 1-3 drinks/day. After trial, client has option of returning to old pattern of drinking.	• Good for clients who are entirely resistant to abstinence.

Pathways to Addiction Service: Abstinence

24 hour withdrawal management ("detox"):

- → Stabilizes intoxicated individuals
- → For high use or complex individuals.
- → Need for structured peer environment.
- May or may not accept MH meds, methadone, suboxone, etc.

  - Regular withdrawal management, which may involve a medical clearance – at 4 centres in Toronto – SMH, St. Joseph's, TEGH, TWH.

  - Medical withdrawal for those who require monitoring by medically trained staff is only offered at CAMH and Humber River Hospital.

Chris Lopez' comments:

- Withdrawal management would be accustomed to and accept persons with ABI.
- Medical withdrawal is difficult to access since there are only 16 beds.

Pathways to Addiction Service: Abstinence

24 hour residential treatment:

- → Must be free of acute withdrawal before entering (72 hours)
- → High level of complexity, risk of relapse and low ADL's.
- → Intensive support to practice life skills.
- Varies in acceptance of medications & lengths of stay.
- Has a variety of programming to find housing, improve ADL's, Limited tolerance for "slipping".
- Often have some after-care programming to prevent relapse.
- Does not include mental health counselling.

Chris Lopez' comments:

- Most would understand ABI symptoms & have adequate staff to accommodate the extra coaching necessary.
- Some agencies may be too isolated or lack staffing.

Pathways to Addiction Service: Abstinence

24 hour transitional residential support:

- → Must be free of acute withdrawal before entering (72 hours)
- → Stabilization before, during, after treatment where there is insufficient community support OR
- → Where still needs assistance due to difficulty with comprehension, managing prescribed medication, ADL's or at high risk of relapse.
- → Programs have graduated opportunities to use community services.

- Programs have various eligibility requirements & lengths of stay.
- Often have some after-care programming to prevent relapse.

Chris Lopez' comments:

- Often sober housing.
- May not be good match for ABI clients needing considerable support,
- May have little staffing or programming or require outside activities during the day.

Pathways to Addiction Service: Harm Reduction

Stand-alone community-based programs:

- → Community-based services more frequently provide a harm reduction approach, with some agencies seeing it as a gateway to eventual abstinence.
  - Example: Withdrawal management's day program (group) and community (1 to 1 counselling)

- → Focused addiction counselling using harm reduction approach are growing.
  - Examples : St. Stephens, Scarborough Housing Help, Breakaway, Fred Victor., LOFT, YSAP, etc. Some of these programs may be office-based rather than mobile.

- → Case management incorporating a harm reduction philosophy is more common. Provides linking to and coordination of required services.

Guide to Addiction Services in Toronto

- Call MAARS (CAMH) for assessment of appropriate service:
  416-535-8501 Press 2

- Call Central Access for a Withdrawal Management System bed:
  1-866-366-9513

- Call Coordinated Access to Addictions (CAA) for referral to all addictions services in Toronto:
  1-855-505-5045

- Call Access Point for access to supportive housing, ACT Teams and case management:
  1-888-640-1934

Questions?

Concurrent Disorders Support Services
Fred Victor Centre
145 Queen Street East (at Jarvis)
Toronto, ON M5A 1S1
Tel: 416-644-3081 Ext. 3311; Fax: 416-364-8526

Lynn Hillman, Ext. 3311
lhillman@fredvictor.org

Download referral & consent forms from
www.fredvictor.org