Fundamentals of Addiction – Trauma Informed, Solution Focused Counselling & Case Management

FUNDAMENTALS OF ADDICTION – TRAUMA INFORMED, SOLUTION FOCUSED COUNSELLING & CASE MANAGEMENT

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Affordable Course Transformation: Centennial College
Toronto

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LAND ACKNOWLEDGEMENT

Through Centennial College, contributors to this resource are connected to the homelands and treaty lands of the Haudenosaunee, Anishinabewaki, Chippewa, Mississaugas of the Credit First Nation, Mississauga and Wendake-Nionwetsïo (https://native-land.ca/) among other peoples who historically lived on the lands, fished from the lakes and rivers and hunted from the forests of Tkaronto, or what some now know as Toronto.

Some of us live here among ancient ancestors and carry on the legacies of First Peoples of these lands. Others of us arrived recently as colonizers, refugees or immigrants. Residing here and being sustained by this land, we all are treaty people governed by several of the over 40 treaties and other agreements that First Nations signed as independent, self-governing nations and by the Dish With One Spoon Treaty between Anishinaabe, Mississaugas and Haudenosaunee that binds us all to share the territory in peace and to protect the land.

In our teaching and learning, we aspire to good hearts and good minds. We acknowledge the land as a sentient and life-sustaining being that surrounds us with cooling forests that refresh our air, with rivers and lakes that provide fresh water and with rich soils that grow our food. We acknowledge the land as a suffering being, ravaged by centuries of colonization, extraction and neglect.

If we truly acknowledge the land, we must acknowledge fully the destruction and loss experienced by those who are dispossessed and dislocated across these lands some call Canada. We must listen now actively to Indigenous, Metis and Inuit peoples and learn how we might atone for ongoing colonization and reconcile ourselves to all our relations.

"This land acknowledgement was created by a student in TLHE720 (June 2021), shaped by content and perspectives from:

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- 1492 Land Back Lane and other reflections on "Canada 150".

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INTRODUCTION TO THE BOOK

Welcome to Fundmentals of Addiction – Trauma Informed, Solution Focused and Case Management!

In this open textbook, you will find 4 chapters.

1. Language and Substance Use
2. Solution Focused Counseling
3. Trauma Informed
4. Addictions Case Management

Please note that in Pressbooks pages are called chapters. When you click on the "next chapter" arrow at the bottom right, you are just going to the next page.

ACKNOWLEDGEMENTS

It truly takes a village to create an open textbook! This project was made possible by the efforts of many people – there are so many to thank. This project was made possible because of our village.

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Denise Halsey

CHAPTER 1: LANGUAGE AND SUBSTANCE USE

CHAPTER 1 INTRODUCTION

As we start our journey into the Fundamentals of Addiction – substance use and process addiction/behavioural disorders we will start with an exploration of the power of language. Can we change how we treat substance use by changing the language?

Let us explore the possibilities. Perhaps this is your first exploration of complex world of substances, substance use, and substance use disorders; maybe you have direct experience with this topic, through family, friends, or community. You may even have struggled with substances yourself. If so, I appreciate your engagement with this topic, all are welcome here! This text will help guide your educational journey from why people use substances, substance use disorders, Canada's policies on substances, theories of substance use, as well as supporting individuals who use substances and finally recovery and prevention.

We will also cover so many other areas that are important as well such as Cultural Competence, Race, Stigma, Gender and Compassion.

I hope this resource will be a helpful guide as we delve into a topic that is complex and challenging. I encourage you to take care of yourself as you work through each chapter, including reaching out to your support system as needed.

Are you ready? Let's get started! Take a minute to think about what you know about addictions and complete the quiz below.

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LEARNING OBJECTIVES

Learning Objectives

By the end of this chapter you should be able to:

1. Recognize the role of the social determinants of health on individuals & specific groups such as Indigenous Peoples, LGBTQ and Black Canadians.
2. Define intersectionality
3. Explain Cultural Competence
4. Describe stigma
5. Recognize appropriate and inappropriate language regarding substance use
6. Explain how language contributes to stigma, and how stigma can impact a person's health
7. Illustrate the role of compassion for others and self

1.1 SUBSTANCE USE AND THE DETERMINANTS OF HEALTH

What makes you who you are? When you think about who you are, everything matters; for example, your physiology (body and brain), the environment around you, your biological makeup, your life experience, your gender, your abilities, your ethnicity, and your psychological well-being (mental health). These are just some of the factors that have gone into your development and where you find yourself at this moment in time. These are part of Canada's Determinants of Health.

Figure 1.1.1 – Photo by note thanun on Unsplash

The determinants of health[1] are a broad range of factors that impact every person's health, including

1. Income and social status
2. Employment and working conditions
3. Education and literacy
4. Childhood experiences
5. Physical environments
6. Social supports and coping skills
7. Healthy behaviours
8. Access to health services
9. Biology and genetic endowment
10. Gender
11. Culture
12. Race / Racism (Government of Canada, 2020)

These factors, along with other social factors like systemic racism and sexism impact your health. For example, "studies have shown that people exposed to racism have poorer health outcomes (particularly for mental health), alongside both reduced access to health care and poorer patient experiences" [2]. The social determinants of health therefore tell us our health is affected by more than just exercise and healthy eating. When we use the social determinants of health to explore our health we are looking at the big picture. Sometimes we are not always aware of the various systems which play a role in our life. To help us understand ourselves a little more, let us start with reflecting on our own experiences.

Key Takeaways

Experiences of discrimination, racism and historical trauma are important social determinants of health for certain groups such as **Indigenous Peoples, LGBTQ and Black Canadians**.

Activities

1. Review the Government of Canada's determinants of health website.
2. Create a picture of yourself. Using the social determinants of health, identify our experiences with one example in each category.
3. What is one intervention that could have impacted your health in a positive way?
4. What is one intervention that could have impacted your health in a negative way?
5. When you think about the social determinants of health, what areas do you think might put you at risk of a substance use disorder? Why?

After participating in this activity, you may have a deeper understanding of yourself. More exploration of the social determinants of health can help you gain a deeper understanding of substance use When people study substance use and the people who live with a substance use disorder, the social determinants of health can be used to look broadly at the many factors and systems that intersect in a person's life. To understand and develop empathy for people living with a substance use disorder, we must examine not only the determinants of health, but how the intersection between those determinants of health impact an individual. For example, if a person has multiple social identities (for example a racial/ethnic minority and a woman) and there are structural inequalities linked to these identities (racism, sexism), these intersections may compound the negative impacts on their health [(3)], which may lead to substance use. In other words, there may not be one single factor that relates to a person's substance use or substance use disorder.

This video may help you understand intersectionality further[(4)].

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Intersectionality and Health Explained – Sociological Studies Sheffield (There are many components that intersect and shape our lives) [4]

Transcript

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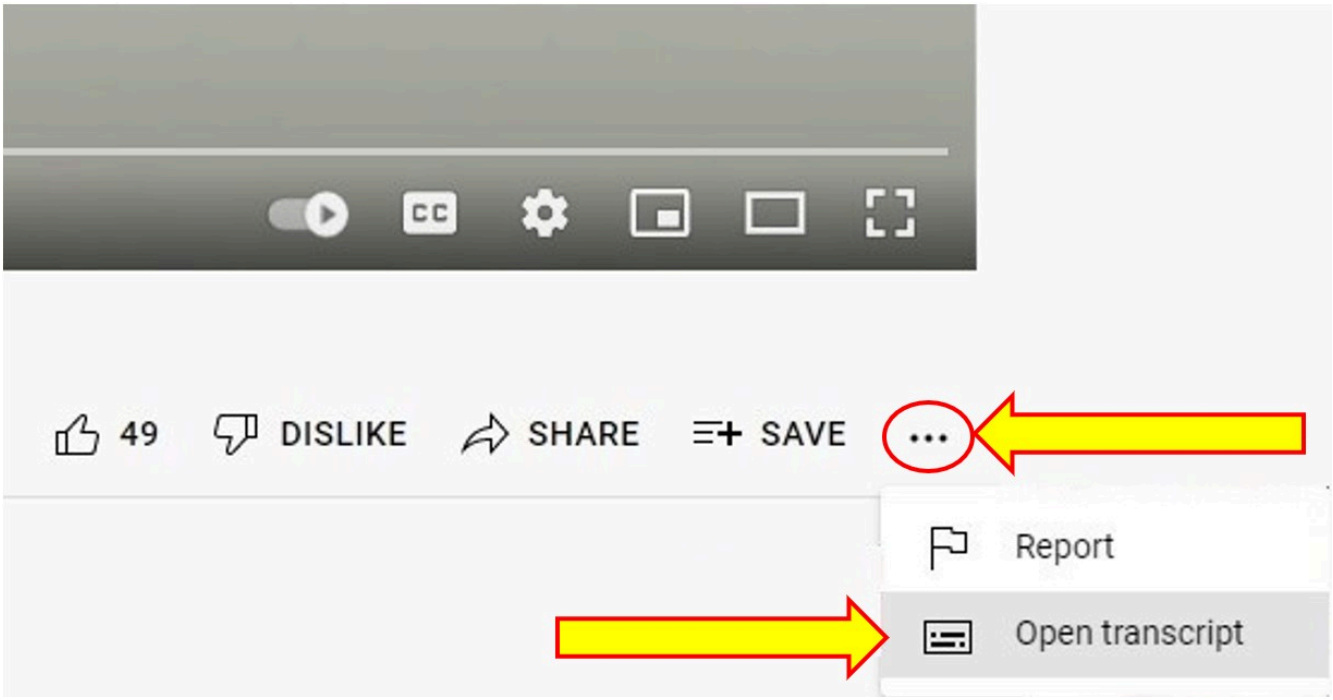

Research suggests we must acknowledge intersectionality, systems, and theories to work effectively in the field of substance use and substance use disorders. As you further your understanding substance use, take time to reflect on each section, participate in the food-for-thought and activity sections, and reflect on your growing understanding.

Food For Thought

- How did you become aware of substance use?

- What do you think the difference is between substance use and substance use disorders?
- Take a moment and reflect honestly on how you feel about substance use and substance use disorders.
- Where do your beliefs about substance use come from? Friends, media, family?

Now that we have established the complexity of substance use, the next section will examine the language we use and the role it plays in the lives of people with substance use disorders, their family, friends, and health care workers.

Figure 1.1.2 – Photo by Larm Rmah on Unsplash

For More Information

- Indigenous Children and Youth
- Roots of Resilience: Overcoming Inequities in Aboriginal Communities
- Health Inequalities and Social Determinants affect Aboriginal Peoples' Health
- Social determinants and inequities in health for Black Canadians: A Snapshot
- Health Inequalities Data Tool
- Understanding the report on Key Health Inequalities in Canada
- How to integrate intersectionality theory in quantitative health equity analysis? A rapid review and checklist of promising practices
- What Are The Social Determinants of Trauma?

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1.2 CHANGING THE LANGUAGE OF "ADDICTION"

Addiction as a diagnosable and treatable illness is recent, though the phenomenon of people misusing substances is not. For example, in the first four iterations of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) used in psychiatry, addiction as a disorder was not included; neither for substances nor behaviour. The DSM is "the standard classification of mental disorders used for clinical, research, policy, and reimbursement purposes in the United States and elsewhere"[(1)] and is a text you will use in your program and in your work. As our understanding of substance use and behaviour has changed, our ability to diagnose and support has also changed; the most recent version, DSM-V, now includes substance-related and addictive disorders. There are some behavioural disorders like gambling which continue to use the term addiction. By changing the language, perhaps we can reduce the stigmatization of the term.

What is stigma? You may have heard the term stigma to describe poverty, disability, mental illness, and culture. Stigmas are negative attitudes or beliefs about a topic[(2)], and are prevalent in the field of substance use; some even suggest stigma is an underlying factor in substance use and behaviours as Matthews et. al. (2017) suggest, "stigma figures in the social construction of addiction" [(3)]. If we can address the stigma of the language, we may begin to tackle the stigma of substance use disorders; "stigma not only impedes access to treatment and care delivery, but it also contributes to the disorder on the individual level"(4). If we change the language of addiction, will it reduce stigma and improve health outcomes for people living with addiction? Only time will tell, though "both scientists and mental health advocates have long suggested that an increase in the lay public's understanding of stigma...may reduce discrimination and prejudice"[(5)]. Substance use is highly stigmatized.

The next step in our learning journey, as we develop greater understanding of substance use and stigma, is to examine the language we use. For many people, substance use disorders are seen simply as "*addiction*". Take a moment and reflect on the word addiction.

Food For Thought

- When you think of the word addiction, what do you think of?
- When you reflect on the word addict, what springs to mind?

Let us start with this short primer.

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Illuminate – CCSA/CCDUS – Elaine Hyshka, PHD, Assistant Professor at the School of Public Health, University of Alberta, and Barry Andres, Executive Director of Addiction and Mental Health, Alberta Health Services, discuss the importance of humanizing addictions treatment and recovery[6].

Transcript

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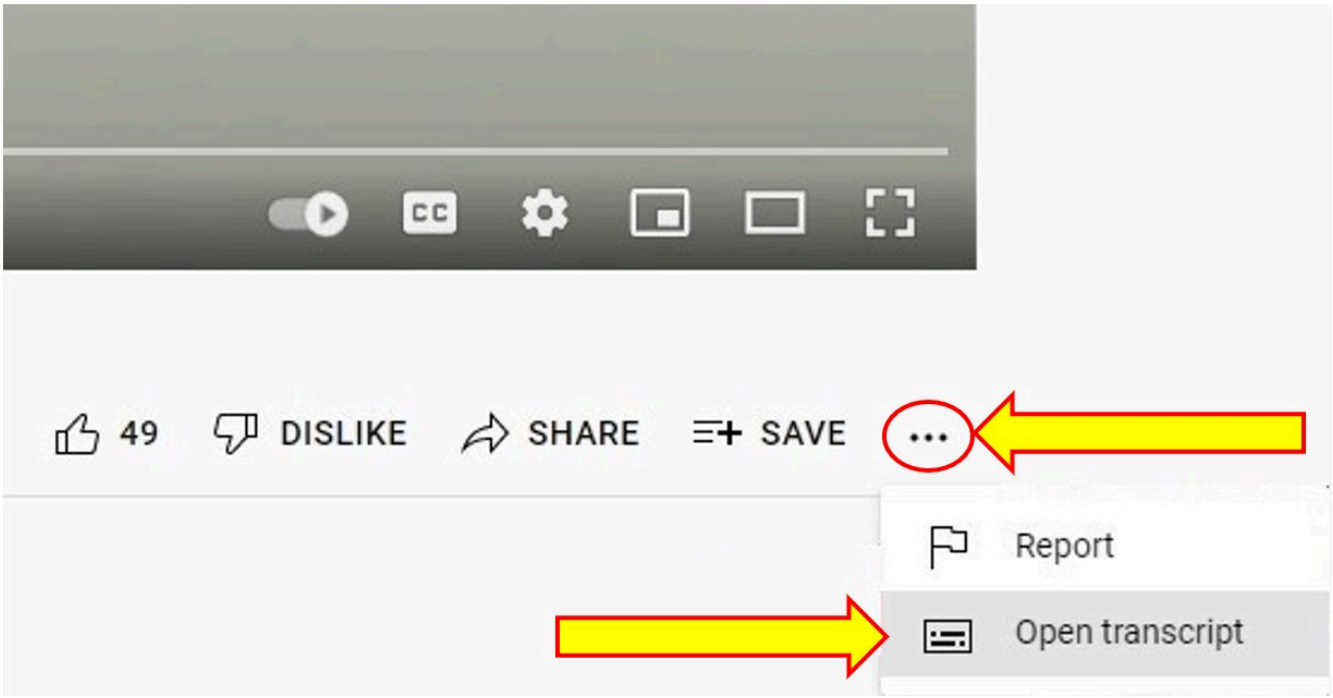

What is your responsibility as a Social Worker for helping to reduce the stigma of substance use disorders (SUD)? Reflect on the video, it is focusing on taking substance use out of the shadows. One way we can do this is to explore the word addiction itself, to understand its meaning and it's history. The term has evolved and only came to use in the 17th century relating to substance use, with the medical conception of addiction beginning around the 19th century[7]. The word addiction has it roots in Latin and was used in the Early Roman Republic as "being bound to"[8]. In the case of the Roman Republic, it was bound to a creditor, to someone you owed something. In today's world should we view a substance use disorder as still being bound to? Does this impact our ability to support individuals with substance use disorders? If we examine the concept of having no will when it comes to substance use, this may contribute to the stigma associated with substance use disorders.

Food For Thought

- Think for a moment about the idea of "being bound to"; what does this make you think of?
- Can you relate this concept of bondage to substances or behaviours?
- What is the "power" of addiction?

- How do you think this concept contributes to stigma?
- Do you think changing the language will reduce stigma? Why or why not?

For many, addiction suggests an inability to manage consumption of *licit* and *illicit* substances or an inability to manage an activity like gambling. For others, the word addiction relates to an activity they love to do; addiction has been used to describe activities people are passionate about. This confusion between the terms adds to the stigma; the "contemporary usage of addiction is contradictory and confusing; the term is highly stigmatizing but popularly used to describe almost any strong desire, passion or pursuit" [9]. Let us think for a moment how you use the word *addiction*? Is this a word you have used before? Has it related to substance use? Perhaps you have used this word to describe your relationship with a particular snack food, "I am addicted to chocolate," or maybe a technology "I am addicted to this new app."


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Figure 1.2.1 – Photo by Behnam Norouzi on Unsplash

Figure 1.2.2 – Photo by Maxim Ilyahov on Unsplash

Addiction, consequently, is a term we not only use to describe substance use disorders, but we use it to describe our relationship with the world around us and we use it interchangeably in both positive and negative ways. If you look up addiction on the internet, you will find the term addiction being used by companies marketing products, celebrity blogs, individual podcasts, and more. The *stigma* of the word addiction, however, seems to relate only to substances and behaviours that society deems inappropriate, dangerous, or unhealthy. Addiction as a term and a concept is so polarizing that in fact "there was an attempt to avoid it entirely by writing it out of the diagnostic manuals and substituting other terms like abuse and dependence" [(10)]. Addiction as a concept relating to substances has been difficult to define and is slowly being replaced by phrases such as substance use, misuse, or substance use disorder. Even the term substance abuse has been highlighted as a negative term due to the negative connotation associated with punishment[(11)]. Addiction, therefore, as a concept relating to substances and activities is often associated with negative behaviours. This association has led to the stigmatization of the term addiction.

Stigma impacts the way we treat people, it impacts the way people who use substances see themselves and

access support. Please watch the following video by people with substance use disorders who talk about how stigma[12] has impacted their lives.

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Stop Stigma. Save Lives Project: Experiences of stigma. Northern Health BC. (looking at the many levels of stigma towards those who use substances such as: discrimination, health, etc)

Transcript

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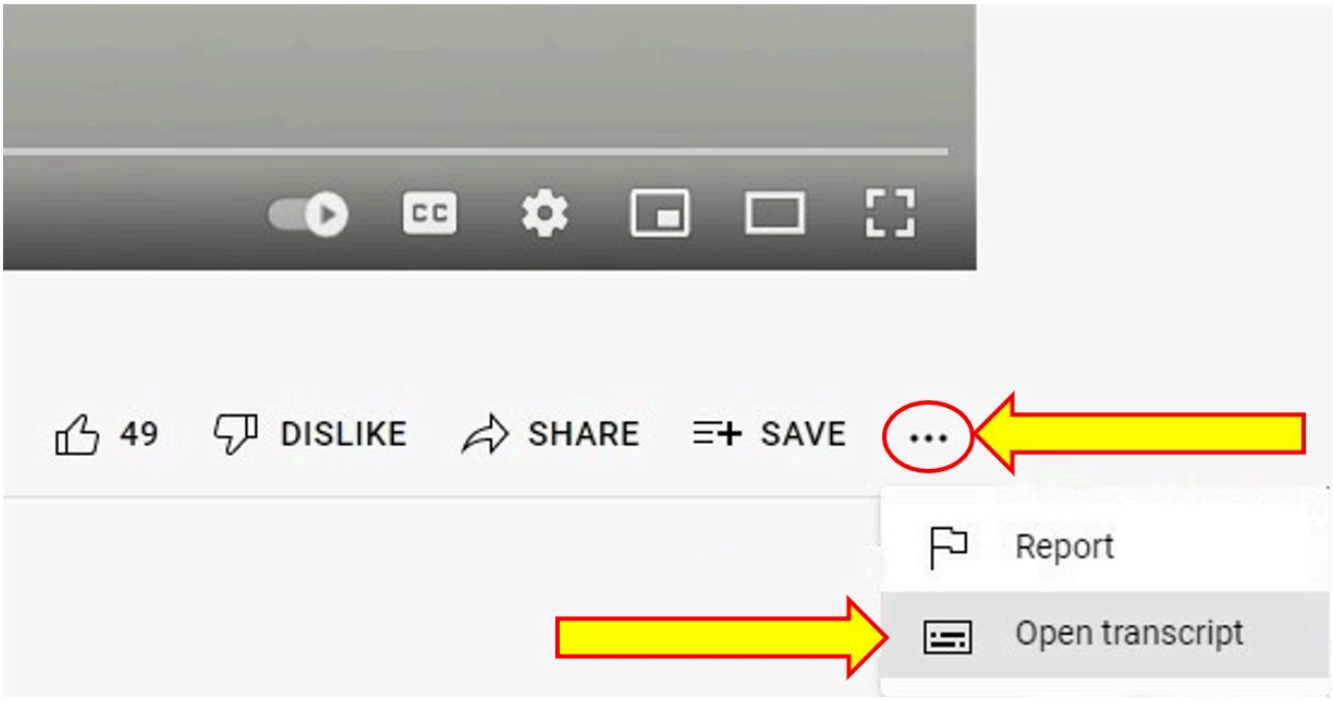

How do we reduce the stigma associated with the words we use when it comes to substance use disorders, or different communities who experience it?

Food For Thought

- Why do you think the word addiction still has stigma?
- Do you prefer substance use disorder rather than addiction? Is there another term you think is less stigmatizing?
- Can you think of a different term than process addiction to address an addiction to food, shopping, sex, gambling, or technology?
- What are terms you can use to describe your love for something that do not include addiction?

As noted above, stigma impacts individuals who use substances. According to Volkow (2020), "people with addiction continue to be blamed for their disease"[13]. This stigma can prevent individuals from accessing support due to self-stigmatization (lack of self-worth, low self-esteem) as well as previous poor experiences with healthcare or other services. As Social workers, we can seek to stop stigma by helping individuals, family, friends, and communities use language that reduces stigma.

Let's listen to Dr. Kenneth Tupper discuss ways we can address stigma and discrimination in substance use disorders[14].

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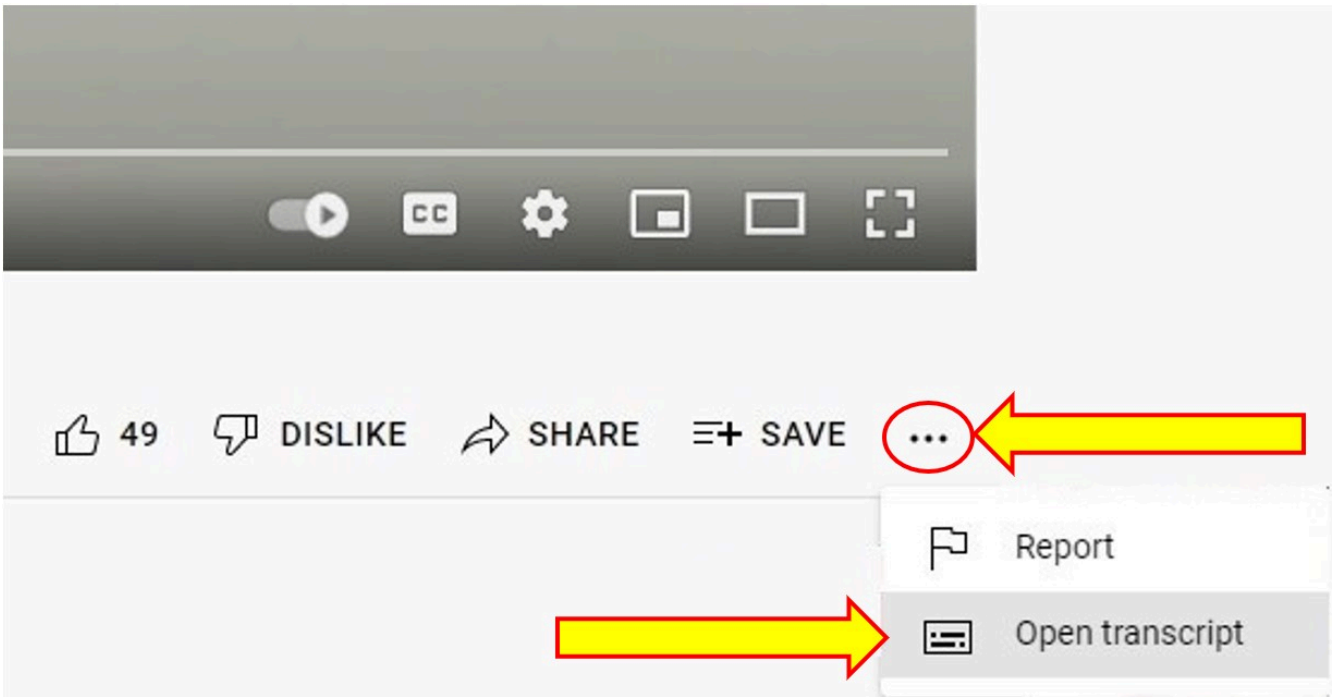

Some researchers have suggested we can reduce stigma of many illnesses, including substance use disorders, by using person-first language. For example, rather than saying an "addicted person," or an "addict," we say "a person with a substance use disorder." Person-first language has also been championed by people living with mental illnesses and other disabilities. This puts a person before a diagnosis, making the person the focus, rather than the illness. When reflecting on the social determinants of health and intersectionality we are looking beyond one factor to the whole individual and multiple connections between these factors, their life, and their experiences. When we choose person first language, we choose to see **all** the parts of the individual. Rather than focusing on the substance use, we see a whole person and work with the unique aspects that make a person who they are. This allows both a Social Service worker and the agency supporting the individual to provide a more comprehensive service.

Activities

1. Write down all the words you have heard or used to describe substance use. Place them on a continuum of positive to negative.
2. What do you notice?

3. How do you think these words impact individuals living with a substance use disorder?
4. How do you think the language you use might impact your professional relationship with clients as a Social worker?
5. What is one way you might challenge your beliefs about substance use disorders?

We are all affected by addiction whether directly or indirectly, and to improve health outcomes of all Canadians the stigma associated with both the term and the activity must be addressed. Greater understanding of the terms we use interchangeably for "addiction," unpacking the stigma associated with the term, and choosing language that highlights the individual rather than the behaviour, we can change how we see and work with people living with a substance use disorder. This can lead to a change in how others view and treat people with substance use disorders in Canada.

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Attribution

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1.3 CULTURAL COMPETENCE

Figure 1.3.1 – Word Art by Denise Halsey – Hello

Creating cultural competence is essential on college campuses, in our communities, and in the workplace. Cultural competence, as defined by the Intercultural Development Inventory, is the capability to shift cultural perspective and adapt—or bridge—behaviour to commonality and difference.

The IDI is an assessment-driven approach to developing individual intercultural competence and to build cultural competence through adaptation of behaviour to cultural differences and commonalities.

What defines cultural competence, according to college students' diverse perspectives ranges from a monocultural to intercultural perspective: Denial, Polarization, Minimization, Acceptance, and Adaptation. The monocultural mindset uses cultural differences and commonalities based on an individual's own cultural perspectives and values and often uses stereotypes as a way to identify cultural differences. The intercultural

mindset is more able to make sense of commonalities and differences of culture based on their own cultural practices and values and those of the other's culture. They are more likely to use cultural generalizations that recognize cultural differences and support more complex perceptions and experiences based on difference and commonality.

Cultural Competence will always be a work in progress. There are so many differences in the communities that we will work with. It is important to be aware of people as individuals as well as their culture and populations. One size does not fit all so it is important to understand that we will serve communities that have different culture backgrounds that may dictate who can do the interview (i.e. Orthodox Jewish Woman would have a female intake worker), as well as those with disabilities, language barriers, or seniors to give a few examples. This being the case there are times when a neighbour or friend can accompany them to assist with the situation.

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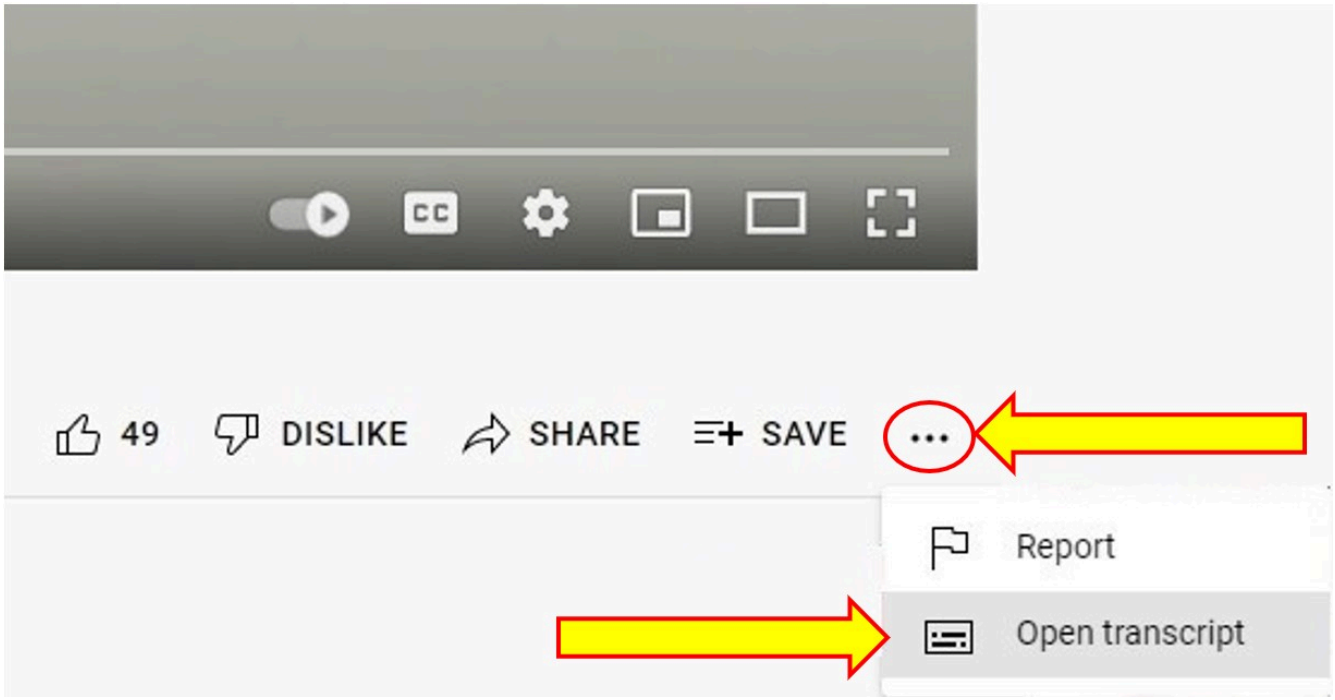
Video 1: What is Cultural Competence. by Arkansas Open Educational Resources (OER). University students talk about what cultural competence is and what cultural competence means to them personally. Project: Creating Cultural Competence by Jacquelyn Wiersma-Mosley and Margaret Miller Butcher.

Transcript



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Video 2: Cultural Competence in Denial and Polarization.by Arkansas Open Educational Resources (OER). University students discuss what their experiences have been with either themselves or with others who have mindsets in Denial and Polarization.

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Video 3: Cultural Competence in MInimilization. by Arkansas Open Educational Resources (OER). University students discuss what their experiences have been with either themselves or with others who have mindsets in Minimization.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=808#oembed-4

Video 4: Cultural Competence in Acceptance and adaptation. by Arkansas Open Educational Resources (OER). University students discuss what their experiences have been with either themselves or with others who have mindsets in.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=808#oembed-5

Video 5: Becoming Cultural Competence. by Arkansas Open Educational Resources (OER). University students discuss what their experiences have been with either themselves or with others who have mindsets in.

Attribution:

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1.4 RACE, STIGMA AND SUBSTANCE USE

Figure 1.4.1 – Reducing Stigma Wordart by Denise Halsey

According to Statistics Canada [1], approximately 23% of Canadians identify as a "minority." This includes People of Color, Indigenous people (Aboriginal, Metis, Innu, Innuit), and immigrants from countries all over the world. If you remember in section 1.1, we discussed race/racism as one of the social determinants of health. When a person experiences racism, research shows that racist incidents are similar to traumatic

experiences; and there are both physical and mental health ramifications [2]. People of Color have experienced racism for centuries. The impacts of slavery, which existed in Canada [3], and colonization of People of Color has been and is both overt, subtle, and systemic (4).

Indigenous people have also been impacted by racism and stigma through colonization. This racism extends through the language we use when it comes to substance use.In this section, we explore how language contributes to racism, which in turn can lead to substance use. We will explore how stigma subsequently plays a large role in creating barriers for treatment and support of substance use disorders.

Let us watch this video to explore how the language of substance use has impacted Indigenous communities [5].

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Decolonizing Substance Use & Addiction / Len Pierre / TEDxSFU (looking at Substance Use & Addiction through an Indigenous lens, Len Pierre is Coast Salish from Katzie First Nation who is an Educator)

Transcript

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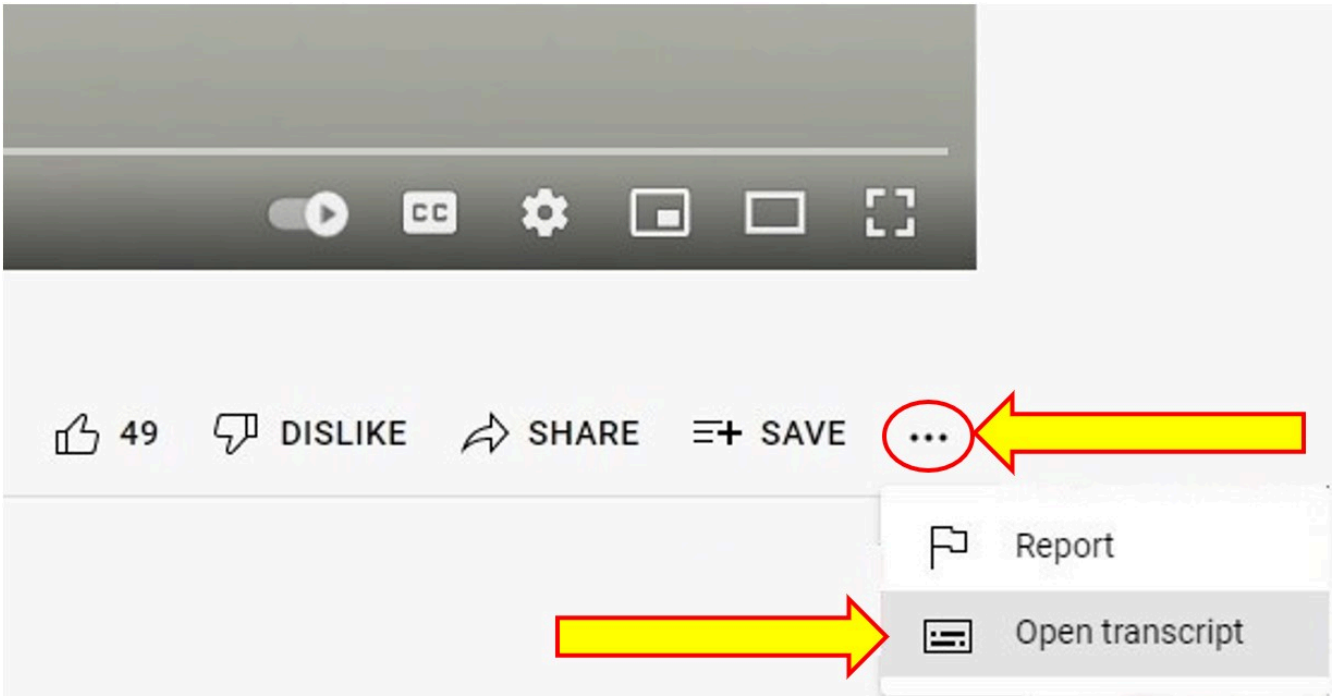
1. Click on **"YouTube"** on the bottom-right of the video. This will take you directly to the YouTube video.
2. Click on the **More Actions** icon (represented by three horizontal dots)
3. Click on **"Open Transcript"**



Food For Thought

- Where does language come from?
- Reflect on specific language/terms you use.
- Are there terms you would change? Why?
- How do you think you can decolonize language?

Numerous studies have documented relationships between self-reports of discriminatory experiences and reports of distress, which can lead to substance use [6]. While further research must be done to determine the causal relationship, the relationship exists. This means that if a person experiences racism they may use substances as a form of coping. Rather than using substances to cope, we can help promote healthier choices through access to healthcare that addresses the social determinants of health, including racism.

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One example of an agency ensuring the intersectionality of health is addressed is the North End Community Health Centre in Halifax, NS [7].

Transcript

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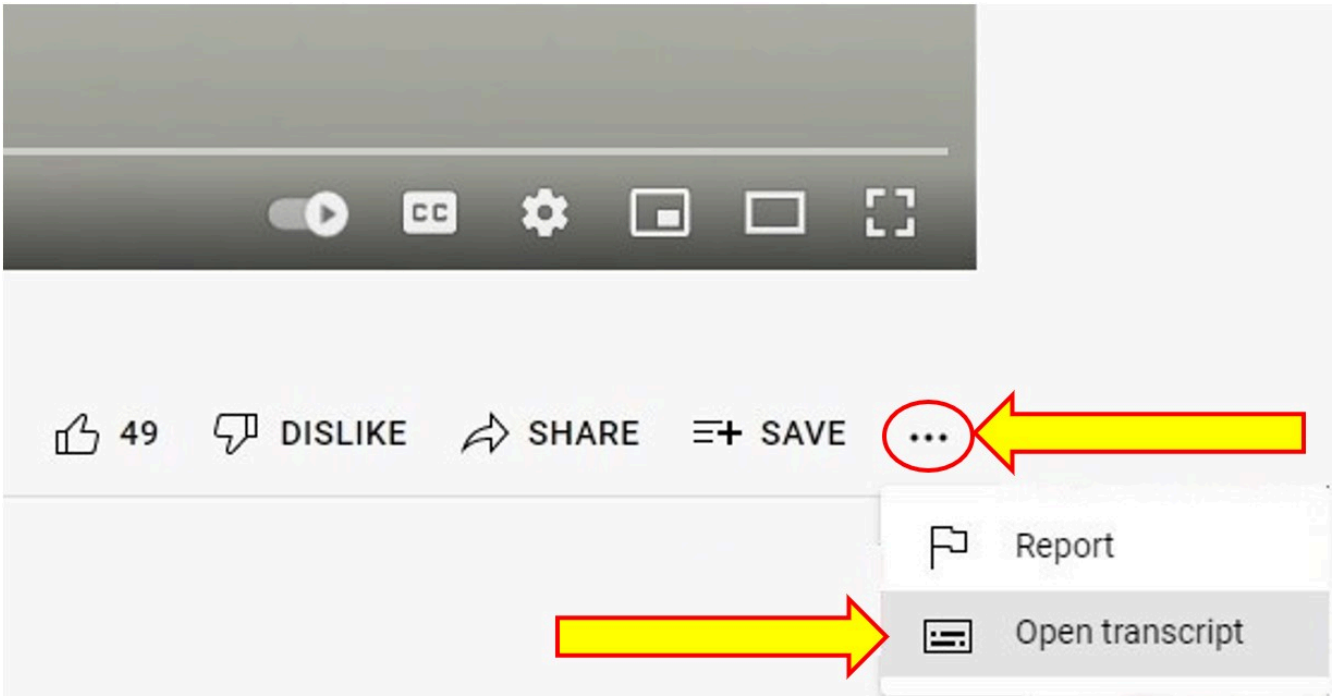

One step we can take as Social workers is to actively talk about racism and how it exists in our lives. Addressing the language we use is an important part of addressing racism, reducing stigma, and supporting the health of minorities in Canada. For example, the intersectionality of black people's lives in Canada includes "age, gender, sexual orientation, ability, religion, immigration status, country of origin, socioeconomic status, and

racialized identity" [8]. For Indigenous Canadians intersectionality also exists between colonialism, residential schools, and trauma. "While the experiences of First Nations, Métis and Inuit in Canada are unique, they have all endured and pushed back against hundreds of years of colonization, persecution and on-going structural violence that was intended to push them to the margins of society" [9].

The knowledge of these overlapping factors and identities are critical when providing service as this can reduce barriers and stigma. Service provision can be more comprehensive, for example, and programming must be culturally and trauma sensitive when working with people who have a racialized identity. Due to their identity, we can assume that they have experienced racism. Racism can lead to further stigma, which in turn creates barriers to treatment and support. This racism has led to *perceptions* of substance use among Indigenous communities. The following is an example of how racism and stigma have impacted Mi'kmaq people in Nova Scotia when it comes to accessing health care.

Food For Thought

- Reflect on racism and stigma in healthcare
- What are three ways racism and stigma are creating a barrier for service in this article?
- What do you think you need to be aware of when providing services?

When you read stories like this and others, it may cause you to feel emotional. This emotional reaction may result in feeling uncomfortable or unsafe. It is important to understand where these feelings begin. As you explore your thoughts, feelings, and emotions, this is an opportunity to also explore your understanding of racism in Canada. This could lead to further education about slavery in Canada, or of residential schools. Perhaps you may wish to learn more about traditional or cultural ways of knowing; exploring the concept of two-eyed seeing, developed by Elder Marshall, Mi'kmaq Indigenous Leader from the Eskasoni First Nation who suggests making change as "one conversation at a time" (personal communication, February 9, 2021). You may reflect on your identity and begin to examine privilege, "an invisible package of unearned assets" [10].

READING:

Check out Peggy McIntosh's Checklist.

As Social workers, it is your responsibility to understand systemic issues that create barriers to service so you may work with empathy, compassion, and knowledge. This will contribute to reducing racism and stigma.

Promoting the importance of traditional knowledge and traditional treatment is another step in the reduction of stigma. It is through the resilience of Indigenous communities that "Indigenous peoples, languages, cultures, and traditions have not only survived, but they have also been revived, reclaimed, and revitalized" (11).

Watch the video below and reflect on the importance of Indigenous culture, practices, and treatment in healthcare.

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Royal College of Physicians and Surgeons of Canada. *Bridging the gap between traditional and western medicine: The remarkable work of Dr. Karen Hill.* Dr. Karen Hill is the inaugural recipient of the Royal College's Dr. Thomas Dignan Indigenous Health Award, which celebrates Canadian doctors who epitomize a zeal and devotion to Indigenous rights and the dogged pursuit of justice for Canada's Indigenous people.

Transcript

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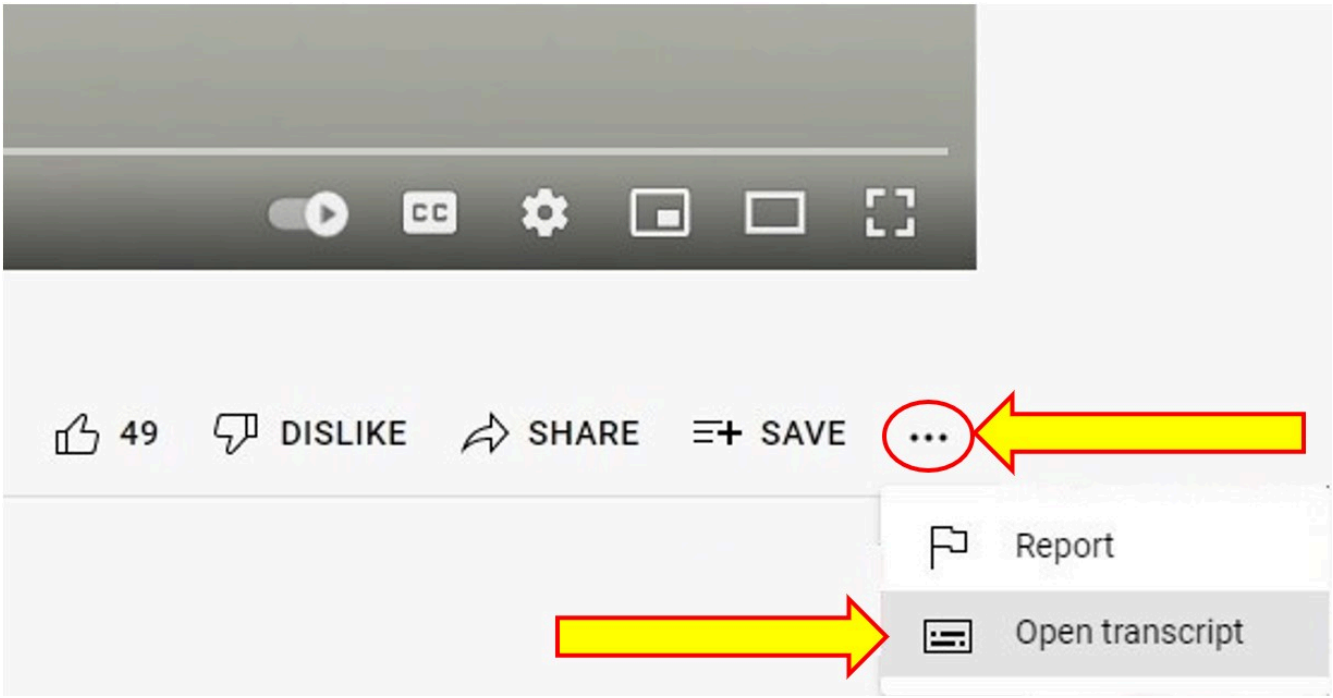

We know "substance use disorders are one of the most stigmatized mental health issues".[12] From the language we use, to the communities we engage with, we must be aware how language plays a role in racism and stigma for people who use substances and have substance use disorders. While we must be prepared to have difficult conversations and be prepared to talk about intersectionality, race, racism, and stigma in our work, it will require further training; seek out training that can support your understanding of language, racism, and stigma.We know "substance use disorders are one of the most stigmatized mental health issues" (13). From the language we use, to the communities we engage with, we must be aware how language plays a role in racism and stigma for people who use substances and have substance use disorders. While we must be prepared to have difficult conversations and be prepared to talk about intersectionality, race, racism, and stigma in our work, it will require further training; seek out training that can support your understanding of language, racism, and stigma.

Attribution

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1.5 GENDER, STIGMA AND SUBSTANCE USE

> When I first started in the divorce, um, when we first separated, I was straight. I was tryin' to do right. I had the kids in church. And it got so hard, and somebody was always goin' "well if you did this if you did that," and I started feelin' beneath. Uh, when I had the car wreck, I knew one way I could support my kids—I started sellin' drugs. [1]

Figure 1.5.1 – Photo by No Revisions on Unsplash

Gender, as we discussed is one of the social determinants of health. Have you thought about how gender plays a role in substance use disorders? Researchers suggest there are "environmental, sociocultural and

developmental influences" [2] when it comes to sex, gender and substance use. This means how a person is born regarding their biological sex (male or female), as well as how they identify (gender), plays a role in their substance use and in their development of substance use disorders.

Please watch the following video [3] to explore sex, gender and substance use.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=55#oembed-1

Sex, Gender and Addiction (National Institute on Drug Abuse) – Dr. Sinha is a Professor of Neurobiology and Child Study in the Department of Psychiatry at Yale University. Its important to understand the effects of stress on emotions, mood, and behaviours, this includes the differences between sex and gender; how stress affects men and women differently, and how various drugs can affect the sexes.

Transcript

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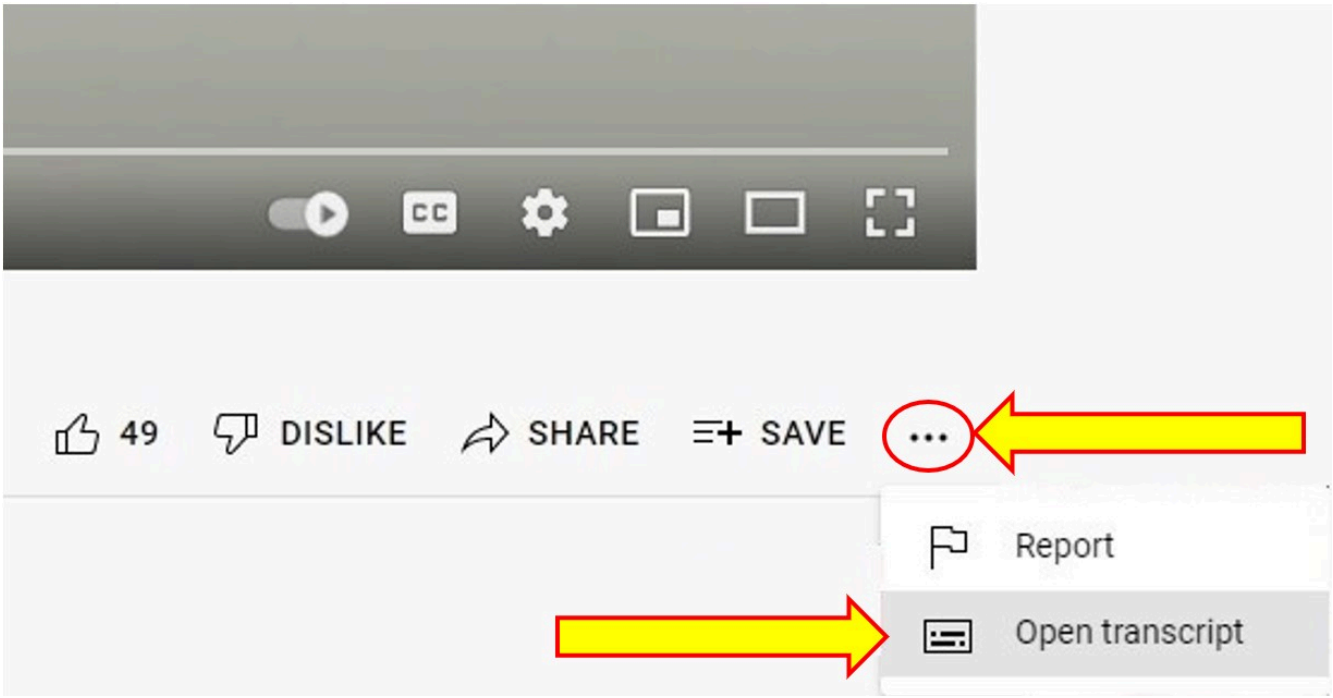

Race and gender, as intersections of identity, also play a role in substance use and the development of a substance use disorder. Research suggests substance use disorders do differ by both biological sex and by gender [4]. Subsequently, there has been an increase in woman-focused research, as the majority of current treatment supports and services are still misinformed by research with a "male-as-norm" bias. [5]

Review the Table on Sex Differences in Substance Use – NCBI. This is important to be aware of, as we are exploring the social determinants of health and beginning to tackle racism, sexism, and the stigma associated with substance use.

Food For Thought

- Why do you think we should be aware of sex and gender when discussing substance use?
- What do you think are some issues specific to sex and gender for those who use substances?

Figure 1.5.2 – Photo by Sharon McCutcheon on Unsplash

Women as a gendered group face greater stigmatization than men for using drugs since they go against the character traits of perceived female identity. The stigma of drug use is also greater for mothers since they are expected to be the caregivers, raise children, and be more family oriented than fathers. (6)

What this suggests is society that societal expectations of women result in moral judgments and women are judged for using substances. As Social workers, it is important to be aware of these stigmas and judgments. When we think about women who use substances and those who have a substance use disorder, we must examine our assumptions. We reflect so we can provide non-judgmental services and ensure the research we are using addresses "unexamined assumptions about how women "should" behave" and how these "have influenced research agendas" (7). These assumptions consequently impact availability of evidence-based services and programs for treatment and prevention. We also must be aware that in general, "women report more problems related to health and mental health, as well as more past trauma and abuse (physical and sexual), and experience more sexual problems. Women are more likely to begin using drugs after a specific traumatic event, and to suffer from post-traumatic stress disorder".(8) How can we ensure that a program for women who live with a substance use disorder is the best it can be?

Several years ago, the United Nations developed a list of the issues that are specific to women who have substance use disorders. Of note is the association between substance use disorders and all forms of

interpersonal violence (physical, sexual, and emotional) in women's lives [9]. To engage with people who identify as women, Social Service workers must be aware of the following issues:

- Shame and stigma
- Physical and sexual abuse
- Relationship issues
- Fear of losing children
- Fear of losing a partner
- Needing a partner's permission to obtain treatment

These issues are not solely issues for a Canadian audience, they are worldwide. Based on these issues, the United Nations developed a list of concerns practitioners should address when supporting women with substance use disorders. These include:

- Lack of sex and gender-specific services for women
- Not understanding women's issues
- Long waiting lists
- Lack of childcare services
- Lack of financial resources
- Lack of clean/sober housing
- Poorly coordinated services [10].

Activities

1. Review the UN lists above.
2. Brainstorm any missing concerns you think would be important to include.
3. Imagine you are providing a program for women with substance use disorders. What would you need to do to ensure your program meets UNODC recommendations?

To support women's health, Social workers must also address the stigma of women using substances. Rather than provide supportive and well-rounded ("wrap-around") services, some services may come from a place

of moral judgment, which puts women who use substances in a greater position for marginalization and reduced health outcomes. "Women living with a history of substance use and addiction encounter many barriers when trying to access forums that are directly related to their life issues" [(11)]. Women have reported "feeling unsupported and judged" [(12)] which negatively impacts their mental health and may prevent them from further accessing health care. Being aware of the societal issues related to women and substance use is one area Social workers can make a real difference, through providing not only a judgment-free service, but a service that provides supportive services based on the UNODC recommendations. Gender based services that also support a *harm reduction* approach and address women's needs are an important part of a social service workers toolbox.

Activities

1. Research harm reduction.
2. Why is harm reduction important in providing services to women?

Harm reduction is simply that, reducing the harms that are associated with substance use (see Chapter 9). Harm reduction in women's programming should be comprehensive, addressing the issues identified above. For example, when working with women who are pregnant and using substances, some people may want to judge. Please watch the following clip and then answer the questions in the activity below.

WATCH

Reflections on Practice: Pregnant Users NFB Video – Nettie Wild – 2007 | 1 min NFB Video: Bevel Up-Becky and Liz

Street nurse Caroline Brunt reflects on the challenges she faces when working with pregnant women who use drugs, and the importance of not judging the mother.

Activities

1. Brainstorm a list of society's attitudes towards pregnant women using substances.
2. How do you think moms who use substances might be judged by a healthcare provider?
3. How do you think moms who use substances might be judged by a workplace or by community services?
4. What risks can this lead to?
5. How can you support a mom who is using substances or has a substance use disorder?

Women are becoming increasingly at risk for substance use disorders; for example, the Canadian Centre on Substance Abuse has suggested women's use of alcohol has been on the rise since 2004 [13]. In 2020, "30.5% of women of reproductive age reported consuming alcohol weekly in the past year and 18.3% reported engaging in heavy alcohol consumption" [14].

Food For Thought

- Why do you think women are increasing their substance use?
- Why do we need to know about women's drinking habits?
- Why do you think women are increasingly at risk of substance use disorders?

There are many issues to be aware of when it comes to gender and substance use. Whether providing support for women who have a substance use disorder or treatment for women's substance use disorders, Social Service workers must acknowledge the realities of women's lives, the stigma they face: "women with histories of addiction and incarceration face stigma regarding their roles in society, particularly with regard to their roles as mothers and women" [15] and the high prevalence of violence and other types of abuse [16]. Services must be comprehensive, from prevention through to treatment and recovery for women and girls, and should be based on a holistic and woman-centered approach that acknowledges their psychosocial needs [17].

Attribution:

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1.6 THE LANGUAGE OF COMPASSION

Figure 1.6.1 – Photo by Rémi Walle on Unsplash

The social determinants of health related to substance use are a complicated topic, and so is providing effective support. Mental Health and Addiction Workers must be aware of these factors and "must be carefully chosen because of the sensitivity of the subject, and the associated pain and trauma experienced by the participants" [(1)]. When we work with people who have substance use disorders we may feel tempted to "fix" the person. Our role as a Social workers is not to diagnose or treat but to provide support and appropriate referrals. One way to provide support is to use compassion.

Food For Thought

- What do you think compassion is?
- Why do you think compassion is important when discussing substance use?
- Why do you think compassion is important when working with clients?
- How can you demonstrate compassion?

To further understand being compassionate in your practice, please review this short video on how to be compassionate and supportive when working with people who use substances.

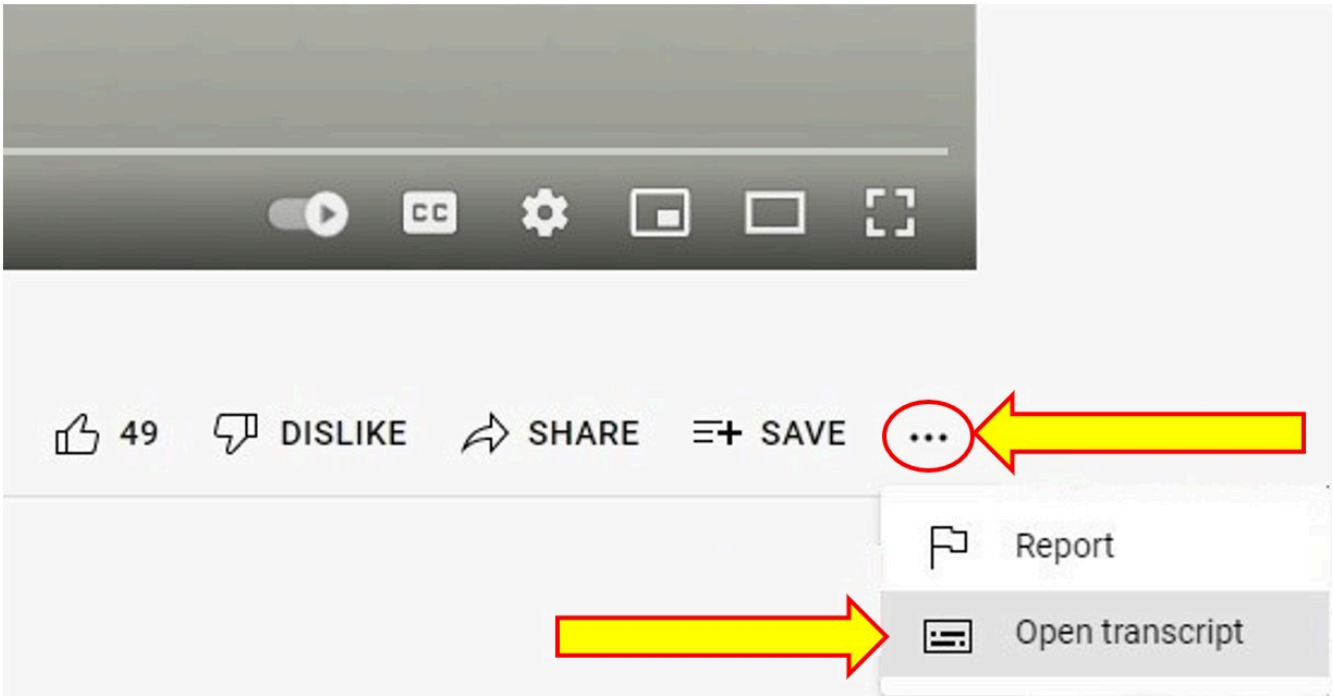
One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=517#oembed-1

My Journey with Compassion – CCSA/CCUDS. Stigma is a major barrier to the well-being and recovery of people with lived and living experience of substance use disorders. This animated video about two friends, Alex and Sam, explores the devastating impact of substance use stigma and how to challenge it in our communities [(2)].

Transcript

To Access the Video Transcript:

1. Click on **"YouTube"** on the bottom-right of the video. This will take you directly to the YouTube video.
2. Click on the **More Actions** icon (represented by three horizontal dots)
3. Click on **"Open Transcript"**



Being compassionate is important, it is also important to understand our boundaries. Investing much time supporting an individual can be taxing and can result in compassion fatigue. "Compassion fatigue is a recent concept that refers to the emotional and physical exhaustion that affects helping professionals and caregivers over time" [3]. Ensuring self care, including compassion for oneself, is one way to improve success in this field. At the end of each chapter there is a section called self-care. Each self-care section provides resources and activities that can improve mental health.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
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Food for Thought

- What are two ways you can prevent compassion fatigue?
- What was one learning from Chapter 1?
- What do you want to know more about?

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1.7 WHY PEOPLE USE SUBSTANCES

> "I grew up around a family of smokers who gave cigarette smoking a classy edge. I would always be mimicking the adults by pretending to smoke. This is the introduction to me normalizing cigarettes and participating in the social norms of tobacco use" [(1)].

There are many reasons why people use psychoactive substances, from medicinal to religion to enjoyment. You may be wondering why; however, some people can use substances and have healthy relationships with substances yet do not develop a disorder while others do [(2)].

Watch the following video of Tyler Sullivan-King who shares their story of using substances and developing a substance use disorder[(3)].

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=520#oembed-1

#SeeThePerson – Tyler. City of Hamilton. The "See the Person" video series aims to raise awareness about the negative impact stigma has on people who use substances, their loved ones, and our community. We all have a role to play in stopping stigma. Learn what actions you can take to stop stigma and help build a healthier, more caring Hamilton

Transcript

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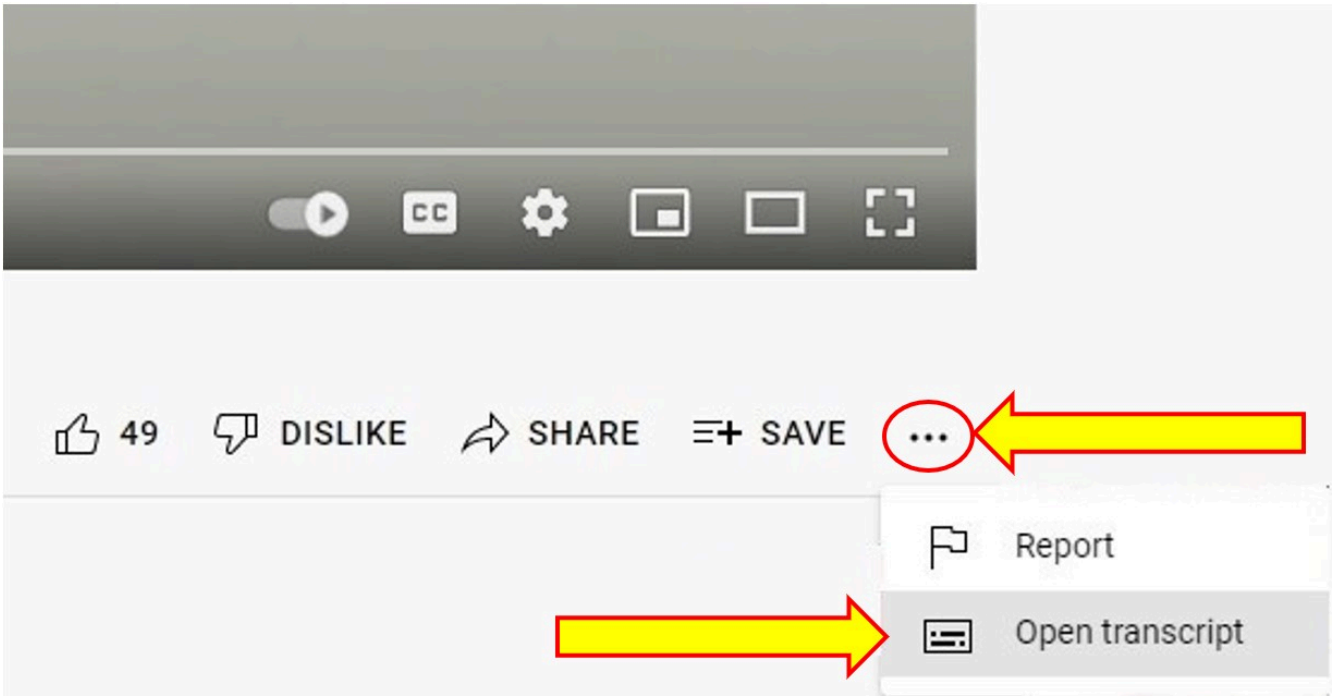

Tyler's prescription for an opiate from an injury was a powerful experience with a powerful substance. Tyler also mentioned their environment as "not ideal". This combination of factors developed into a substance use disorder.

What is a substance use disorder (SUD)? A substance use disorder according to the American Psychiatric Association [4] is a "pattern of symptoms resulting from the use of a substance that you continue to take, despite experiencing problems as a result" [5]. As with other diseases and disorders, the likelihood of developing a substance use disorder differs from person to person, and no single factor determines whether a person will develop a substance use disorder [6]. In general, the more *risk factors* a person has, the greater the chance that taking substances may lead to substance use and a SUD. "Risk factors are those that make drug use *more* likely" [7]. *Protective factors,* on the other hand, "are those associated with reduced potential for drug use" [8].

Table 1.7.1 – Key Risk and Protective Factors for Drug Use. [9].

Catagories/ Domains	Risk Factors	Protective Factors
Community	• Community disorganization • Laws and norms favourable to drug use • Perceived availability of drugs	• Community cohesion • Community norms not supportive of drug use
School	• Academic failure • Little commitment to school	• Participation in school activities • School bonding
Family	• Parental attitudes favourable to drug use • Poor family management • Family history of antisocial behaviour	• Family sanctions against use • Positive parent relationships
Peer/Individual	• Early initiation of antisocial behaviour • Attitudes favourable to drug use • Peer drug use	• Positive peer relationships • Network of non-drug using peers

According to this research, "for individuals who begin using illicit substances at an early age, several risk factors may increase the likelihood of continued and problematic use in later ages" [10].

Please watch this video from the Canadian Centre on Substance Use and Addiction exploring the power of protective factors in lifetime wellness.

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7 – 1 Community Connections Supporting Lifetime Wellbeing. CCSA / CCDUS. Wanda Kampijan, Community Connector, YMCAs of Cambridge & Kitchener-Waterloo, Ontario, joined the Brain Builders Lab to influence practice, policy and the community conversation around brain science[11].

Transcript

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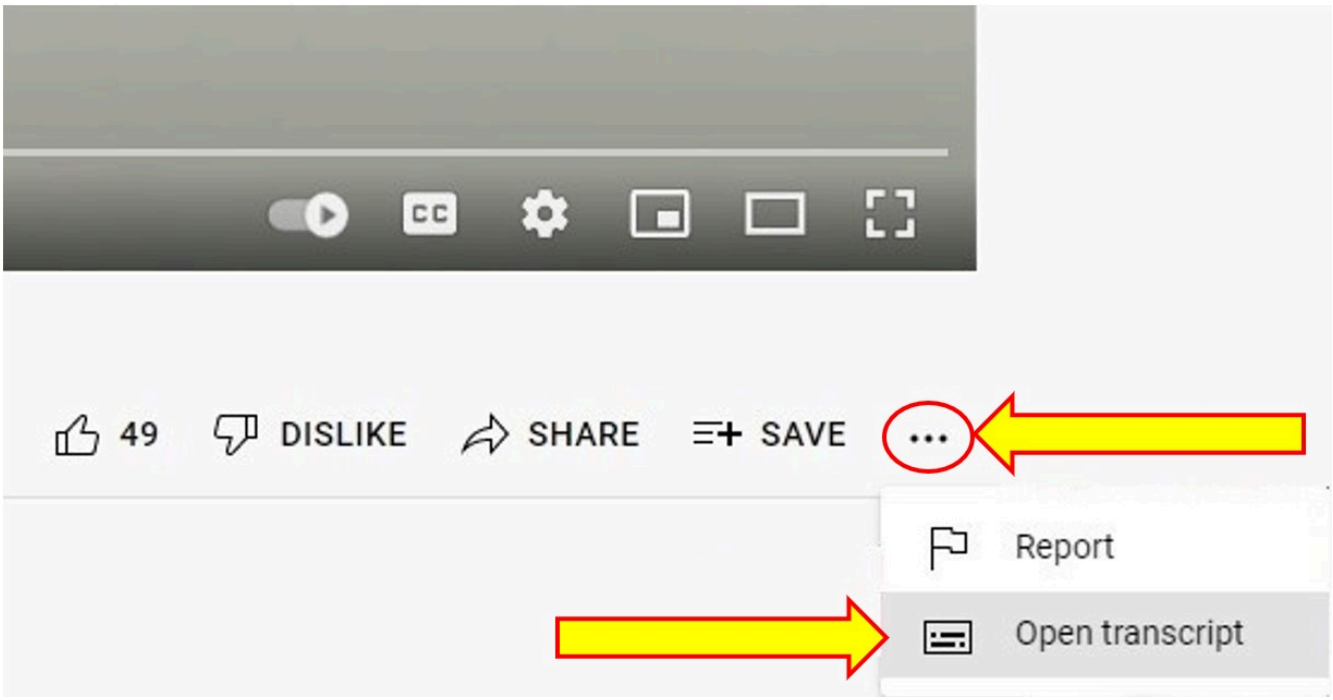

Activities

1. Review the risk and protective factors.
2. Reflect on the social determinants of health. How many of these risks or protective factors can you identify relate to the social determinants of health?
3. Reflect on Tyler: can you identify any risk factors that may have impacted his development of a substance use disorder?
4. Why do you think those with all the risk factors may not develop a substance use disorder?
5. On the other hand, why might someone who has all the protective factors develop a substance use disorder?

In Canada, there is a social acceptance within many cultures around the use of substances, including weddings, graduations, funerals, celebrations.

Activities

1. Reflect on the social acceptance of substances. Name the activities that accept substances.
2. Reflect on how companies promote the use of alcohol through the media.
3. What is the narrative you have heard about using alcohol throughout the lifespan?
4. What does this suggest about substance use and age? What does this suggest about substance use and gender?
5. Substance abuse and dependency is stigmatized, yet alcohol use is often culturally accepted. Why is that?

There are many reasons why societies, cultures and people use substances. As Social workers you may have the opportunity to explore an individual's journey, using your individual helping skills. You may have the opportunity to engage with a community, focusing on a specific group of people. For example, you may be working with a school, developing a survey on substance use among the youth. What types of interventions might you explore based on what you know about why people use substances? Be prepared, as you have learned, to explore every story, from a lens of "nothing about us, without us". The individual and the community must be the leader in their stories.

Attributions

Schwab, J.E. (2018). Drugs, Health & Behavior. OER Pressbook. Penn State. https://psu.pb.unizin.org/bbh143/

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1.8 WHY PEOPLE CONTINUE TO USE SUBSTANCES

Why do people *continue* to use substances, as part of a substance use disorder? You may think of substance use as a habit, as something that gets reinforced through daily repetitions and habits.

Food For Thought

- Reflect on a "normal day". What do you do from the moment you wake until the moment you go to sleep? Are any of these activities' habits?
- Identify the habits you have?
- Do you think these are healthy or unhealthy habits? Why do you believe this to be so?
- How does this habit make you feel? Why?
- Have you ever tried to change a habit? Were you successful? How?
- Reflect on a negative habit you currently have. Where does this habit come from? What does this habit solve for you? Have you ever thought about changing it? What would it take to change it?

A substance use disorder is an *unhealthy* habit and every time a person uses a substance (repetition) it causes a reaction in both the body (physical) and the mind (psychological). The substance use is pleasurable, and the repetition can work like an enforcer, drilling those habits deeper and deeper. In time, through the repetition of use and the reinforcement of the habit, this can make the substance use a very difficult habit to break. The habit may become both physical and psychological.

Activities

1. Brainstorm all the ways you think a person can become physically dependent on a drug and review with your class.
2. Brainstorm all the ways you think a person can become psychologically dependent on a drug and review with your class.
3. Compare and contrast your ideas from your brainstorm.

What is physical dependence?

What is physical dependence? Physical dependence is "a physiological state of cellular adaptation occurring when the body becomes so accustomed to a drug that it can only function normally when the drug is present" (Csiernik, 2015, p. 19). This means without the substance in the body, the body simply does not function "normally". When someone experiences these symptoms, it is called withdrawal. This can include shaking or trembling, nausea, cramping, muscle spasms and more. People who have a substance use disorder may experience withdrawal, "the development of physical disturbances or physical illness when drug use is suddenly discontinued in the opposite direction to the original effects of the drug" (p. 31). This is the body's physical response to the absence of the drug. Withdrawal can range from discomfort to death, depending on the physical dependence (how long a person was using a substance, how often) and the type of substance a person is using. All these factors will impact their withdrawal, for example, withdrawal from opioids is different than withdrawal from alcohol. When working with people in withdrawal, it is important to remember it is painful, for both physical and psychological reasons.

With physical dependence also comes tolerance. Tolerance is the "body's adaption to the presence of the drug requiring increased amounts to produce the same outcome as originally experienced (Csiernik, 2015, p. 29). This means that over time it takes more of the substance or drug to produce the same feeling. This has been known as "chasing the dragon".

Activities

1. Brainstorm a comprehensive list of factors that impact tolerance.
2. Why do you believe some people develop a tolerance to substances quicker than others? Discuss with your classmates.

What is psychological dependence?

What is psychological dependence? Individuals who have a substance use disorder may also develop a psychological dependence. When you reviewed the activity exploring your habits, perhaps you determined a habit you engage in makes you feel happy. A psychological dependence is the "mind need" for a substance, "a drug becomes so important to a person's thoughts or activities that the person believes that he or she cannot manage without the substance" (Csiernik, 2015, p. 20). There is also the belief that persons with substance use disorders suffer in the extreme with their feelings, either being overwhelmed with painful affects or seeming not to feel their emotions at all. Substances of abuse help such individuals to relieve painful affects or to experience or control emotions when they are absent or confusing. (Khantzian, 1997, p. 231)

In this case, a person simply wants to numb their emotional pain and knows that by using and continuing to use a substance their pain can be numbed. Psychological dependence is just as intense as physical dependence, if not more so. If you believe you need a particular substance to manage your daily life, the withdrawal from that substance can be difficult.

Activities

1. What have you heard about withdrawal?
2. What types of substances do you think create physical withdrawal?

3. What types of substances create psychological withdrawal?
4. Do you think physical or psychological is more intense? Why?

Both physical and psychological withdrawal may be reasons why a person continues to use substances, and /or experiences a substance use disorder. According to the American Psychiatric Association (2013), to diagnose a substance use disorder a person must have dependence and have experienced withdrawal. This would include substances like alcohol, heroin, cocaine, and even cannabis, which was a recent addition to the DSM-V. Withdrawal, both physical and psychological can be quite painful, particularly for people who are using opiates. Let's watch the John Lenec discuss his experiences with opioid use and withdrawal. Note the language used by the Canadian Press. How might you change this language to reduce stigma?

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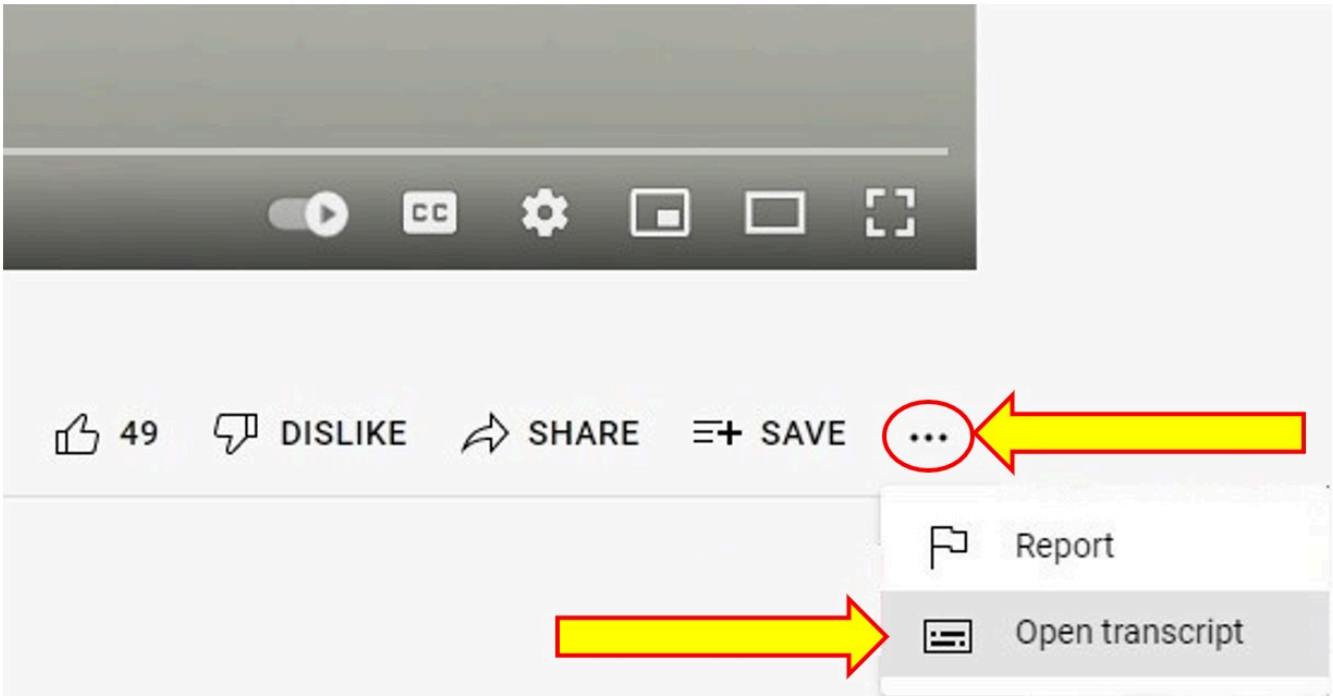

What did you notice? What were the physical symptoms of withdrawal John discussed? What were the psychological symptoms of withdrawal John mentioned? The symptoms of withdrawal may prevent some people from reducing or stopping their substance use. The table below indicates a number of substances. Please review the types of dependence for the most commonly used substances.

Table 1.8.1 Psychoactive Drugs by Class: Stimulants

Stimulants block the re-uptake of dopamine, norepinephrine, and serotonin in the synapses of the CNS.

Symptoms: Enhanced mood and increased energy.

Drug	Dangers and side effects	Psychological dependence	Physical dependence	Addiction potential
Caffeine	May create dependence	Low	Low	Low
Nicotine	Has major negative health effects if smoked or chewed	High	High	High
Cocaine	Decreased appetite, headache	Low	Low	Moderate
Amphetamines	Possible dependence, accompanied by severe "crash" with depression as drug effects wear off, particularly if smoked or injected	Moderate	Low	Moderate to high

Table 1.8.1 – Adapted from: Schwab, J.E. (2018). Drugs, Health & Behavior. OER Pressbook. Penn State. https://psu.pb.unizin.org/bbh143/ (Updated with Canadian Content)

Table 1.8.2 Psychoactive Drugs by Class: Depressants

Depressants change consciousness by increasing the production of the neurotransmitter GABA and decreasing the production of the neurotransmitter acetylcholine, usually at the level of the thalamus and the reticular formation.

Symptoms: Calming effects, sleep, pain relief, slowed heart rate and respiration

Drug	Dangers and side effects	Psychological dependence	Physical dependence	Addiction potential
Alcohol	Impaired judgment, loss of coordination, dizziness, nausea, and eventually a loss of consciousness	Moderate	Moderate	Moderate
Barbiturates and benzodiazepines	Sluggishness, slowed speech, drowsiness, in severe cases, coma or death	Moderate	Moderate	Moderate
Toxic inhalants	Brain damage and death	High	High	High

Table 1.8.2 – Adapted from: Schwab, J.E. (2018). Drugs, Health & Behavior. OER Pressbook. Penn State. https://psu.pb.unizin.org/bbh143/ (Updated with Canadian Content)

Table 1.8.3 Psychoactive Drugs by Class: Opioids

The chemical makeup of opioids is similar to the endorphins, the neurotransmitters that serve as the body's "natural pain reducers."

Symptoms: Slowing of many body functions, constipation, respiratory and cardiac depression, and the rapid development of tolerance.

Drug	Dangers and side effects	Psychological dependence	Physical dependence	Addiction potential
Opium	Side effects include nausea, vomiting, tolerance, and addiction.	Moderate	Moderate	Moderate
Morphine	Restlessness, irritability, headache and body aches, tremors, nausea, vomiting, and severe abdominal pain	High	Moderate	Moderate
Heroin	All side effects of morphine but about twice as addictive as morphine	High	Moderate	High

Table 1.8.3 – Adapted from: Schwab, J.E. (2018). Drugs, Health & Behavior. OER Pressbook. Penn State. https://psu.pb.unizin.org/bbh143/ (Updated with Canadian Content)

Table 1.8.4 Psychoactive Drugs by Class: Hallucinogens

The chemical compositions of the hallucinogens are similar to the neurotransmitters serotonin and epinephrine, and they act primarily by mimicking them. Symptoms: Altered consciousness; hallucinations

Drug	Dangers and side effects	Psychological dependence	Physical dependence	Addiction potential
Marijuana	Mild intoxication; enhanced perception	Low	Low	Low
LSD, mescaline, PCP, and peyote	Hallucinations; enhanced perception	Low	Low	Low

Table 1.8.4 – Adapted from: Schwab, J.E. (2018). Drugs, Health & Behavior. OER Pressbook. Penn State. https://psu.pb.unizin.org/bbh143/ (Updated with Canadian Content)

It is important to note cannabis is not indicated above; however, in the DSM-V it is included as a substance with psychological dependence as people can experience withdrawal. Were you surprised by any of the states of dependence on any of the substances? The dependence on a substance is one factor that can keep people in a cycle of use. Uncomfortable withdrawal may make it difficult to go to school, work, or take care of a family. In some cases, it is extreme, as mentioned in the video.

Are you a regular coffee drinker? Have you ever tried to give up coffee? Did you experience any symptoms? Do you smoke tobacco? Have you tried quitting? What was that like? When we think about substance use and withdrawal, we may immediately go to substances we see in the media, like heroin and cocaine. It is important to note, based on the chart above, every substance is different, and psychological and physical dependence will be experienced differently depending on the substance and the person who uses it.

Activities

Based on what you learned about physical and psychological dependence, as well as all the reasons people use substances, brainstorm:

1. Reasons why individuals start using substances
2. Reasons why individuals continue/maintain use

3. Reasons why individuals escalate/increase frequency or amount of substance use
4. Reasons why individuals stop using substances
5. Reasons why individuals start using substances again

All substances have *some* risk, as they impact our body and brain in different ways.

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1.9 KEY TERMS STUDY GUIDE

Figure 1.9.1 Word Art of Hello by Denise Halsey

The material in this chapter are the core of being an effective with key terms around **Language and Substance Abuse**. Once you understand the important knowledge base, skills and guidelines for case management you will have a solid foundation for understanding how to be more effective as a case manager. You may be familiar with these terms, but If you are not familiar with the terms below, I recommend you download this study sheet, add more spaces to write in definitions and relevant information (or make flashcards) as you read the chapter and watch videos.

1. Addiction
2. BIPOC
3. Case manager
4. Compassion
5. Cultural Competence
6. Decolonization
7. Determinants of Health
8. Discrimination
9. DSM

10. Gender
11. Indigenous
12. Intersectionality
13. LGBTQ
14. Pronouns
15. Race
16. Stigma
17. Substance Abuse

1.10 SELF CARE

Figure 1.10.1 – Self Care – Photo by Kaylee Garrett on Unsplash

Each chapter has a self care section because taking care of oneself is an important part of being an effective Social worker. In this self-care section we will be exploring strategies for coping while working in the field of substance use and living in the world of the Covid pandemic.

Read

Please take a moment to review the Health-Care Providers Infographic by the Canadian Centre on Substance Use & Addiction.

- Try one of the strategies suggested.
- Report back on your experience.
- Create your own strategies, try new things

Figure 1.10.2 – Photo by Connor McSheffrey on Unsplash

LICENSE

References

- *Managing Stress, Anxiety And Substance Use During Covid-19: A Resource For Healthcare Providers [infographic] | Canadian Centre on Substance Use and Addiction.* (n.d.). https://www.ccsa.ca/managing-stress-anxiety-and-substance-use-during-covid-19-resource-healthcare-providers-infographic

ADDITIONAL RESOURCES

Films Related to Cultural Competence

- Attenborough, R. [Producer/Director]. [DVD]. 1990. Gandhi. Burbank, CA: Columbia Tristar Home Video.
- Avildsen, J. G. [Director]. [DVD]. 1992. The Power of One. Burbank, CA: Time Warner Home Video. (127 minutes)
- Caro, N. [Director]. 2015. [DVD]. McFarland USA. Burbank, CA: Buena Vista Home Entertainment, Inc.
- Eastwood, C. [Director/Producer]. 2008. [DVD]. Gran Torino. Burbank, CA: Time Warner Home Video. (116 minutes)
- Frye, E. M. [Writer/Director]. 1993. [DVD]. Amos and Andrew. Burbank, CA: Castle Rock Entertainment. (96 minutes)
- Haines, R. [Director]. 2006. [DVD]. The Ron Clark Story. Atlanta, GA: Turner Broadcasting System, Inc. (90 minutes)
- Hancock, J. L. [Writer/Director]. [DVD]. 2008. The Blind Side. Burbank, CA: Time Warner Home Video. (128 minutes)
- Lee, S. [Director]. [DVD]. 1998. 4 Little Girls. Burbank, CA: Time Warner Home Video. (102 minutes)
- McCarthy, T. [Director]. [DVD]. 2008. The Visitor. Burbank, CA: Anchor Bay Entertainment, LLC. (104 minutes)
- Schumacher, J. [Director]. [DVD]. 1996. A Time to Kill. Burbank, CA: Warner Brothers Entertainment. (150 minutes)
- Washington, D. [Director]. [DVD]. 2007. The Great Debaters. Santa Monica, CA: The Weinstein Co., LLC.
- Yakin, B. [Director]. [DVD]. 1989. Remember the Titans. Burbank, CA: Buena Vista Home Entertainment, Inc. (114 minutes)

CHAPTER 2: SOLUTION FOCUSED & MOTIVATIONAL INTERVIEWING COUNSELLING

CHAPTER 2 - INTRODUCTION

Solution-Focused Therapy (SFT), which is also known as Solution-Focused Brief Therapy (SFBT) was developed by Steve de Shazer (1940-2005), and Insoo Kim Berg (1934-2007) in collaboration with their colleagues at the Milwaukee Brief Family Therapy Center beginning in the late 1970s. As the name suggests, SFBT is a short-term goal-focused evidence-based therapeutic approach, which incorporates positive psychology principles and practices, and which helps clients change by constructing solutions rather than focusing on problems.

Figure 2.0.1. – Photo by Dylan Ferreira on Unsplash

Solution-Focused Therapy (SFT), which is also known as Solution-Focused Brief Therapy (SFBT) was

developed by Steve de Shazer (1940-2005), and Insoo Kim Berg (1934-2007) in collaboration with their colleagues at the Milwaukee Brief Family Therapy Center beginning in the late 1970s. As the name suggests, SFBT is a short-term goal-focused evidence-based therapeutic approach, which incorporates positive psychology principles and practices, and which helps clients change by constructing solutions rather than focusing on problems.

Figure 2.0.2 – Photo by Linkedin Sales Solutions on Unsplash

We will explore evidence based counselling strategies, based in motivational, cognitive and dialectical behavioural techniques and skills, and apply them in practice to promote the well being of individuals. This will include Solution-Focused Therapy (SFT), MI (Motivational Interviewing Skills), Trauma-informed awareness and all the many areas that are used. We will look at how and where this happens which applies to many communities as well as cultural competence.

Counselling can take place in many ways, in an office, online, outdoors, group settings, prison, hospitals, doctors offices, or at home to name a few. COVID has changed many services and options, as well it is delivered and by who. This can also be done in person, online, email, zoom support groups, telephone counselling

and many other ways as well. Counselling can also include: Motivational Interviewing, Stages of Change, Biopsychosocial Plus, Support groups, Peer groups and diverse communities.

References

- Pictures – Unsplash License
- Lutz, A. (2022, April 21). *What is Solution-Focused Therapy · Solution-Focused Therapy Institute*. The Institute for Solution-Focused Therapy. https://solutionfocused.net/what-is-solution-focused-therapy/

LEARNING OBJECTIVES

Learning Objectives

By the end of this chapter you should be able to:

1. Explain evidence based counseling strategies, based in motivational, cognitive and dialectical behavioural techniques and skills, and apply them in practice to promote the well being of individuals.
2. Use the five foundational skills in MI (open questions, affirmations, reflective statements, summaries, provide advice and information) to enhance client engagement in treatment.
3. Design trauma-informed interventions that will be more effective with trauma-based behaviour and will support individuals in developing emotional distress regulation and highlight the importance of safety.
4. Discuss the underlying concepts of principles of counseling and demonstrate awareness of how these are played out in practice

2.1 SOLUTION FOCUSED COUNSELLING

Figure 2.1.1 Photo by TienDat Nguyen on Unsplash

Solution-Focused Brief Therapy (SFBT) places focus on the person, the present and future circumstances and goals rather than past experiences. There is a discussion around developing a vision of the future and offers support as they determine the skills, resources, and abilities needed to achieve that vision successfully. *SFBT* is a *short-term goal-focused evidence-based therapeutic approach.*

Solution-Focused Brief Therapy (SFBT), also called Solution-Focused Therapy (SFT) was developed by Steve de Shazer (1940-2005), and Insoo Kim Berg (1934-2007) in collaboration with their colleagues at the Milwaukee Brief Family Therapy Center beginning in the late 1970s.

Steve de Shazer who, along with Insoo Kim Berg, co-founded the Solution-Focused Brief Therapy (SFBT) approach. Future directions for SFBT, such as the emergence of professional associations, the increased research interest in SFBT as evidenced-based practice, the recent focus on process-research to determine the mechanisms of change within SFBT, and the application of SFBT to education are discussed. [1]

Video: What Makes Solution-Focused Therapy Different

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=1296#oembed-1

How Does SFBF Work?

The focus for SFBT involves first developing a vision of one's future and then determining how internal abilities can be enhanced in order to attain the desired outcome. The therapist is a partner in this with the client as the expert. By working with them to explore the vision and work with self-directed strategies and encourage them to acknowledge and celebrate success.

Asking specific types of questions assisting the client through the session. By asking **coping questions**, this can assist in exploring the many ways they are capable of coping with challenges in their lives. For example "when this situation happens, how do you manage it, and continue with your daily obligations"? The conversation is assist people in recognizing their resilience and their skills in coping with adversity.

Miracle questions are used to help people envision a future in which the problem is absent. This allows people to explain how their lives would look different if the problem did not exist, which can help them identify small, practical steps they can take immediately toward change. "What would it look like if this problem was solved?". By allowing the person to explore that conversation, quite often they begin to see that behavioural changes are possible and allow them to see possibilities of what can be done to create this change.

Scaling questions use a scale from 0–10 to assess present circumstances, progress, or how one is viewed by others. If there is not time to explore the miracle question, scaling questions can assist both the counsellor and the client to gain insight into the possibilities, motivation, and confidence to consider new possibilities. "On a scale of 1 to 10 how important is this to you?". People who have difficulty verbalizing their experiences, or imagining new options may find this approach less challenging.

Who can Use SFBT

SFBT can be used by individuals, families and couples. It was created to help those in counselling to find solutions to challenges in many different areas such as families, schools, and workplaces. SFBT works well with individuals from different cultures, backgrounds, and age groups have all been shown to benefit from this type of therapy.

SFBT highlights a client's ability to solve problems, rather than why or how the problem was created. It works with day to day challenges and works with mental health issues as well.

Video: Solution-Focused counselling with Insoo Kim Berg

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=1296#oembed-2

Transcript

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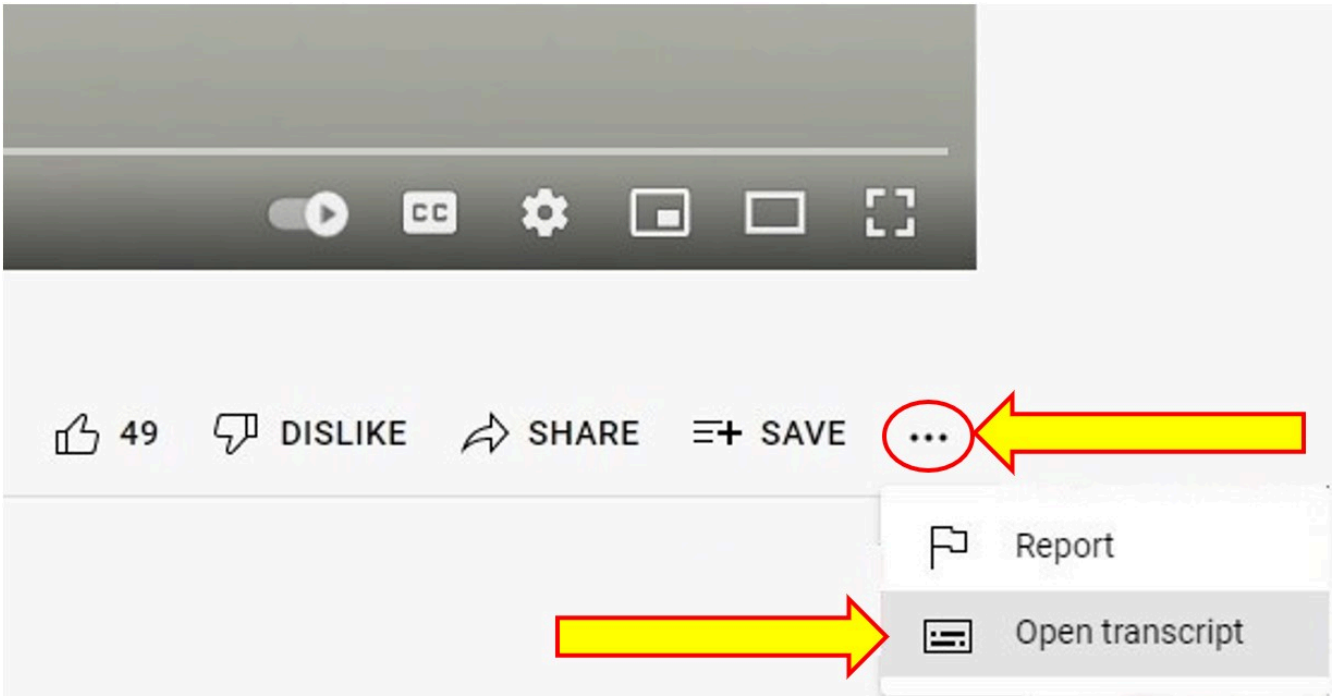

SFBT has continued to grow in popularity, both for its usefulness and its brevity, and is currently one of the leading schools of psychotherapy in the world.

"The Miracle Question, or the "problem is gone" question, is a method of questioning that a therapist can utilize to invite the client to envision and describe in detail how the future will be different when the problem is no longer present.

> Imagine that tonight as you sleep, a miracle occurs in your life. A magical momentous happening has completely solved this problem and perhaps rippled out to cover and infinitely improve other areas of your life too. Think for a moment and tell me, how is life going to be different now? Describe it in detail. What's the first thing you'll notice as you wake up in the morning?"(de Shazer)"

This is not used often, but there are times when it is a great question to use. It allows someone to look at what it would look like and allow thinking of what actions need to be taken.

For more Information around Solution Focused Counselling:

- Steve de Shazer and the future of solution-focused therapy
- Solution-Focused Brief Therapy (SFBT) – Good Therapy

- Institute for Solution Focused Therapy
- Positive Psychology – 7 Solution-Focused Therapy Techniques and Worksheets (+PDF)

References

- Video: Lutz, A. (2022b, April 21). *What is Solution-Focused Therapy · Solution-Focused Therapy Institute*. The Institute for Solution-Focused Therapy. https://solutionfocused.net/what-is-solution-focused-therapy/
- Video: PsychotherapyNet. (2009, April 2). *Solution-Focused Couples Therapy Insoo Kim Berg Video* [Video]. YouTube. https://www.youtube.com/watch?v=fQBZlgmebwY
- GoodTherapy Editor Team. (2018b, August 3). *Solution-Focused Brief Therapy (SFBT)* . https://www.goodtherapy.org/learn-about-therapy/types/solution-focused-therapy
- Lutz, A. (2022c, April 21). *What is Solution-Focused Therapy · Solution-Focused Therapy Institute* [Video]. The Institute for Solution-Focused Therapy. https://solutionfocused.net/what-is-solution-focused-therapy/
- Miller, B. K. A. (2022, August 21). *7 Solution-Focused Therapy Techniques and Worksheets (+PDF)*. PositivePsychology.com. https://positivepsychology.com/solution-focused-therapy-techniques-worksheets/
- *Solution-Focused Couples Therapy Insoo Kim Berg Video*. (2009, April 2). [Video]. YouTube. https://www.youtube.com/watch?v=fQBZlgmebwY
- Trepper, T. S., Dolan, Y., McCollum, E. E., & Nelson, T. (2006). Steve de Shazer and the future of solution-focused therapy. *Journal of marital and family therapy*, *32*(2), 133–139. https://doi.org/10.1111/j.1752-0606.2006.tb01595.x
- De Shazer, S., Berg, I. K., Lipchik, E. V. E., Nunnally, E., Molnar, A., Gingerich, W., & Weiner-Davis, M. (1986). Brief therapy: Focused solution development. *Family Process, 25*(2), 207–221

2.2 MOTIVATIONAL INTERVIEWING

“Motivational Interviewing is by definition a conversation about change, and focusing involves establishing the direction of travel.”

Miller, William R.; Rollnick, Stephen. Motivational Interviewing, Third Edition (Applications of Motivational Interviewing) . Guilford Publications. Kindle Edition.

Figure 2.2.1 – Wordart by Denise Halsey

What is Motivational Interviewing?

Motivational Interviewing (MI) is an effective way of talking with People around **change**. It can be applied in a large variety of settings. This makes it an effective counselling method that helps people resolve ambivalent feelings and insecurities to be able to find the necessary motivation to make changes in their behaviour and lives.

Depending on the environment MI is used in, the recipients might be referred to as clients, patients, offenders, residents, or consumers etc. As well as those who are providing MI might be counsellors, doctors, coaches, nurses, practitioners, clinicians or educators.

Introduction to Motivational Interviewing

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=64#oembed-1

Introduction to Motivational Interviewing – Bill Matulich. In this slide presentation I talk about the basic concepts of Motivational Interviewing (MI). After a brief definition, topics include: the Spirit of MI, The four basic OARS skills, and the "processes" of MI[1]

Transcript

To Access the Video Transcript:

1. Click on **"YouTube"** on the bottom-right of the video. This will take you directly to the YouTube video.
2. Click on the **More Actions** icon (represented by three horizontal dots)
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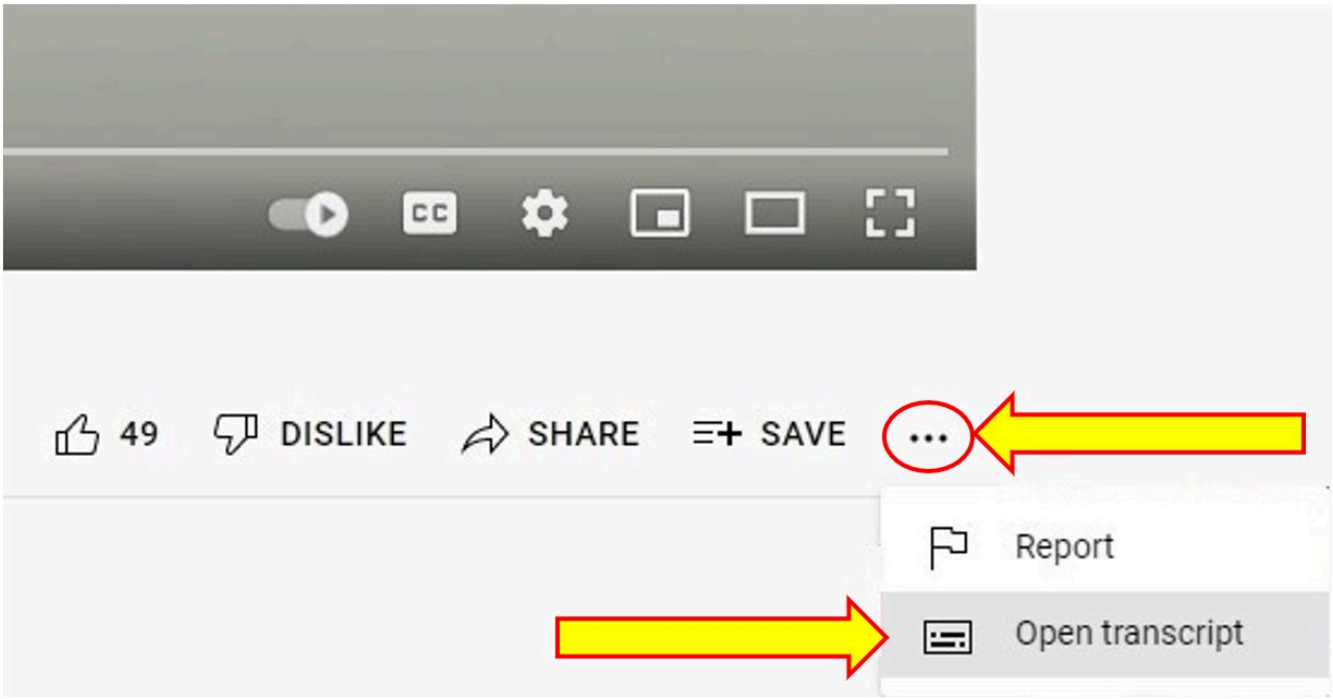


Spirit of Motivational Interviewing

The **Spirit** of Motivational Interviewing is an important component of Motivational Interviewing. There are 2 very important pieces that come into play with Motivational Interviewing.

These are:

- tools, techniques, strategies
- Spirit

The Spirit guides Motivational Interviewing without this it is like riding a bike without handle bars. It is an important piece to allow us to assist our clients. The spirit of MI is based on three key elements: **collaboration between the therapist and the client; evoking or drawing out the client's ideas about change; and emphasizing the autonomy of the client**.

The Spirit of MI is like the roots of a tree – both supporting and nourishing the practice of MI. (Bill Matullich)

Figure 2.2.2 Photo by Valeriu Costea on Unsplash

The spirit of MI is teamwork. The Clinician and the client work together to create a plan that works well for the client. The client is the pilot and the clinician is the co-pilot working together.

Let's Watch this video on: Spirit of Motivational Interviewing

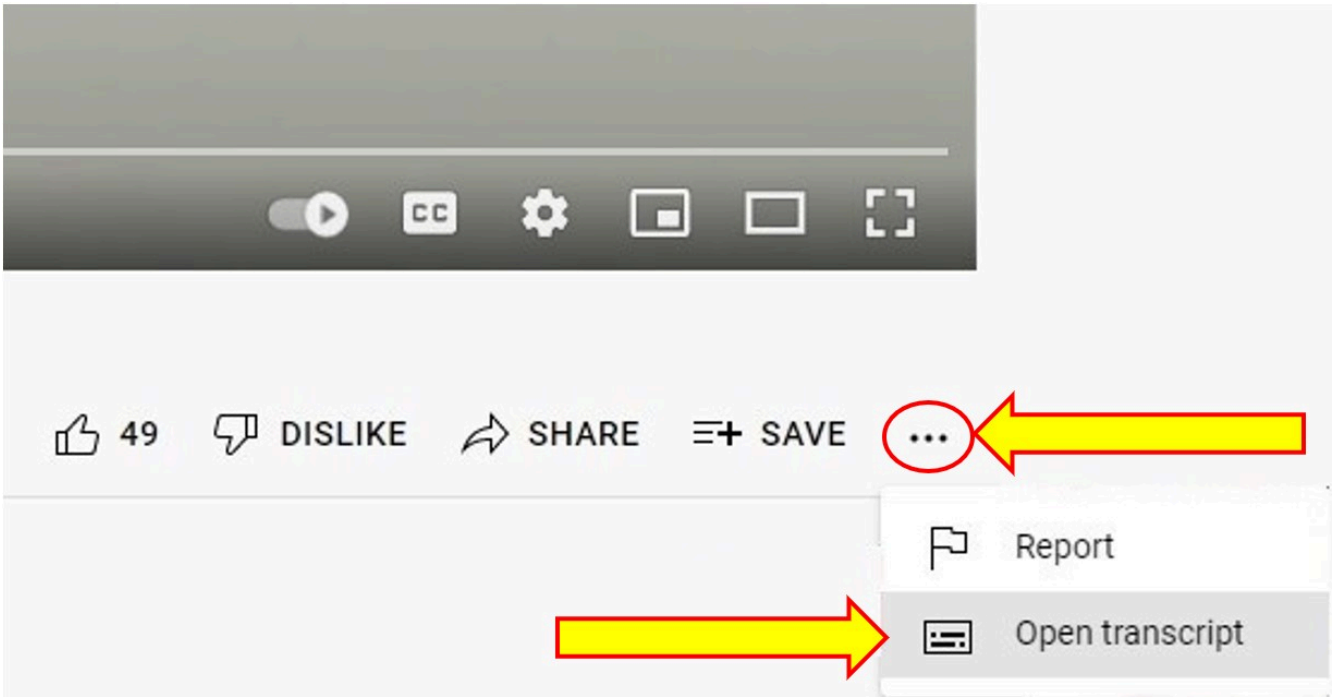
One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=64#oembed-4

Spirit of Motivational Interviewing by Bill Matulich. This video is about the Spirit of Motivational Interviewing. Spirit is the guide to the ethical practice of using the powerful strategies and techniques of Motivational Interviewing. (2)

Transcript

To Access the Video Transcript:

1. Click on **"YouTube"** on the bottom-right of the video. This will take you directly to the YouTube video.
2. Click on the **More Actions** icon (represented by three horizontal dots)
3. Click on **"Open Transcript"**



The 4 key pieces of the spirit of MI include:

1. **Partnership** – working as a team, both bring experience and knowledge to the partnership.
2. **Acceptance** – Absolute worth, Accurate Empathy, Autonomy Support & Affirmation
3. **Compassion** – is putting the clients' needs first, it is crucial to the relationship
4. **Evocation** – the clients' experience, knowledge, strengths

The Spirit of MI is applied differently by different professionals, but it is a crucial component for Motivational Interviewing to be successful.

Method of Motivational Interviewing

> **"People are generally better persuaded by the reasons which they have themselves discovered than by those which have come into the mind of others."**
>
> —BLAISE PASCAL
>
> Miller, William R.; Rollnick, Stephen. Motivational Interviewing, Third Edition (Applications of Motivational Interviewing) . Guilford Publications. Kindle Edition.

In Motivational Interviewing there are 4 processes that are incredibly important: engaging, focusing, evoking and planning. **Engaging** is how we connect with the client and create a positive working relationship. When we are effectively **focusing** we can develop and maintain a conversation about change that continues to go in a specific direction. **Evoking** is when the client's own motivations for change are honoured and involved while working with them. This is a critical piece of MI. The last process is the **planning process** which includes the developing commitment to change as well as creating and formulating a concrete plan of action.

It is important to remember that in MI the Client is the expert. We also need to make sure that when we communicate with the client that we focus on our communications skills as these are just as important as the client being the expert. Although MI is a collaborative relationship, it is important to honour the client's individuality, autonomy and that we continually show respect for them.

The Communications skills that we need to be aware of and use effectively in MI are: open-ended questions, affirming, reflecting, summarizing and offering information and advice with consent. When we use these skills it is also important to be authentic when applying them.

Which picture do you see engagement in? Explain Why?

Figure 2.2.3 – Photo by Vitolda Klein on Unsplash

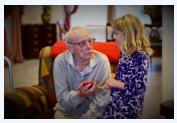


Figure 2.2.4 – Photo by: Tim Kilby on Unsplash" data-url="" http://Photo by

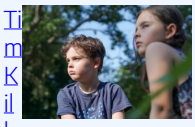


Figure 2.2.5 – Photo by Izzy Parkon Unsplash

Tim Kil by on Unsplash" > Tim Kil by on Unsplash

Engagement or Disengagement

The purpose of engagement or disengagement is very important. In MI it is a working collaboration, therefore engagement is a very key piece to the working relationship. The agency you work for and the services that are offered, when you are working with MI **engagement** is the key. (trusting relationship, collaboration on negotiated tasks & treatment goals). **Disengagement** happens when the counsellor presents as the expert, and the driving force behind the whole process.

It's important to create, establish and maintain a trusting, respectful and mutual working relationship.

Through an active collaboration, discussion and agreement on tasks & goals, it is easier to obtain the goals of the client.

How to Listen to Understand

Watch this video on 5 ways to listen better – Julian Treasure

> *One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=64#oembed-2*

5 ways to listen better | Julian Treasure. By Ted Talks. In our louder and louder world, says sound expert Julian Treasure, "We are losing our listening." In this short, fascinating talk, Treasure shares five ways to re-tune your ears for conscious listening — to other people and the world around you.[3]

Transcript

To Access the Video Transcript:

1. Click on **"YouTube"** on the bottom-right of the video. This will take you directly to the YouTube video.
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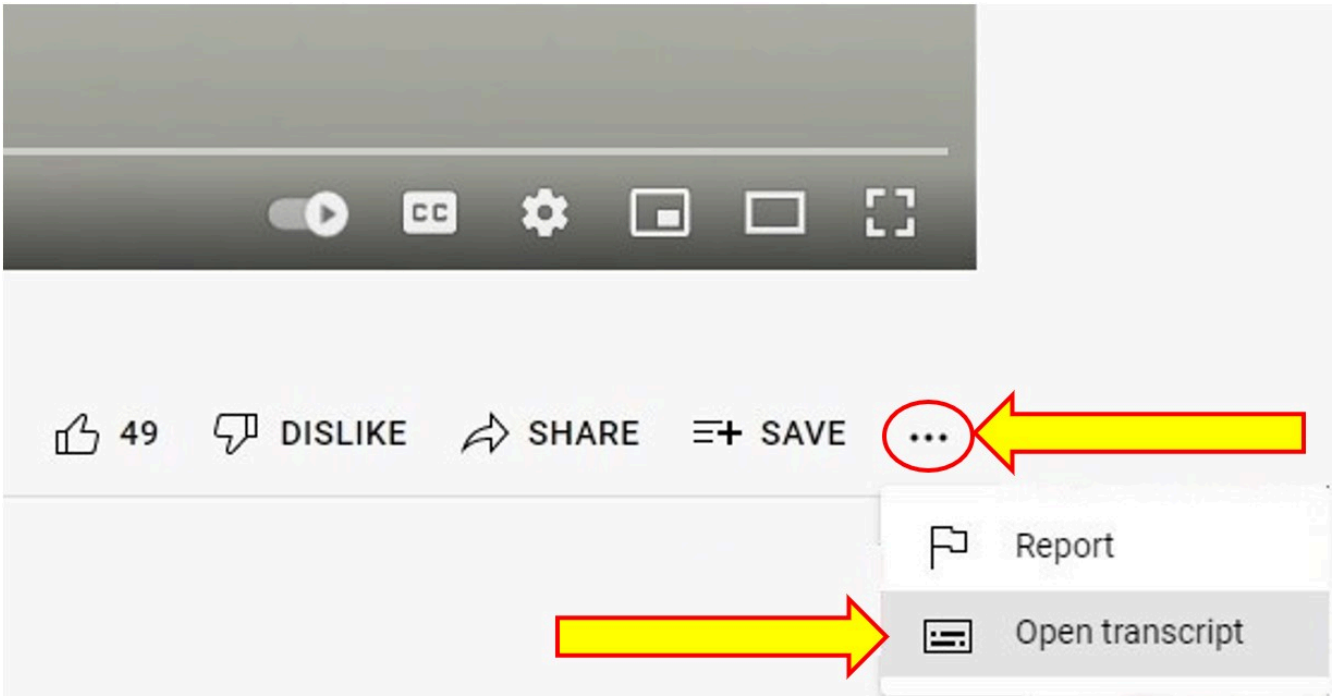

Active listening is a very important skill that is necessary to MI. It is something that we need to be mindful of to practice and be present to actually hear what the person is saying. There is a skill to reflective listening and although it is a basic skill, it is a critical skill for the 4 process of MI. It does take time and practice to become skillful in active listening. Active listening is a critical skill when being client-centred.

There are many different roadblocks that we use everyday without realizing how it shuts down communications vs active listening. Dr. Thomas Gordon created 12 Roadblocks to communications that people commonly give to each other, when they are not listening.

It's important to be aware of your Active Listening Skills and work on them to be effective in communicating. Things that can challenge our Active Listening Skills can be as simple as our body language, interrupting the other person, giving advice, not making eye contact,fidgeting, withdrawing, and talking at someone vs talking with them are just a few to consider.

Exercises – Active Listening

Create a list:

- Roadblocks that you have been on the receiving end of and how you felt about it

- Roadblocks you've seen others use
- Roadblocks you use and what can you do to change that

12 Roadblocks to Communications

- 12 Roadblocks to Communications – Gordon Training
- Did you just Roadblock me – Gordon Training
- 12 Roadblocks to Communication – Drug Free Australia

Core Interviewing Skills: OARS

Figure 2.2.6 – Photo by Jonathan Borba on Unsplash

When we think of Core Interviewing Skills it's important to focus on OARS. We need to be mindful and present before beginning to ask questions when someone has come for assistance. We may have an idea of why someone has come into our agency, but until we engage with them, we truly won't know what their journey has been and what brought them into our agency or need our services until they share this with us.

In our society it is not an easy thing to ask for assistance, and this is where using the Core Interviewing skills makes it more effective and supports those who have come into our agency.

The OARS model helps to establish interactive encounters with clients focused on their goals, needs, and

preferences. OARS is intended to be simple, comprehensive, and to improve communication and counselling skills.

Core Interviewing Skills (OARS) Activity

Create a list of all 4 areas of what you could use for each

- **O = OPEN ENDED QUESTIONS**
- **A = AFFIRMING**
- **R – REFLECTIVE LISTENING**
- **S – SUMMARIZING**

Exploring Values & Goals

Values and Goals are important to all of us. We all have values & goals. We also have motivation for change always present in our lives and it changes. To assist others we need to understand their goals, values, and what's important to them. When we are engaged in conversation with them, it allows us to understand their internal frame of reference, then it is easier to understand their goals and values and what motivates them.

We are all motivated. Maslow's hierarchy of needs is a motivational theory in psychology comprising a five-tier model of human needs, often depicted as hierarchical levels within a pyramid. (Mcleod, 2020)

Once we know these key pieces of someone it is a lot easier to understand what motivates them. They are the experts in themselves, so it's important that we have an understanding of this to be able to assist them in obtaining their goals.

Motivational Interviewing: Exploring Goals and Values

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=64#oembed-3

Motivational Interviewing: Exploring Goals and Values. By Nathan Gehlert. In this video about Motivational Interviewing, I talk about the importance of exploring client motivation as it relates to goals and values. I also discuss strategies for doing this[4]

Transcript

To Access the Video Transcript:

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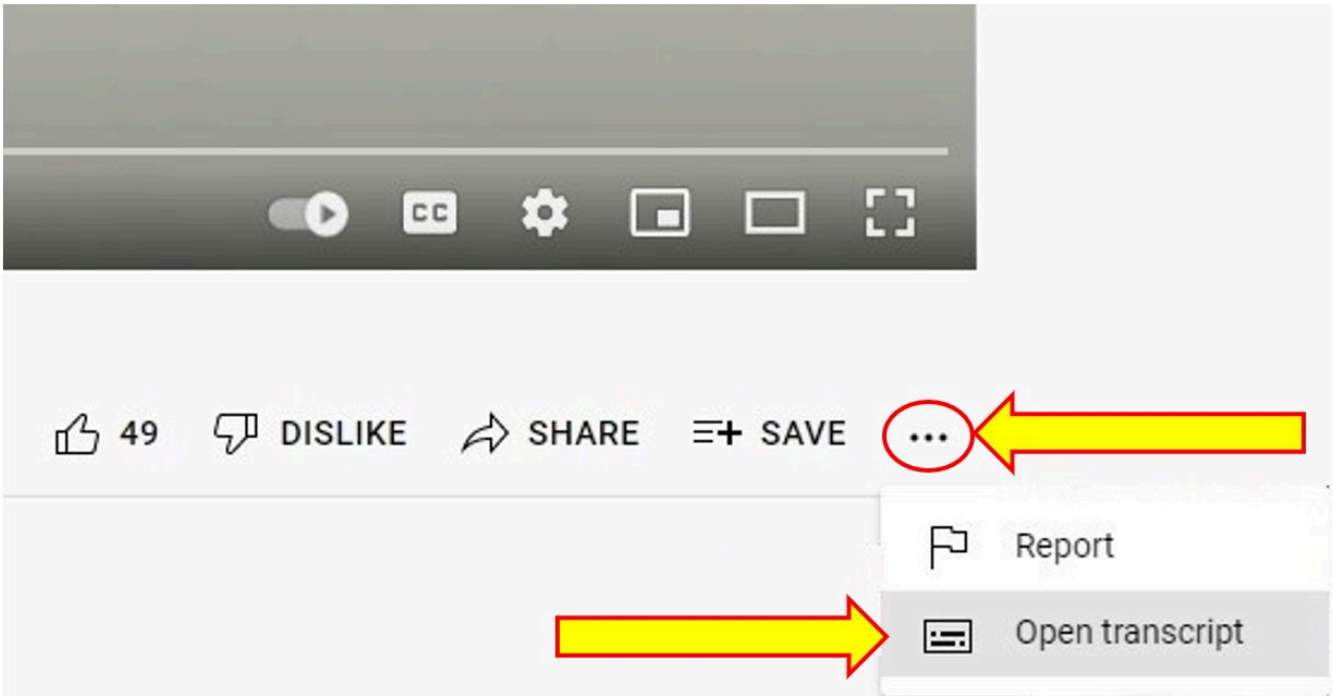

FOCUS is a Key Strategy in MI

When we **focus** we concentrate or giving special attention or effort to something. This is important as it contributes to being an effective counsellor when we are working with others.

We've already done the basic groundwork for engagement in place, so to move ahead in MI, it is important to know what the focus is for those we are working with. Focusing is a necessary prerequisite for the next two processes in MI, which are evoking and planning for change.

We continue to work on our core skills and adding to them to become more effective when working with MI. We assist a client with a goal-directed activity in which you explore whether, why, how, and when they might change. Without a focus MI can't get off the ground. Each focus is different with each client and it's

not always immediately clear, but if it becomes blurred there are constructive ways of realigning and finding direction for your conversation.

Figure 2.2.7 Photo by Nadine Shaabana on Unsplash

It is through the engagement that we discovery where this journey will be going and why. Not all clients are totally clear of what the goal is and through focusing the process of becomes clearer about goals and direction in MI, which then provides us the foundation for subsequent evoking and planning to get the goals in place.

Focus is about strategies for the journey as well as knowing what the key pieces are that are necessary for basic groundwork and engagement.

Activity

When you decide to go on a trip somewhere, we don't usually just get on a train, plan or automobile without finding information. What strategies for this journey do I need?

1. Make a list of questions / challenges you might have with this trip?
2. Where can you find information or assistance to answer these questions / challenges? (This could be what documentation do I need? Travel Insurance)
3. After completing 1 & 2, reflect on this exercise and the challenges & solutions you experienced.

To be effective we need to have an understanding of what exactly it means to have strategic focus and how to work within that framework. Engagement is an important part of this process for the client, they are the expert in themselves, so when they are engaged this empowers the whole process for the client. It also assists in coming up with more impactful outcomes.

There are 3 focuses: **the client** (source of direction), **the setting** (the direction of the specific agency – what specific options they offer due to funding, etc.) and **the Clinician Expertise** (the client comes in with a goal in mind, but through the conversation other challenges are also present that might require looking at as well – so how this is discussed is where the clinician expertise comes into play).

Three styles of focusing:. directing (the provider/agency decides the focus), **following** (client's priorities, whatever they may be – it can take time and clients tend to be more engaged) and **guiding** (promotes a collaborative relationship).

It is a work in progress that can have different expectations and goals, as you begin the journey. The journey changes are revisited, discussion and changes may be implemented as the direction can change, new goals or ideas come up or a different path is decided to go. The client is the pilot and we are the co-pilot assisting in this process. At times we need to ask open ended questions and possibly redirect, always being aware that it is their journey.

New information or challenges can arise such as: legal issues, child services, anger issues, mental health,

addictions, fear of judgement, housing, relationship issues, penalties or judgements aimed at them. This can once again can impact and change direction, goals, plans or even destinations.

> When Focusing on Motivational Interviewing it is more about the conversation then the transaction

Finding The Horizon

Figure 2.2.8 Photo by Diego Jimenez on Unsplash

When we discuss finding the horizon this builds on the previous topic of focusing which involves establishing the direction of travel. Focusing on the horizon assists us in establishing the direction we are going.

Through this process we will figure out:

1. What the goal is, we will know what to focus on

2. If there are severals options, we need to look at this and explore them
3. If it is unclear, we need to clarify what the focus is

Once we have looked at these options, we can step back and consider the many different aspects of the spirit of MI that we've been through and refocus.

When we are working at this stage there can be many different challenges. These can include: uncertainty, no clear direction to go, impatient, sharing control, revisiting strengths and options. Through this process we will come to: clear direction, several choices to be explored (agenda mapping – visual aids), structuring (looking at specific options), considering options, zooming in on a specific path, going in circles, taking a step back or depending on your agency, there could be necessary protocols to follow.

There is no direct path for this and its as individual as our clients are. There are times when we need to step back and regroup at a later time.

What to do When Goals Differ

This is a challenge that often happens when therapies have traditional roles when the counsellor role is the expert and MI where we look at the client as the expert in their life. So although the goals may appear different it is important to assist the client with their goals and move them towards those.

There are many different journeys to take with each agency as well as with individual clients. There are times when the agency we are working for has specific components we can work on, and some that we cannot work on. These are pieces that we will be aware of and if necessary make referrals as needed.

There are times when someone would like a specific outcomes, such as going into residential or treatment centre, but they have physical injuries or a life threatening illness that needs to be addressed first.

Ethical values: nonmaleficence (do no harm) , beneficence (do good to others), autonomy (independence) and Justice and will impact the work that is done in MI.

How to exchange Information Effectively

When we discuss how to exchange information effectively it seems simple enough, but it is an actual fact that it is not. As experts with knowledge in our specialty areas, we want to not only assist the clients we work with, but want to share all the knowledge we have to assist. We will clarify and illustrate good practice in those situations where information from you might help the client to make changes and when that is so.

Figure 2.2.9 – Photo by Priscilla Du Preez on Unsplash

Information exchange can be vital to the client and conversation with the professional. It is central in the planning process as well as motivating to move ahead in the process.

There are many different areas to be covered around exchanging information effectively. Depending on the agency, the province, territory, country, medical, legal, cultural, and electronically (computer/phone/writing) to name a few.

It is important to be able to effectively communicate with clients and other agencies. Some common traps can be that the counsellor is the expert in the process and how it plays out, or they have expectations or are not supportive. There are many different strategies for information exchange and it is important to be aware of what they are in your agency. There are different forms for information to be released from your agency as well as other agencies.

It is important to use autonomy-supportive language. Understanding what the client wishes to be addresses as or finds comfortable vs not comfortable with. Part of this is also to make sure that the information you are sharing is clear and easy to understand. Checking with the client is important, but not talking down to them, but with respect.

Principles of Good Practice:

- that the counsellor recognizes they are the expert but the client is the expert in themselves
- counsellor explores what the clients wants and needs
- gather information to match what the client feels they want and need
- client explains the value of different information / options through their eyes

- supports clients autonomy and gives options

In all areas it is important that the counsellor asks permission to give a suggestion, is always respectful, offers suggestions and understands when its not taken or turned down. It's important to focus on what the clients wants or needs (prioritize), explain all options (as needed), speaks respectfully, use supportive tones and language, and allow the client to feel how they feel and speak honestly.

It is important to remember that it is a relationship and engagement earlier on, makes this all simpler and more beneficial.

Preparing for Change in Motivational Interviewing

Why AMBIVALENCE is an important Stage of Change

Ambivalence (Contemplation): is where people recognize there is a habit or a behaviour that is not a healthy behaviour, but they are not yet prepared to make a change. The thought of making a change may cause a person to begin to feel anxiety. This could be fear of the loss of the behaviour, it could be fear of withdrawal or change. At this stage you may see individuals develop barriers to change, for example using terms like "I know, but...". The person may also see the benefits of change but are ambivalent about making that change. They can argue why they should change, and why they shouldn't change.

Sometimes we call it sitting on the fence. You can't decide which side you want to be on.

Figure 2.2.10 – Sitting on a Fence – Photo by Tyler Nix on Unsplash

Evoke the Person's Own Motivation

In MI the process of change is not an unusual one. There is a normal process that we all experience toward change. There is a period of ambivalence before there is a shift to making a decision in the favour of one or the other options. Usually in this process we use a pros & cons view to assist us in the decision making, then allow

the client to decide which decision is the one they are going to choose. MI is a great tool to assist our clients through this process.

The process of change has to go through ambivalence quite often for the change to happen. Some decisions are easier than others, and so take much longer for the decision to happen. It is as different as each individual and every situation. It might seem simple to someone on the outside looking in, but when it is personal there are many different shades & options to the choice.

When we can assist the client in accessing their own motivations, it is a much more effective process and with stronger results.

Respond to Change Talk

When we begin hearing more Change Talk from the client, we become aware that they are beginning the process of change. We recognize change talk, and it's important to recognize when this is happening. There are ways that we can respond to evoke change talk, so how we respond is important. Using the OARS is a great way to support a client's decision. Asking for clarification on what their decisions is can assist greatly – but non directional, just supportive.

Figure 2.2.11 – Photo by Jessica Wilson on Unsplash

Respond To Sustain Talk & Discord

When we hear Sustain Talk & discord its important to pay attention to what it means to the client. MI is a great help at these times and staying in the spirit of MI means that is it supportive and not directing or telling them what to do.

When we understand that the process for change is not simple and there will be challenges and difficulties that will arise around making changes. There will be times when the client will question things that they had been comfortable with previously, such as credibility of us as processionals, credibility of the reality of this change being ok to give two examples.

MI recognizes resistance as part of the process, not as a negative. It means there is locus (a given condition or situation) within the client that is happening. There are times when client's preference returns to keeping things as they are. This is where the sustain talk in MI comes into play to assist the client to truly see the options and to make a choice.

Evoke Hope & Confidence when a client lacks confidence for Change

When MI was originally conceived it was as a method for evoking motivation to change in situations where it was important to make changes, but that it was more apparent to the counsellor than it was to the client. We'll look further down the continuum to evoke home and confidence, counselling neutrality – client centred and goal-status discrepancy. It does take time to practice all the MI skills and strategies. It is important to understand the importance of all the MI skills and the impact it will have on our clients.

Assisting our clients in figuring out what avenue they want to take. Discussing what the problem is? Some of the tools we'll use will include recognizing where the client is at. We can hear their **strengthening confidence** and ask open ended questions and then use reflective listening to hear what they are saying. We can then use **Confidence Talk** and ask how their confidence is changing. They're more comfortable with the idea. We can ask open-ended questions that they can easily answer which gives them more confidence in the idea.

We can continue by using the **Confidence Ruler,** asking on a scale of 0 to 10, how confident are you that you could do this if that was your choice? There are times when the client will ask you your opinion, and there are times when we can use **Identifying and Affirming Strengths** toward their strengths. The words we use should be positive and endorsing positive changes they've made. Then we can **review past successes** that they have had to remind them of their general strength, resources and the possibilities that are there for them.

Brainstorming can also be a great tool to use at this stage, where you can discuss the many options and

possibilities that can happen moving forward from this stage. The point is to create a list and stimulate their creativity, divergent ideas, innovative thinking about the changes that are possible and can be achieved. It's ok to be part of this process and occasional suggest an idea but mostly it is important that its the client's creativity creating the list of possibilities

Figure 2.2.12 – Photo by Kvalifik on Unsplash

Counselling with Neutrality, being able to focus solely on being client-centred

There are many who believe it is impossible to Neutral as a Counsellor. It can be challenging at times, but we cannot make decisions for those we work with. We need to focus on being client-centred, by equipping our clients with information, encouraging them to make an educated decision.

Neutrality means not supporting either side in decisions, conflict or disagreement. Although that doesn't mean it is simple, there are times when we feel it is important to give direction, but it is important to allow clients to make their informed decision.

Equipoise means the clinician's decision to counsel with neutrality in a way that consciously avoids guiding a client toward one decision or another, or to any change instead explores the available options equally, encouraging clients to make their own decision.

Figure 2.2.13 – Photo by Kristina Flour on Unsplash

Goal-status discrepancy and why it is one of the most fundamental drivers of motivation for Change

Discrepancy has been part of MI since the very beginning. Cognitive dissonance was originally how it was framed but showing a discrepancy between present and desired states, or the discrepancy between a personal goal and the status quo. It's important to show discrepancy in the goal-status, as this is a huge motivation for change.

Discrepancy can be either positive or negative, either way it is an opportunity for change for the better.

Quite often our clients already see the discrepancy and come to us for a conversation around it. This can also create many different feelings around this, from overwhelming choices, the goal is not achievable, or remind them of a previous uncomfortable situation they had experienced previously.

The focus is on why the goal was chosen. In MI we will never induce behaviour change unless the person perceives that such change is what they want and has it serves a value to them and it is their choice.

It's important not to tell, direct or encourage clients down a path when they are resistant. It is important to revisit and ask why did you consider this an option? When they tell us it assists them in remembering why it was an idea they chose.

It's always important to honour their decisions and autonomy.

Prepare / Create / Develop a Change Plan

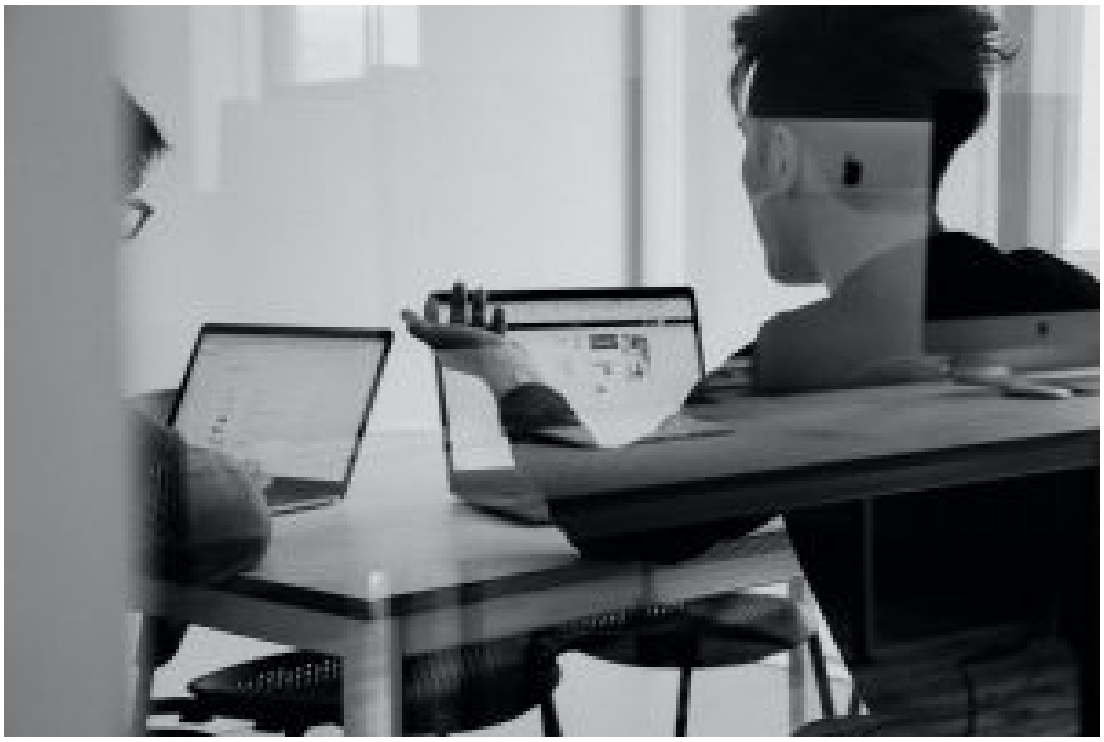

Figure 2.2.14 – Photo by charlesdeluvio on Unsplash

Change Plan for Motivational Interviewing – Motivational Interviewing Network

How do we know when it is important to move from evoking into creating a Change Plan. With each client is is individually decided. Majority of the time you will know, and your client will tell you.

There are different signs that emerge, that we can watch for, but the signal for readiness to plan is different with each client. Part of this is how willing the client is wanting to discuss the change and commit to begin the creation of a Change Plan.

There can be a challenge around evoking sufficient motivation for change. It moves differently for all clients, some move slowly and some move quickly into that decision, but the process can still be slow with the step-by-step process that is necessary. When the progress feels steady, and effortful, there are likely to still be a few backslides. It is not a simple process, or one size fits all.

Planning continues to be a collaboration, which includes input mostly from the client's own experiences, knowledge and choices. It is necessary to use all the tools of MI while creating the plan including keeping our eyes on focussed on the horizon.

A change plan is different than a treatment plan, it has a broader application for the client's life long term. We cannot be a change advocate but to work with the client on their plan.

The final phase will be when you summarize the plan and discuss it with the client. It's important that all information be clear and precise so that the client understands and commits to their plan. There are also times when the plan will hit a speed bump or a roadblock and it might have to be fine-tuned, but that is ok. Revisiting why the client wanted change and continue the change talk and get it to the destination the client was wanting and can live with it is the long-term goal.

Principles of Motivational Interviewing

- Express Empathy: Build rapport by expressing genuine empathy for the patient's experience.
- Develop Discrepancy: Elicit the pros and cons of behaviors. Identify the difference between their goals and current behaviors.
- Avoid Argumentation: Direct confrontation will put the patient on the defense and make change talk difficult.
- Roll with Resistance: Respect the patient's autonomy and help them uncover their own motivations for behavior change.
- Support Self Efficacy: Communicate to the patient that he/she/they are capable of change.

More Information around Motivational Interviewing

- What Do I Do After Asking? | Motivational Interviewing – Stanford Medicine
- Lifting the Burden in Motivational Interviewing
- Motivational Interviewing (FRAMES MODEL)

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2.3 THE STAGES OF CHANGE

Figure 2.3.1 Photo by Ross Findon on Unsplash

It's important to have a deeper understanding of why people use substances, we can explore the various stages in which they may use substances or choose to change their substance use. In 1984, Prochaska and Diclemente developed a model to explore change among people who smoked tobacco and who wanted to quit. They determined change happens in different stages and at each stage has different internal motivators and different tasks. Prochaska and DiClemente's Transtheoretical Model of Change or the Stages of Change is used when working with people who live with a substance use disorder.

Circle diagram of the states of change: precontemplation (not ready for change), contemplation (getting ready), decision (ready), action, maintenance, relapse. There are two arrows on either side of the circle indicating a cycle.

Figure 2.3.2 – Diagram of the states of change. "Stages of Change Model Diagram" by Sarah Lunn, Louise Restrick, and Myra Stern. CC-BY-NC.

This model can also be used for other health interventions including diabetes management, high blood pressure, and high cholesterol. "Change interventions are especially useful in addressing lifestyle modification for disease prevention, long-term disease management and addictions".[1]People living with a substance use disorder may not be ready to acknowledge their habits, particularly when it comes to their substance use. Understanding where a person may place themselves on this model is helpful for you as a Social Service worker and for them. This will help you and them develop strategies to move through the stages, if reduction in use, change in substance, harm reduction, or recovery is something they would like to achieve. This is important to note, **this is their choice**, not yours and whatever changes they make, if any, are their decision.How do you use this model? The graphic below indicates the stages of change; note the arrows. There is no beginning or end; this is because people can start making changes at any time. People may also skip through stages. When using this model, it is important to be nonjudgmental and supportive at each stage.

The Stages of Change Model

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=72#oembed-1

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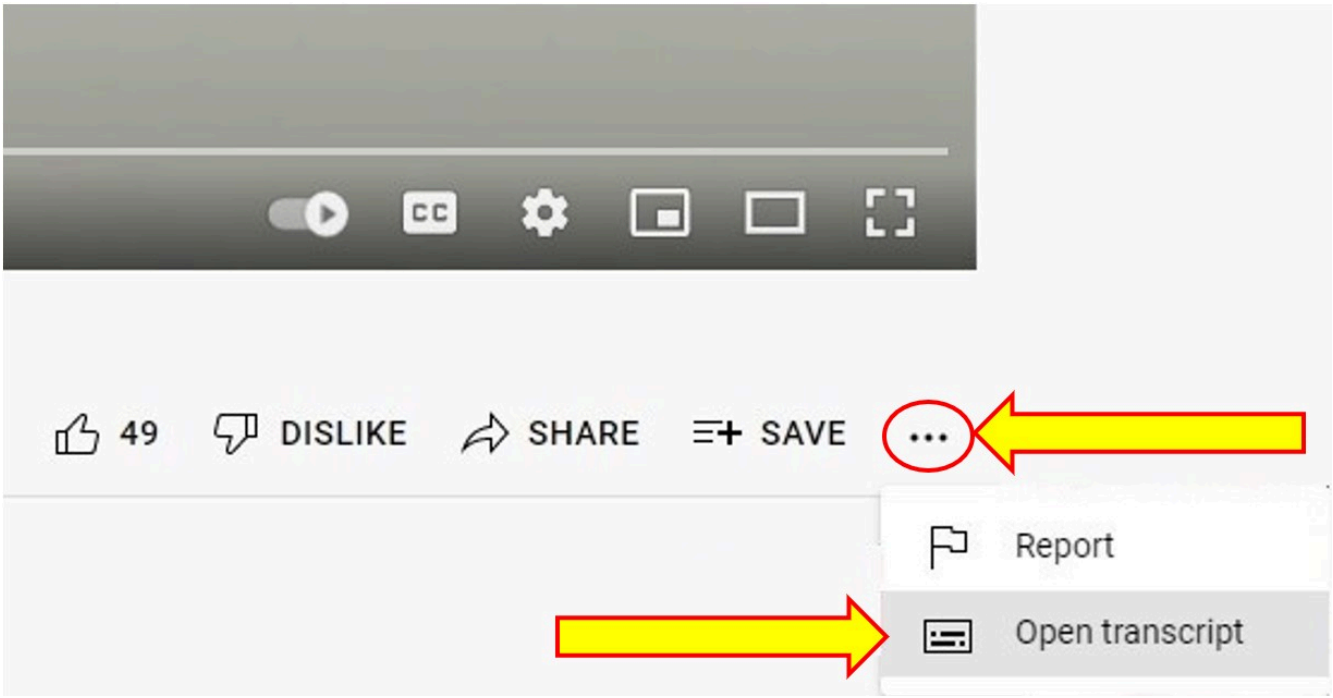

Now that you have viewed the stages of change, let's explore each stage individually.

Pre-contemplation: Remember when you reflected on your habits? Had you thought about what you were doing every day? If not, that's ok! This is the stage that we called pre-contemplation, it is the stage where you are doing what you do, without considering making any changes. You may feel comfortable or confident in the choices you are making. You may also see your choices as helpful. In the context of substance use, we know people use substances for many reasons. Imagine someone who has experienced trauma and is using substances to cope. In pre-contemplation they may see their substance use as the only way to cope, in which case they are not prepared to make a change. They may have also tried changing many times and have simply given up.

Figure 2.3.3 – Photo by Sander Sammy on Unsplash

Exercises

1. How could you determine if a client is in pre-contemplation?
2. What are three questions you could ask a client who you believe is in pre-contemplation?
3. What should you be aware of in this stage?

Contemplation: In this stage, people have *acknowledged* there is a habit or a behaviour that is not a healthy behaviour, but they are not yet prepared to make a change. The thought of making a change may cause a person to begin to feel pain. This could be fear of the loss of the behaviour, it could be fear of withdrawal. At this stage you may see individuals develop barriers to change, for example using terms like "I know, but...". The person may also see the benefits of change but are ambivalent about making that change.

Figure 2.3.4 Photo by Caleb Jones on Unsplash

Exercises

1. How could you determine if a client is in contemplation?
2. What are three questions you could ask a client who you believe is in contemplation?
3. What should you be aware of in this stage?

Decision (also called Preparation): In this stage, the behaviour has been acknowledged and the person has made the decision to make a change. It may be a small change, for example, a reduction in the amount of substance used, or the type, it could be a change in behaviour (safer injection). Whatever the change, it is exciting to get to this stage, as it is a critical stage for a person with a substance use disorder. The person has

moved from ambivalence to planning to change. This is also a critical stage for you, the Social Service worker. This is an opportunity to reflect on the behaviour of the individual and develop a set of goals. Starting small is helpful, rather than going "cold turkey". Whatever the goal is, it is the choice of the individual and respecting the goal is paramount to building a relationship. The preparation stage is simply planning, so using a SMART goal model may be helpful.

Figure 2.3.5 Photo by Brett Jordan on Unsplash

WHAT ARE SMART GOALS?

Statements of the important results you are working to accomplish

Designed in a way to foster clear and mutual understanding of what constitutes expected level of performance and successful professional development.

WHAT IS THE SMART CRITERIA

S	Specific	What will be accomplished? What actions will you take?
M	Measurable	What data will you measure? How much? How well?
A	Achievable	Is the goal doable? Do you have the necessary skills and resources?
R	Relevant	How does the goal align with broader goals? Why is the result important?
T	Time-Bound	What is the time frame for accomplishing the goal?

Exercises

1. How could you determine if a client is in preparation?
2. What are three questions you could ask a client who you believe is in preparation?
3. What should you be aware of in this stage?

Action: You have helped your client set goals, now they are going to do the work to achieve them. This can be the easy period in some cases, there is excitement and hope. In the first few days of the action phase, people with substance use disorders should receive a lot of encouragement. This may be the first time or the fiftieth time a person has tried to change their behaviour; every time should be praised.

Figure 2.3.6 Photo by Jakob Owens on Unsplash

Exercises

1. How could you determine if a client is in action?
2. What are three questions you could ask a client who you believe is in action?
3. What should you be aware of in this stage?

Maintenance: This is the make-or-break stage, as the person with the substance use disorder is maintaining their behavioural change, whether a reduction in the amount of substance use, a reduction in risky behaviours, a change in substances or whatever their initial goal was. Continuing to encourage and praise is helpful in this stage. Peer support can be very helpful in the maintenance phase, and there are many different programs that use a peer support model that allow for check in's can be helpful for some people. Being able to provide appropriate referrals to other services is helpful in the maintenance phase.

Figure 2.3.7 Photo by Sam Balye on Unsplash

Peer Support Groups

For those who are interested in recovery from drugs or alcohol and want to participate in support groups there are different groups that can provide support for long-term recovery from substance abuse in Canada.

Peer Support Groups

- AA, NA, Alanon etc (12 step)
- SMART Recovery
- Celebrate Recovery
- Refuge Recovery
- Lifering Secular Recovery
- Secular Organizations for Sobriety (SOS)

- Moderation Management (MM)

Exercises

1. How could you determine if a client is in maintenance?
2. What are three questions you could ask a client who you believe is in maintenance?
3. What should you be aware of in this stage?

Relapse: Relapse is part of substance use disorders, which is why it is part of the model. While we want to help people prevent relapse, depending on their life circumstances, relapse may happen frequently or infrequently. We are there to help individuals understand that relapse is ok, and don't quit quitting! If we discourage an individual, they may give up entirely. The reality is many individuals will go through the stages of change more than once. Just like you, it takes time to make a change. Reflect on your habits and any habits you have tried to change. If you were successful the first time, congratulations! If not, you're human!

Figure 2.3.8 Photo by Jim Wilson on Unsplash

Exercises

1. Review the SMART goal model.
2. Review the website Addiction Rehab Toronto
3. Brainstorm any missing concerns you think would be important to include.
4. Imagine you are providing a program for women with substance use disorders. What would you need to do to ensure your program meets UNODC recommendations?

For a exploration on how to use the Stages of Change to help people quit smoking, let's watch this video narrated by Dr. Mike Evans.

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them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=72#oembed-2

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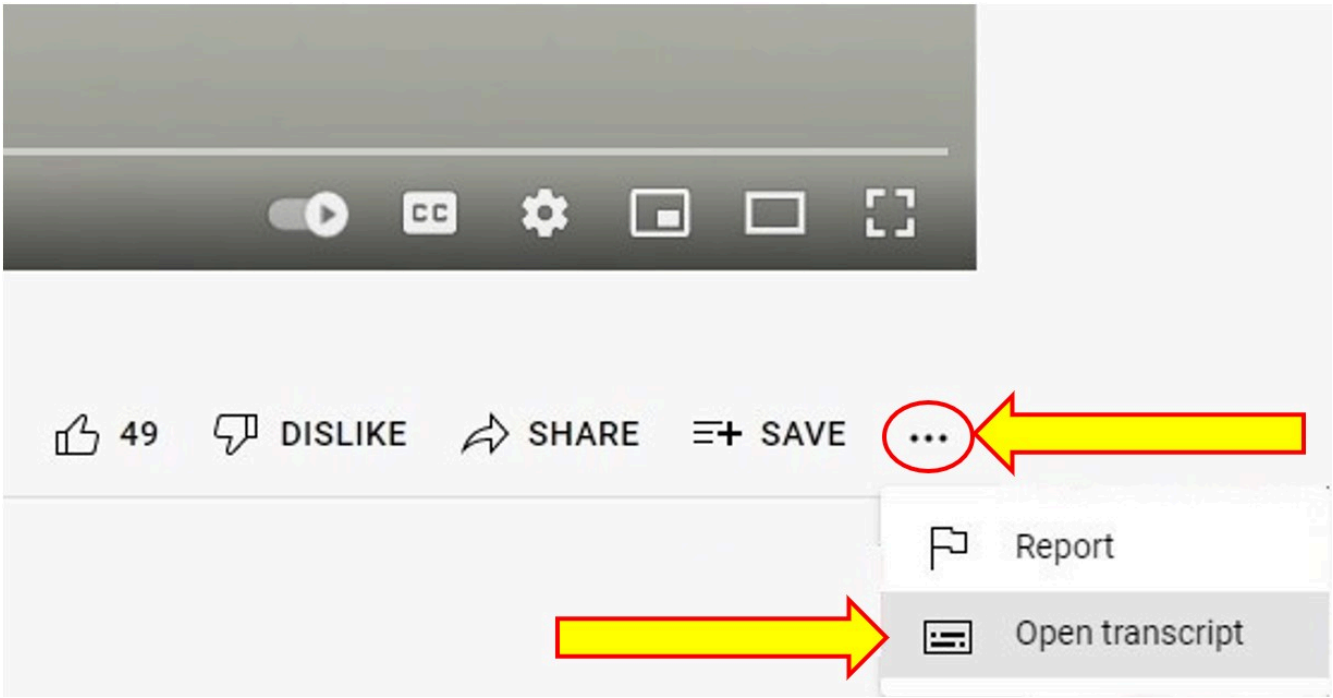

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2.4 BIOPSYCHOSOCIAL PLUS

The Biopsychosocial Plus Model reflects a dimensional understanding of addiction. The Biopsychosocial Plus Model recognizes the complex interactions between the biological, psychological, social, cultural, and spiritual aspects of addiction. The model provides you with a framework to dynamically engage with clients wherever they are on the addiction continuum – from absent, mild, moderate to severe – and adjust treatment/care as clients' needs change and evolve.

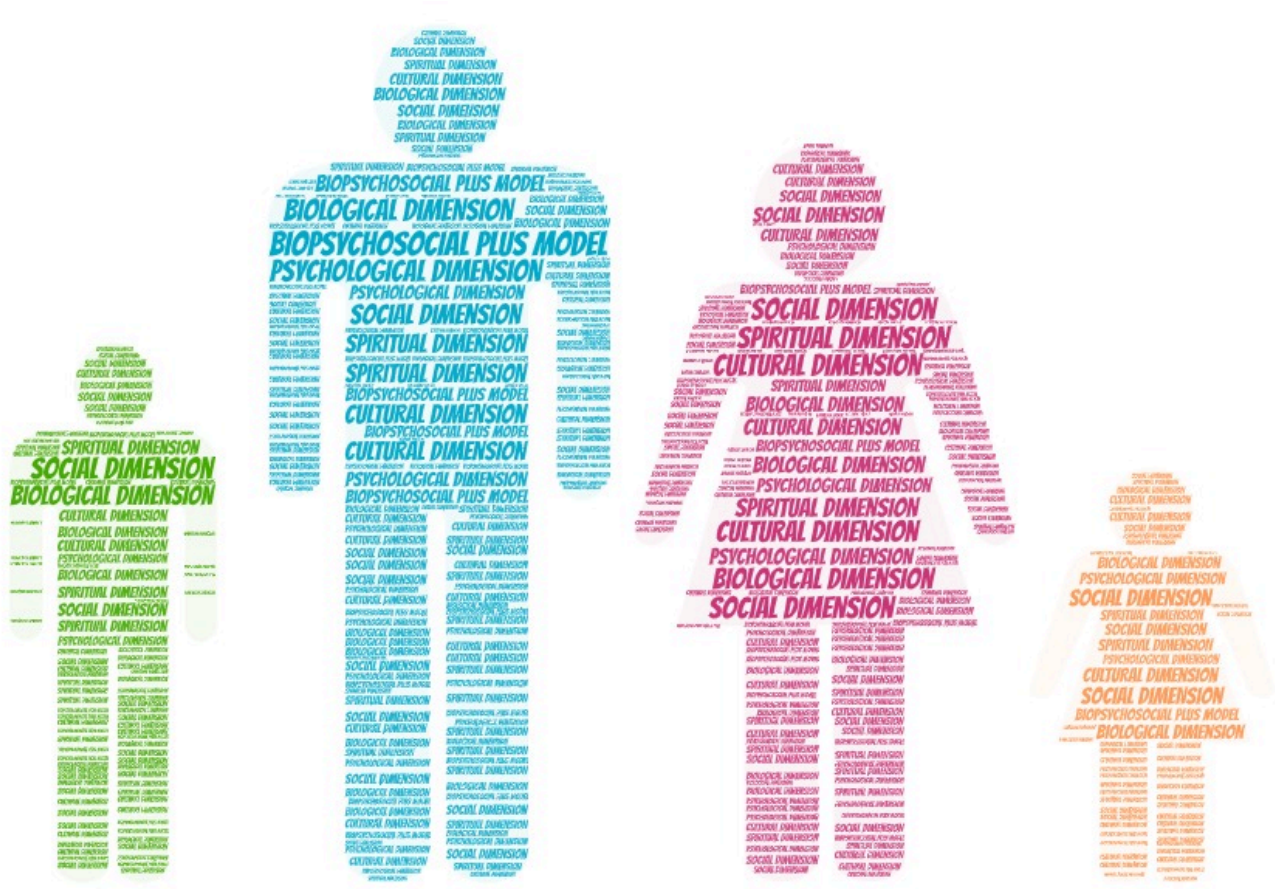

Figure 2.4.1 – WordArt by Denise Halsey

Substance use disorders / Addictions as a Biopsychosocial Plus phenomenon

When we see substance use disorders/addictions in a binary fashion, we are choosing one lens or another, which does not give us a clear picture of the person. When we look at substance use/addictions through

a Biopsychosocial Plus model by connecting to biological, psychological, social, cultural and spiritual dimensions then we can as a social/mental health/addictions worker take an opportunity to see a "whole" person and be able to provide wrap-around supports that can help a person meet their individual goals related to their substance use/addiction. You can further explore poverty, race, gender, and other examples of intersectionality that may play a role in a person's substance use/addiction as you are working with them, ensuring your work is cultural, spiritual, gender-sensitive and trauma-informed.

It is important to note substance use disorders/addiction do not often have a one-specific cause. You may use a combination of theories to help your clients explore why they use substances, why they continue to use substances, the increasing substance use, or choosing to change their substance use, always remembering you are not diagnosing and they are the expert in their journey. Using all these theories may help you understand the complexity of substance use and why one theory/lens is generally not enough.

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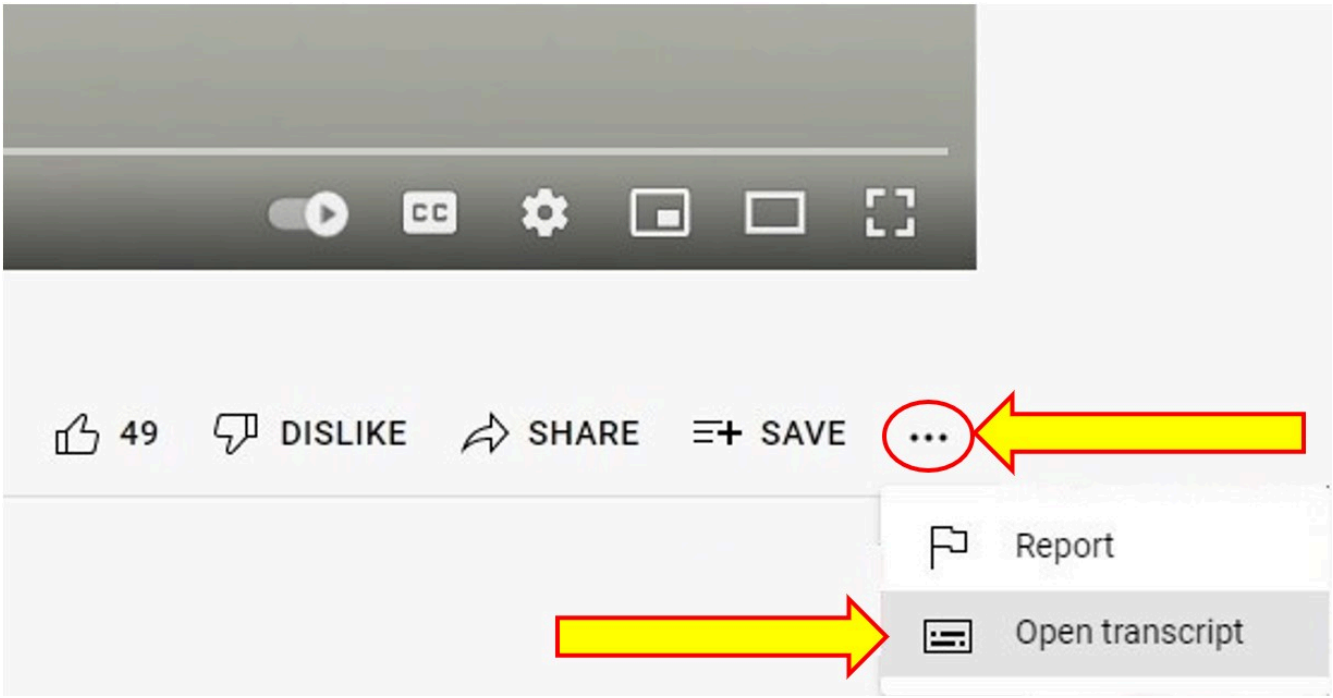

Biopsychosocial Plus Model

Biological Dimension

Figure 2.4.2 – Photo by Brano on Unsplash

It is important not to look at the biological dimension as neurobiology alone. It also takes into consideration aspects of health functioning such as addictive behaviour, diet, exercise, self-care, nutrition, sleep and genetics. We look at all aspects of health, whether it is positive, neutral or challenging. Understanding the impact this information has on the person as well as the additive behaviour gives us a clearer picture for positive changes and for the person to actively participate in their recovery and treatment plan.

It is important not to look at the biological dimension as neurobiology alone, but to also take into consideration aspects of health functioning such as addictive behaviour, diet, exercise, self-care, nutrition, sleep and genetics. What is present, what is missing and what could be added.

The Biological Dimension Considers:

- Genetic factors that influence the variability of addiction
- Pharmacological solutions for treating addiction (overdose to pharmacotherapy)
- Effects on the body
- Importance of nutrition, sleep, and exercise

Psychological Dimension

Figure 2.4.3 by Pixabay

The mind is to the psychological dimension what the brain is to neuroscience. The term "psychology" refers to a behavioural process that relates to motivation, emotions, mood, or the mind. Informed by science, many psychological models, govern our understanding of addiction. When we look at classical and operant conditioning to social learning theory, the transtheoretical model and the behavioural perspective we can see

how the psychological dimension strongly affects addiction. All these areas contribute to the Psychological Dimension and what motivates the reward system.

When we look at the psychological dimension, it also allows us to understand and work more effectively in helping individuals, families and communities thrive and flourish in a positive way. When we understand the impact of our perception, purpose of rewards, motivation, expectancy, and maturation, it helps us to find solutions to the addictive behaviours that may not have been an option previously. It allows for the development of more positive behaviours by understanding alternatives, and more possibilities and gives opportunities for making positive decisions with those options.

Some refer to addiction as the disorder of choice.

The Psychological Dimension considers:

- Thoughts, feelings, and behaviours surrounding and generated by misuse (triggers)
- Early and persistent problem behaviours
- Issues related to trauma, victimization, and extreme stress experiences
- Motivators to reduce or stop drug use

Social Dimension

Figure 2.4.4 – Photo by Brooke Cagle on Unsplash

The social dimension is considered to be vitally important, it is the immediate interpersonal domain that is most proximal to the person who develops an addictive disorder. Who is in the social dimension includes, family, friends, workplace, social, exercise, the community of choice, leisure companions and faith community. It also takes into consideration the socio-structural perspective of the individual as it relates strongly to the many decisions that are made around addictions. This also takes into consideration the social determinants of health, social factors, culture, age, gender and other stressful situations that were experienced.

The Social Dimension considers:

- Family and family-of-choice relationships (interpersonal)
- Class, race, age and gender
- Early life exposures to stressful situations, such as conflict, hunger, violence and prejudice
- Association with alcohol and drug users

Cultural Dimension

Figure 2.4.5 – Photo by Ruben Hutabarat on Unsplash

Culture is very personal and we need to allow it to be whatever the person identifies it as. Culture is a missing piece and very important to those who have an addiction. It may have been lost, not yet experienced, which leaves a person feeling like there are missing pieces. Sometimes it is by choice, or experience, a negative representation of what they believed culture meant. It is important to be aware of the importance of understanding the client's cultural belief system as they feel it is, through their eyes.

Culture is different for everyone, even if they were brought up in the same environment. It is what the person feels it is or is not. It is also connected to the spiritual dimension.

The Cultural Dimension considers:

- Community, race, gender, disabilities, etc.
- Association or disassociation from culture and community has an impact
- The client's cultural belief system

Spiritual Dimension

Figure 2.4.6 – Photo by Ruben Hutabarat on Unsplash

Spiritual Dimension is very personal to people. You will hear about the importance of spirituality to people, whether it is religious or non-religious. It is very important to be respectful around all spiritual dimensions as it is very important to people. Think of it as the therapeutic imagination of what spirituality means to the individual and show respect to each person, so that they can have the freedom to find, explore, revisit or discover their own beliefs. It is a very personal, powerful journey and individual to all.

Spirituality affects our mental health as well as our well-being. It is important to allow them the journey of peer support, mutual aid, culture, nature, and spirituality to find their own spiritual dimension and it's important to them.

The Spiritual Dimension considers:

- Personal perceptions and beliefs
- Spiritual and religious beliefs by which people live

Biopsychosocial Plus Model Activity

The Biopsychosocial Plus Model is a very effective tool when working with mental health and addictions. Do you see it as a model you would use? Where and when would you use it? Do you feel that one specific area would be easier for you to support or would have a stronger effect on a person?

Figure 2.4.7 – WordArt by Denise Halsey

Substance Use Disorders as Biopsychosocial Phenomenon

Reflect on the theories you have explored this far. As you have come to understand, to look at substance use disorders in a binary fashion, choosing one lens or another is not effective. Breaking down substance use and connecting it to biological factors, psychological factors, and social factors can help provide Social Service workers an opportunity to see a "whole" person and to provide wrap-around supports that can help a person meet their individual goals related to their substance use. You can further explore poverty, race, gender, and

other examples of intersectionality that may play a role in a person's substance use as you are working with them, ensuring your work is culturally and gender sensitive.

It is important to note substance use disorders do not often have one-specific cause. You may use a combination of theories to help your clients explore why they use substances and why they continue to use substances, are increasing substance use, or choosing to change their substance use, remembering you are not diagnosing. Using theories may help you understand the complexity of substance use and why one theory is generally not enough.

More Information

- The Biopsychosocial-Spiritual Model
- Psychology Today

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- Figure 2.4.3 – Pixabay
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- Figure 2.5.7 – Halsey, D. (2022, February 27). *Biospychosocial Plus – different on everyone* [WordArt].
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2.5 KEY TERMS STUDY GUIDE

Figure 2.5.1 – Created by Denise Halsey

The material in this chapter are the core of Motivating Interviewing. Once you understand the importance of the many areas necessary you will be more effective with motivating interviewing. You may be familiar with these terms, but If you are not familiar with the terms below, I recommend you download this study sheet, add more spaces to write in definitions and relevant information (or make flashcards) as you read the chapter and watch videos.

1. Action
2. Ambivalence
3. Biopsychosocial Plus
4. Biological
5. Contemplative
6. Coping Questions
7. CORE
8. Culture
9. Engagement
10. Exchange Information
11. FRAMES
12. Find The Horizon
13. Focus
14. Goals
15. Key Strategy
16. Maintenance
17. Miracle Questions
18. Motivational Interviewing
19. Pre-contemplative
20. Preparation
21. Psychological
22. Relapse / Return to Old Behaviour
23. Relational Foundation
24. Scaling Questions
25. Solution Focused Brief Therapy SFBT
26. Social
27. SMART Goals
28. Spiritual
29. Spirit of MI
30. Stages of Change
31. Transtheoretical Model of

Change

2.6 SELF-CARE

This module's self care continues to explore mindfulness. To practice mindfulness this week, please listen to the guided meditation with Tara Brach.

This activity takes approximately 20 minutes, please ensure you have the time and space to engage in this activity.

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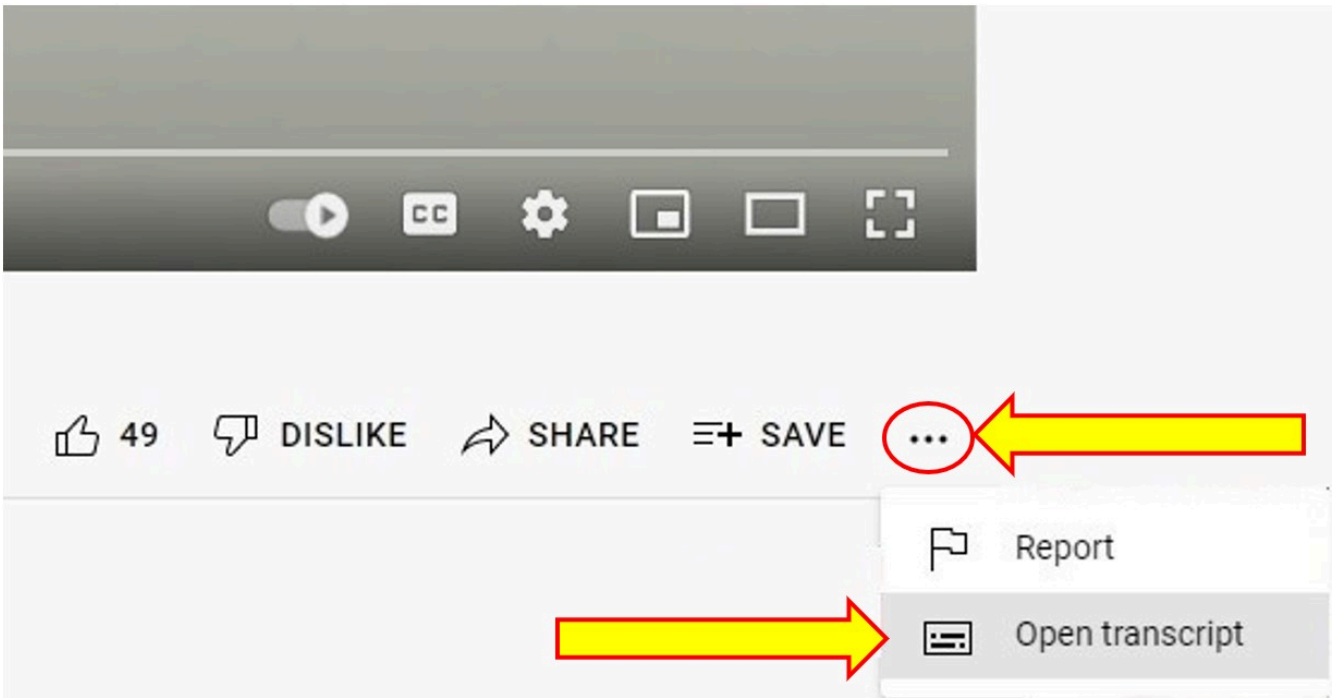

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CHAPTER 3: TRAUMA INFORMED

CHAPTER 3 - INTRODUCTION

The goal of this chapter is to take a look at Trauma and the complexity of it. Mention the word **Trauma** and most of us will think of conflict/war, challenging or difficult situations that you have encountered. Trauma is the response to a deeply distressing or disturbing event that overwhelms an individual's ability to cope, causes feelings of helplessness, diminishes their sense of self and their ability to feel a full range of emotions and experiences. It does not discriminate, it is pervasive throughout the world and can be different for everyone. It is often discussed in the media, to describe some childhoods or marginalization of vulnerable groups. Trauma is not the same thing as loss, it is more complex.

Figure 3.1 – Photo by Benjamin Zanatta on Unsplash

With each individual that we work with, we come to realize that there are many different pieces in each person's life. Their journey with Trauma is as individual as they are.

It is important to take a look at what Trauma-Informed means in Theory, Practice, how if affects both the individuals as well as service providers. There is such differences between being Trauma-Informed and working with Trauma-Specific Practices.

We will explore many topics and perhaps come up with more questions than answers, but with the many

layers of Trauma experience by individuals there is not a simple answer. This is why we are exploring working with those who have Trauma as well as becoming **Trauma-informed**.

Trauma Specific Practices are an intricate part of being Trauma-informed and we will also learn what these are and add to our knowledge base along the way.

We will discuss Trauma Informed Care (Ch 3.1), Trauma Informed in Theory (Ch 3.2), Trauma Informed Practice (Ch 3.3), Trauma Informed Clients' Rights (Ch 3.4), Trauma Informed Diverse Clients' Groups (Ch 3.5), Trauma Informed of Childhood Trauma (Ch 3.6), Trauma Informed Practice for Indigenous Groups (Ch 3.7), Trauma Informed for Incarcerated (Ch 3.8), Integrated Screening, Assessment and Training in Trauma Informed Care (Ch 3.9) and Vicarious Trauma (Ch 3.10).

LEARNING OBJECTIVES

Learning Objectives

By the end of this chapter you should be able to:

1. Explain What being Trauma Informed means and the importance of Developing Understanding of Complex Trauma (Biopsychosocial Lens)
2. Discuss the rational being using a Feminist and Trauma Informed Approach with Women
3. Analyze the intersectional connection with violence and trauma – Intergenerational & Cultural
4. Discuss how to Integrate Trauma Informed Care and Motivational Interviewing with Women
5. Explain the impact of the powerful effect of gender role socialization and how it impacts Trauma Informed work with men
6. Discuss the importance & complexity of integrated Screening, Assessment and Training as Critical Components of Trauma informed Care

3.1 TRAUMA INFORMED CARE

Trauma-Informed Care (TIC) is **an approach in the human service field that assumes that an individual is more likely than not to have a history of trauma**

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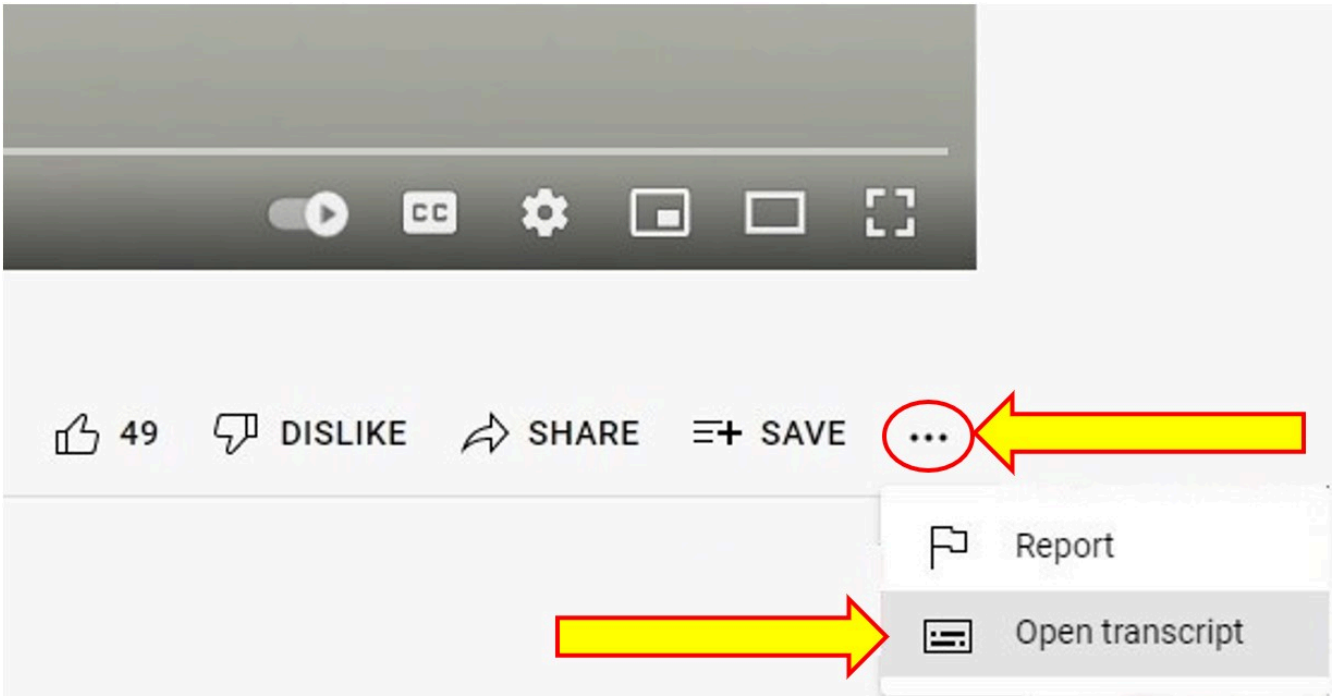

Trauma is a word that is used frequently these days. It describes conflict/war, it is shared in media, it describes some childhoods, it is discussed in the marginalization of vulnerable groups. You may have used trauma to describe difficult situations you have experienced. Is trauma the same thing as loss? Trauma is more complex. A traumatic experience can be something that happens to us, for example an accident or a loss. A traumatic experience can cause trauma. Is trauma something that happens each time a difficult situation arises in your life? No. The Canadian Association of Mental Health describes trauma as "the lasting emotional response that often results from living through a distressing event. Experiencing a traumatic event can harm a person's sense of safety, sense of self, and ability to regulate emotions and navigate relationships". Trauma as an initial or latent experience can happen at any time at any place.

Food For Thought

- Reflect on a time (at least one year ago) that you experienced a difficult situation. Perhaps it was the loss of a pet, or the challenge of not being able to see your friends or family for an important celebration during a COVID lockdown.
- What were some of the emotions you felt?

- What strategies did you use to cope?
- How are you coping now?

We live in a world where difficult, sad, frustrating, upsetting, devastating acts occur in our lives. *Some* of these acts may be considered traumatic. Another voice on trauma, one of the world's most renowned experts, Dr. Gabor Mate considers trauma as "the invisible force that shapes our lives. It shapes the way we live, the way we love and the way we make sense of the world. It is the root of our deepest wounds".

Figure 3.1.1 Photo by Benjamin Zanatta on Unsplash

Listen / Podcast

Dr. Gabor Maté on Trauma, Addiction, and Healing a Mindspace Podcast.

In this episode of the Mindspace podcast, Dr. Joe speaks with Dr. Gabor Maté, retired physician, author, and world renowned educator. Dr. Maté has more than 20 years experience in family practice and palliative care. He has worked for more than a decade at the Portland Hotel in downtown East Side Vancouver with patients who suffer from mental illness and addiction.

Did this help you understand trauma? Holmes suggests trauma must include "stigmatization, marginalization, or oppression because of gender, sex, race, class, sexual orientation, age, ethnicity, culture, spirituality, ability/disability". This means that trauma is complex and must be understood as not necessarily having just one experience. Other researchers looking at trauma, mental health, and coping suggest "trauma has been found to contribute to a range of mental health conditions" and for some, coping with trauma means using substances. When trauma affects people's coping mechanisms they may not be able to appropriately respond to any stressors, much less recover.

Watch this video on how substance use and trauma are related.

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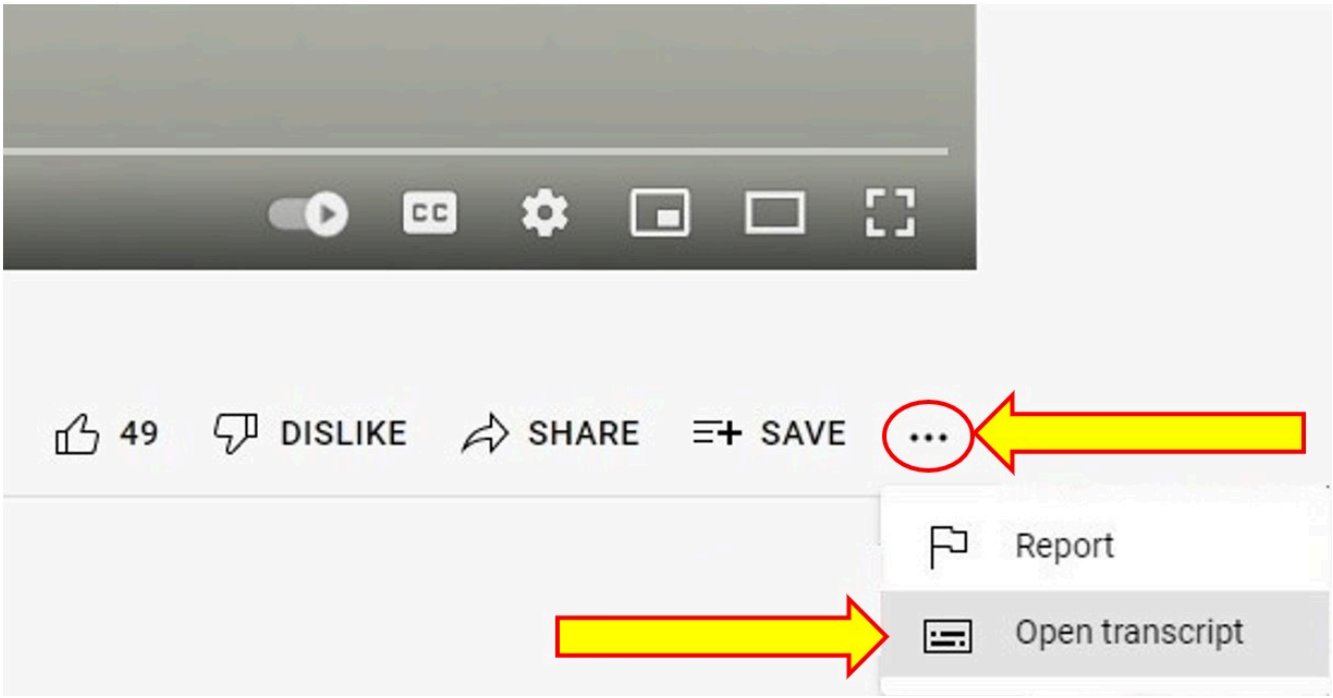

Activities

1. Brainstorm a list of groups that have been heavily impacted by trauma.
2. What do you notice about these groups?
3. Brainstorm as many ways as you can think how trauma manifests physically and mentally.

There has been a concerted effort in the past twenty years to study trauma and identify the links between trauma and substance use to improve service provision. Trauma informed care recognizes the prevalence of trauma, how it manifests and impacts people and focuses on supporting the needs of an individual while minimizing the risk of re-traumatization, and maximizing choice and empowerment (Cleary, 2020). When trauma and a substance use disorder are connected, it is imperative that a trauma-informed approach is used. Listen to this short podcast by Dr. David Trealeven and Anjuli Sherin on embracing a trauma-informed approach using mindfulness.

Listen / Podcast

Resilience, Mindfulness, and Healing Trauma. The Trauma-Sensitive Mindfulness Podcast hosted by David Treleaven.

In this episode, David speaks with Anjuli Sherin, author of the book *Joyous Resilience: A Path to Individual Healing and Collective Thriving in an Inequitable World*.

Activities

1. What are two ways you can introduce a trauma-informed lens in your work?
2. Where can you find evidence-based information on trauma and substance use

Trauma is an important factor to be aware of. You may consider engaging in trauma-informed training to ensure you are working with your clients safely and appropriately.

For more information:

- Trauma Informed Care – CAMH
- Trauma Informed Care – CAMH – GGTU
- Trauma Informed Care Resources for families & Individuals – Oregon
- The Neurobiology of Trauma

We will finish by a watching a video on Being Informed to Trauma-Informed Care?

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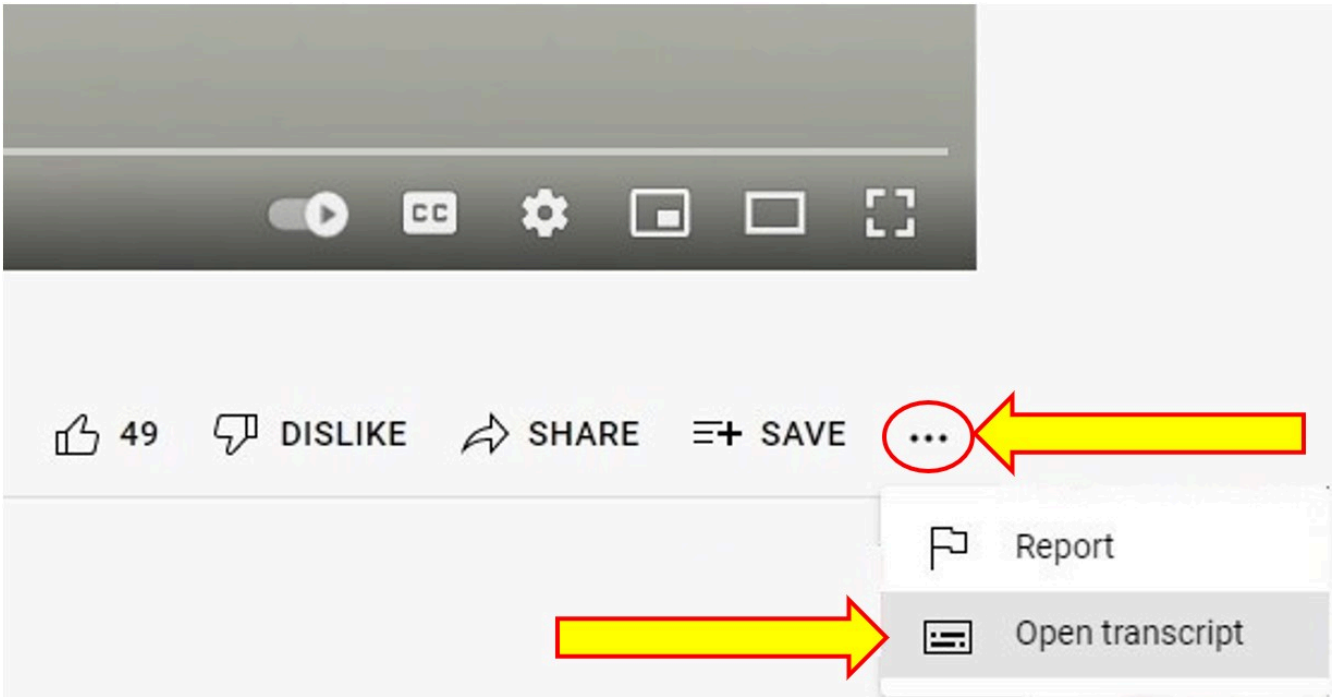

Activities – Reflection

- What stood out for you?
- Where could you see Being Informed to Trauma would be helpful?

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3.2 TRAUMA INFORMED IN THEORY

Photo by Vardan Papikyan on Unsplash

Trauma-Informed Principles & Practices

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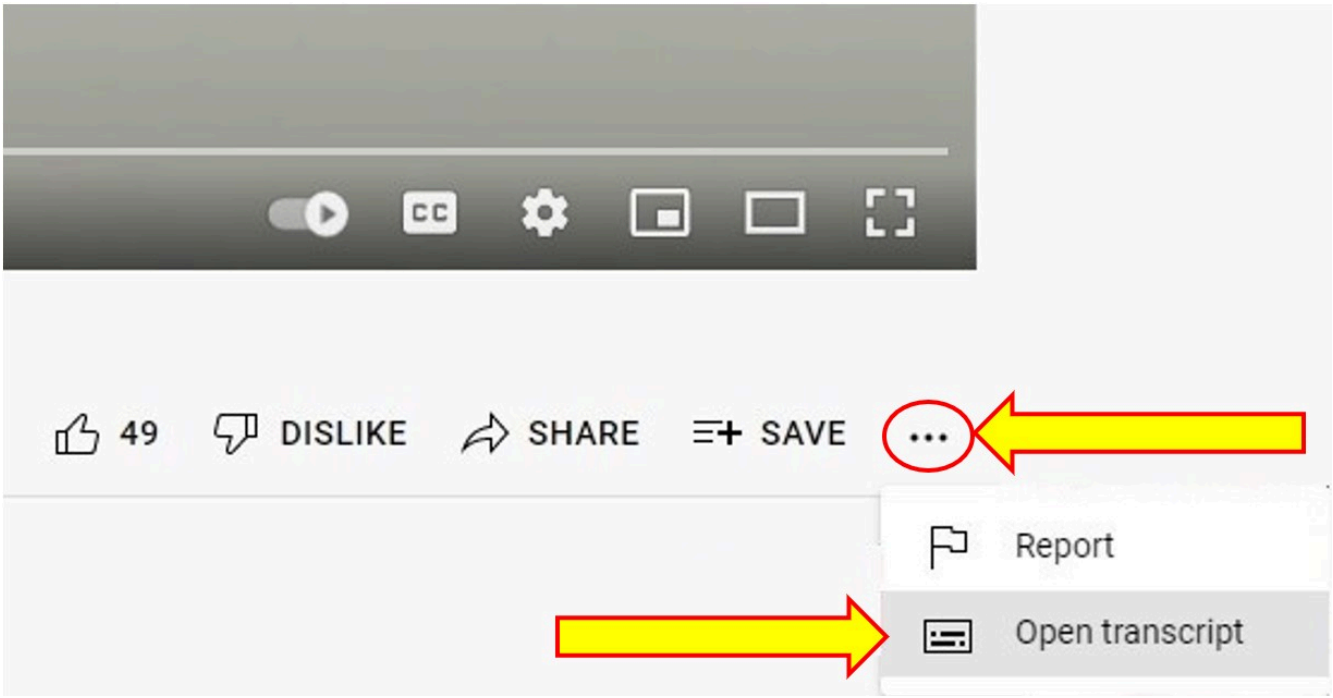

Being Trauma Informed is about being Trauma Aware. It is important to know about the Principles & Practices.

Traumatic experiences typically do not result in long-term impairment for most individuals. It is normal to experience such events across the lifespan; often, individuals, families, and communities respond to them with resilience. An important piece is to use the Biopsychosocial Plus model whenever we are discussing Trauma.

There are many different kinds of trauma and depending on the community that we work in, there are different tools that are used to support that community with knowledge that is specific to that community. An example could be a feminist, critical mental health, or a decolonization of knowledge which perspectives work effectively with a specific community.

Figure 3.2.3 Word Art of Hello by Denise Halsey

Trauma-informed in theory is simply a program, organization, or system that recognizes the need for being trauma-informed. It also realizes the widespread impact of **trauma** and understands potential paths for recovery; recognizes the signs and symptoms of **trauma** in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about being trauma informed systems.

Working in a trauma-informed way involves more than just general principles, it requires service providers to be trained and have a thorough understanding of the complex and diverse alternations in many domains of a traumatized person's development.

The three main foci are: types of trauma, objective and subjective characteristics of trauma, and individual and sociocultural features that serve as risk or protective factors.

There are many different kinds of Trauma. These include:

- Natural or Human-Caused Traumas
- Individual, Group, Community and Mass Traumas

Group Trauma would include those who can experience ongoing trauma in their line of work. These would include: Doctors, paramedics, first responders, police officers, nurses, military

Those who have experienced group trauma, could have very different views on this experience as well as trauma.

The importance of Developing Understanding of Complex Trauma (Biopsychosocial Lens)

The Impact of Complex Trauma: Part One

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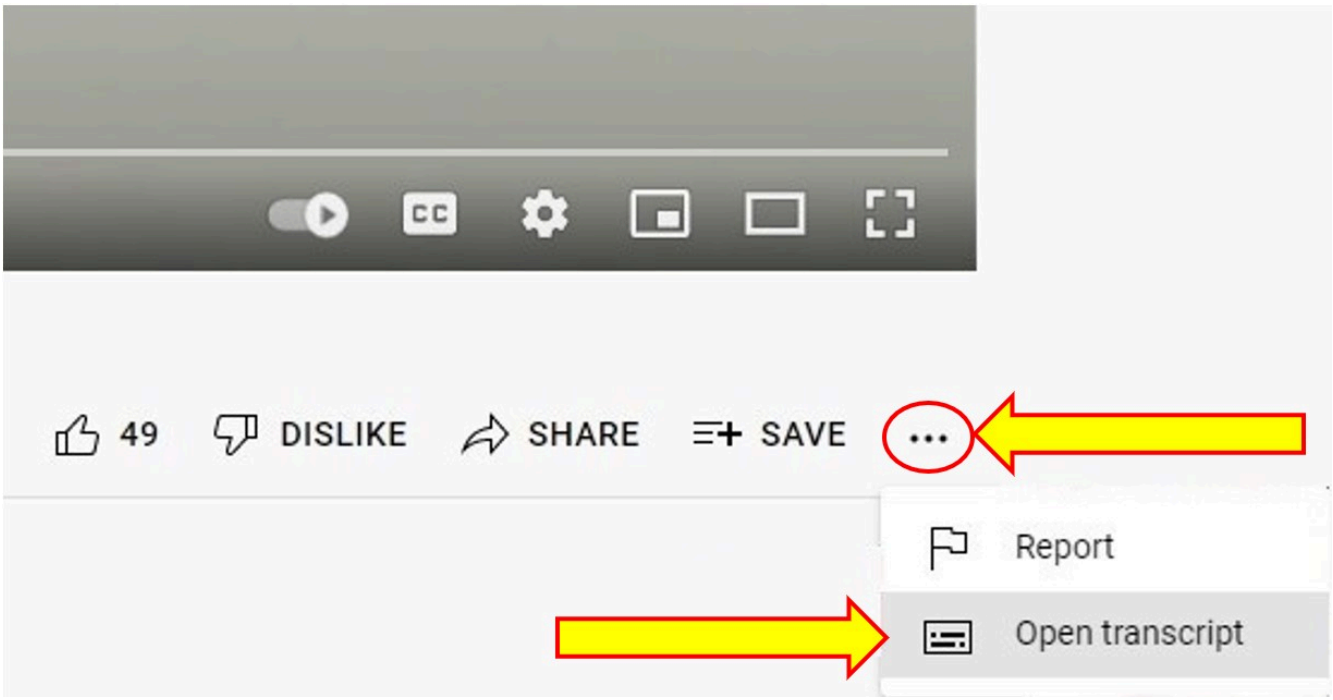

The Impact of Complex Trauma Part Two

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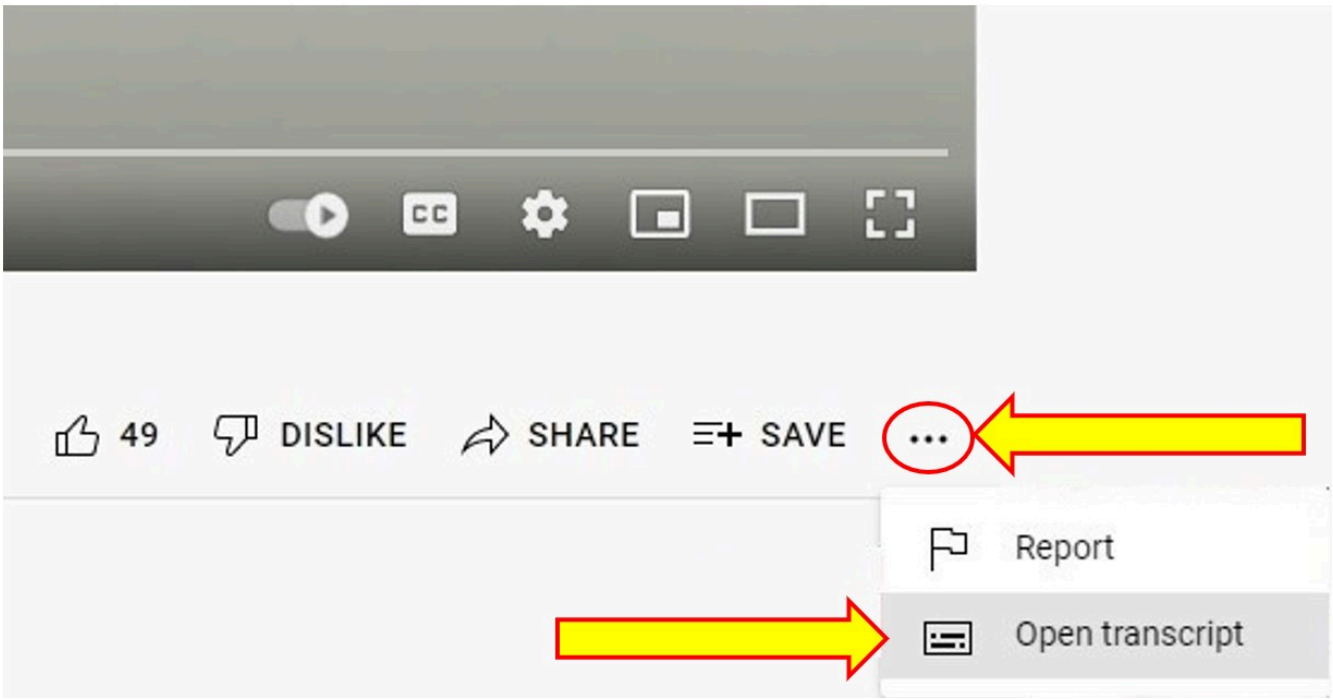

The Impact of Complex Trauma: Part Three

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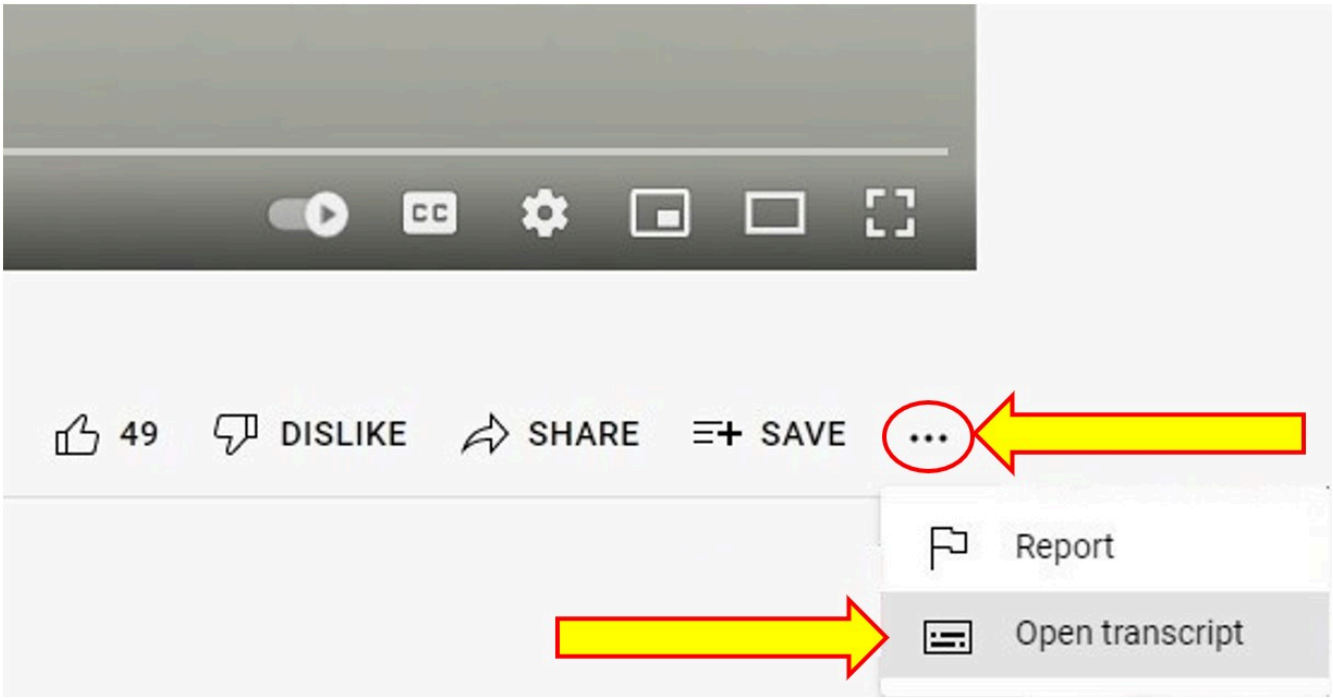

Understanding Complex Trauma

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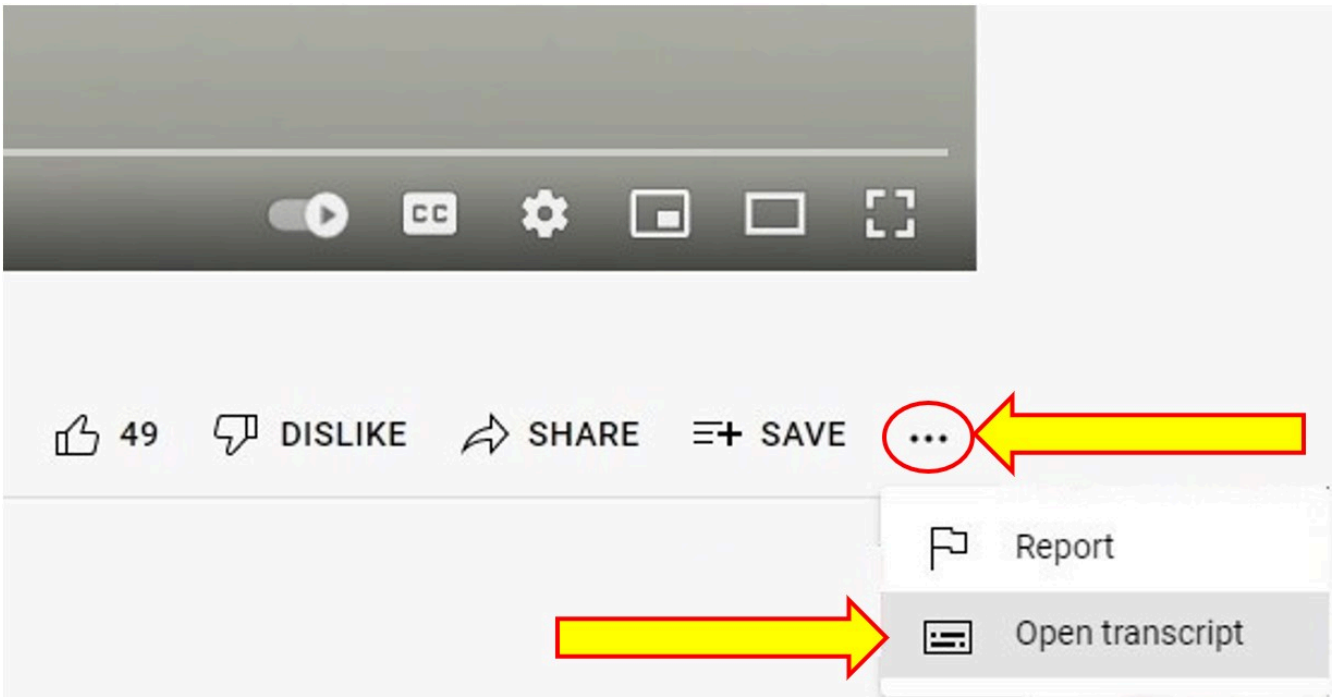

Explore:

- Understanding Complex Trauma (What is Trauma Informed in Social Work – Virginia Commonwealth University)
- Trauma-Informed Social Work Practice (Journal Article – Oxford Academy)
- How Social Workers Can Practice Trauma-Informed Care (SWHelper)

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3.3 TRAUMA INFORMED PRACTICE

Figure 3.3.1 Photo by Gustavo Torres on Unsplash (There is a balance between theory & practice)

Imagine for a moment that someone you know experienced a traumatic incident. How would they cope? Do they have positive experiences and supports in their life that can help with their ability to cope? As a Social worker, it is important to recognize the scope of your practice so you do not inadvertently activate someone who has experienced trauma.

Activities

1. Please review The Canadian Centre on Substance Abuse toolkit on trauma informed practice
2. What is trauma informed?
3. What are the four principles of a trauma informed approach?
4. Why does gender, age, ability and ethnicity matter when we discuss trauma?
5. Imagine you are facilitating a substance use disorder support group. What are two activities you could implement to ensure your group is trauma informed using an intersectional approach

Trauma-Informed Practice is guided by six principles:

- Safety
- Trust and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice and choice
- The importance of cultural, historical and gender issues

This approach, in which clinicians acknowledge what has happened, allows clients and patients to be more engaged in their care.

What is Therapeutic and Relational Security

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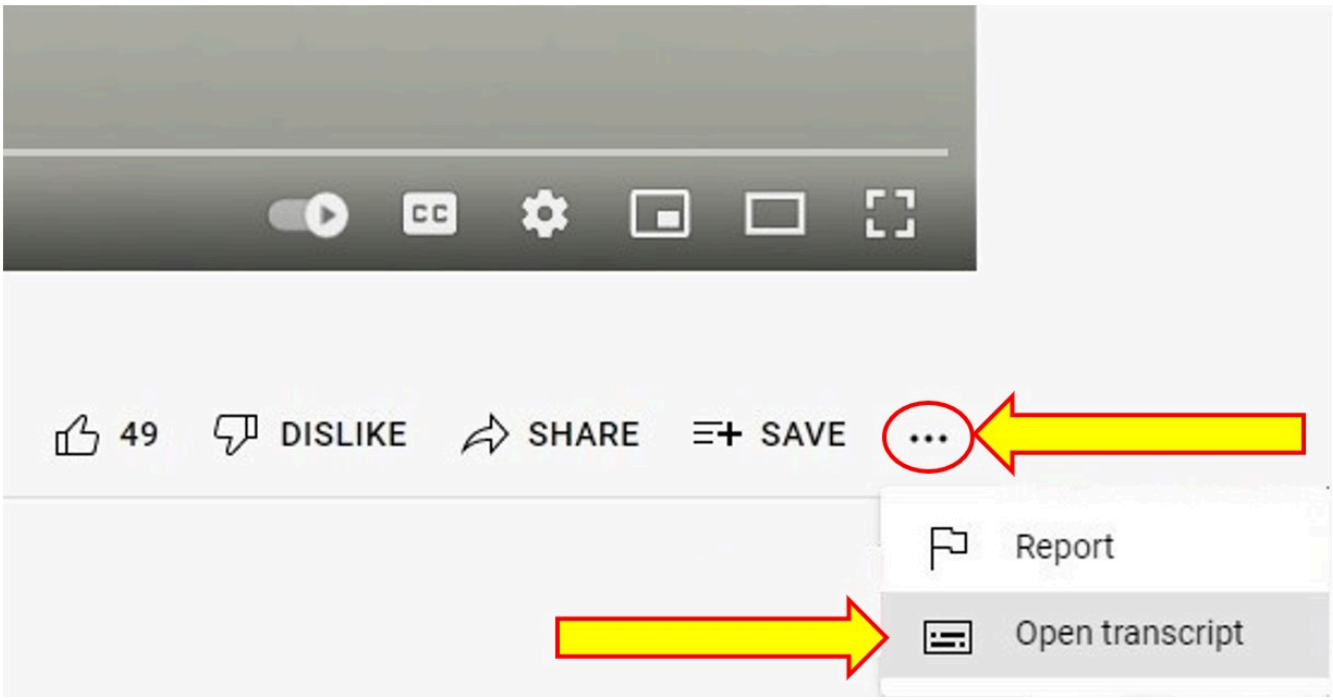

Trauma Informed Practices For Women

Why is gender important when we discuss a trauma-informed approach to support the people we work with? Women have different needs and women also have different experiences. Research tells us women are more likely to have experienced sexualized violence, are more likely to engage in survival sex, and are more likely to live in poverty.

Knowing the issues that impact women specifically, for example, "adverse and traumatic experiences in early childhood, continuation of adversities and trauma in adulthood, intimate partner violence, structural violence, and transgenerational traumas".

Trauma, Gender, Sex and Substance Use

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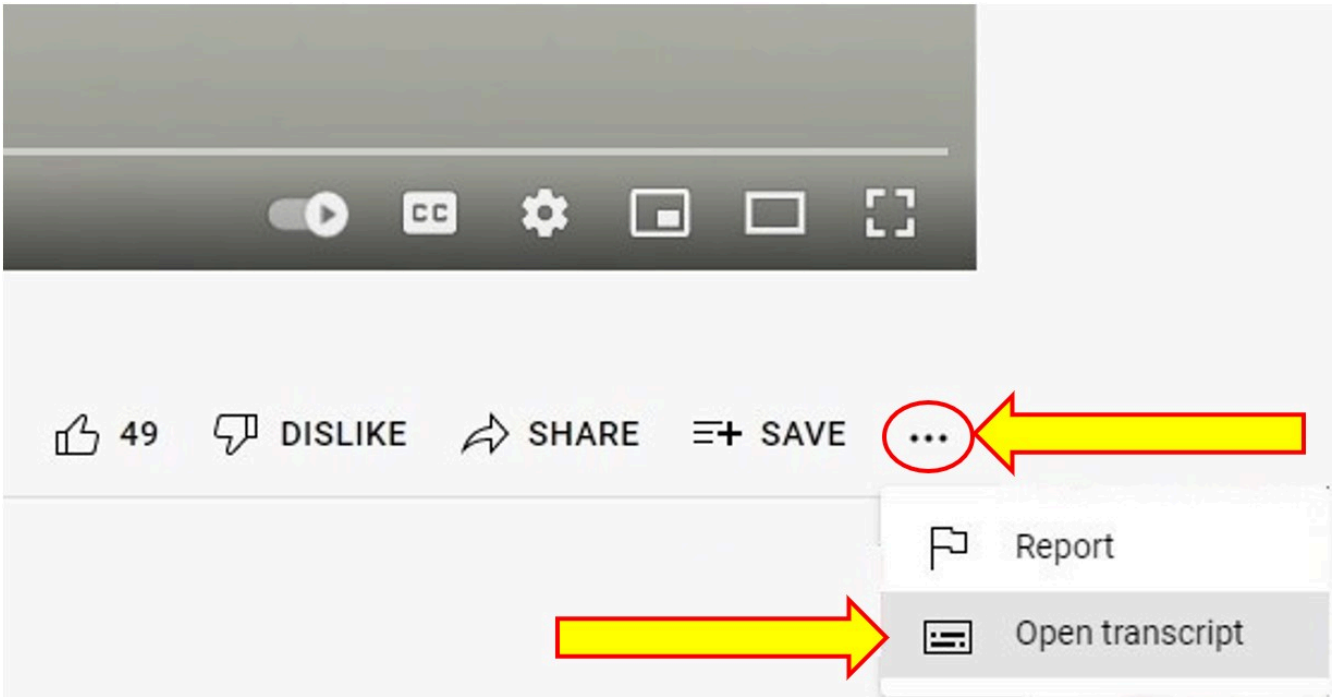

Figure 3.3.2 – Wordart by Denise Halsey

Activities

1. The British Columbia Centre of Excellence for Women's Health created the following discussion guide to focus on supporting women's health by ensuring a gendered approach. Please review the Guide.
2. Brainstorm a list of services that would be specific for programs for women with a substance use disorder
3. What are some of the concerns women may have? How can these be addressed?
4. In the creation of a women's program, what are some of the supports that need to be embedded in the program?
5. How do the social determinants of health impact women

According to Homes, "the majority of substance use services lack a gender-responsive and anti-oppressive approach, that specifically addresses the intersectional violence, oppressive barriers, and diverse experiences of women and femmes". This will take a concerted effort to change; being aware of gender in service provision is a start.

Trauma Informed Practices For Indigenous Communities

Trauma due to genocide, colonization, residential schools, and the concerted effort to eradicate Indigenous communities in Canada has had a tremendous impact on Indigenous people. Understanding these experiences using a two-eyed seeing approach will help provide a more culturally safe and trauma informed service.

Food For Thought

- Review the Four Directions Medicine Wheel Booklet
- What did you notice about the contributors to the document?
- Why is this booklet helpful in developing trauma-informed programs?
- How can you learn more about trauma informed, culturally respectful programs and services in Nova Scotia?

Trauma Informed Practices For 2slgbtq Communities

Figure 3.3.3 – Photo by James A. Molnar on Unsplash

Research suggests that individuals who identify as 2SLGBTQ are impacted by discrimination, victimization, bullying, violence, and trauma; consequently, sexual and gender minority youth are at elevated risk for suicide. This group is also at a higher risk of substance use disorders due to the trauma they face because of their sexuality. To provide a trauma-informed practice for this group, Social Service workers must understand the daily realities of people who identify as 2SLGBTQ. Rojas et al. suggest the following when working with 2SLGBTQ communities and substance use disorders.

- Focusing on the psychological impact of homophobia and heterosexism can help explain vulnerability to mental health disorders.
- Asking about compounded stigma: how does the client feel about having a substance use disorder, mental health disorder, and/or trauma? What experiences have they had with stigma?
- When referring out, confirming providers are knowledgeable in LGBTQ+ affirming practices
- Consulting frequently and refer when outside of your area of expertise
- Encouraging participation of partner/significant other in treatment
- Querying about family of origin messages toward LGBTQ+ patients
- If applicable, querying about "coming out" process and/or experiences with family

Activities

1. Review Rainbow Health Ontario for resources that may support learning about 2SLGBTQ* individuals and a substance use disorder. https://www.rainbowhealthontario.ca/
2. Can you identify one learning?

For More Information

- Trauma Informed Practice – BC Mental Health & Substance Abuse
- Healing Families, Helping Systems: A Trauma-Informed Practice Guide for Working with Children, Youth and Families
- Trauma-Informed Practice Guide
- San'yas Indigenous Cultural Safety Training (Anti-Racism Indigenous Cultural Safety Training Program)
- Red Fish Healing Centre for Mental Health and Addiction

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3.4 TRAUMA INFORMED CLIENTS' RIGHTS

Clients' Rights intersect with Trauma-Informed Care

Figure 3.4.1 Photo by Deva Darshan on Unsplash (Not all Intersections are the same)

It is important to recognize that Trauma-Informed Care & Clients' Rights intersect and how we deal with them greatly affects those we work with. When we look through the lens of client empowerment, we begin to understand how individuals are affected when they try to access health care services and are impacted by policies, organization cultures that greatly impact clients and the many challenges and barriers that are in place.

Often health care services and the approach of service providers seems to be at odds, so when we allow clients to have a voice to say how they are impacted by traumatic experiences it empowers them greatly.

When we look at this through the lens of how these challenges affect clients than we can start making changes so that services can be easier to access, and more effective.

There are many agencies such as CAMH who focus on client empowerment and have them involved in programs that can create and sustain their own patient councils and make long term changes.

Often we find programs and councils run by those who've accessed these services and become peer support.

Let's look at what that can look like in the next video.

Trauma Informed and Human Rights Perspective

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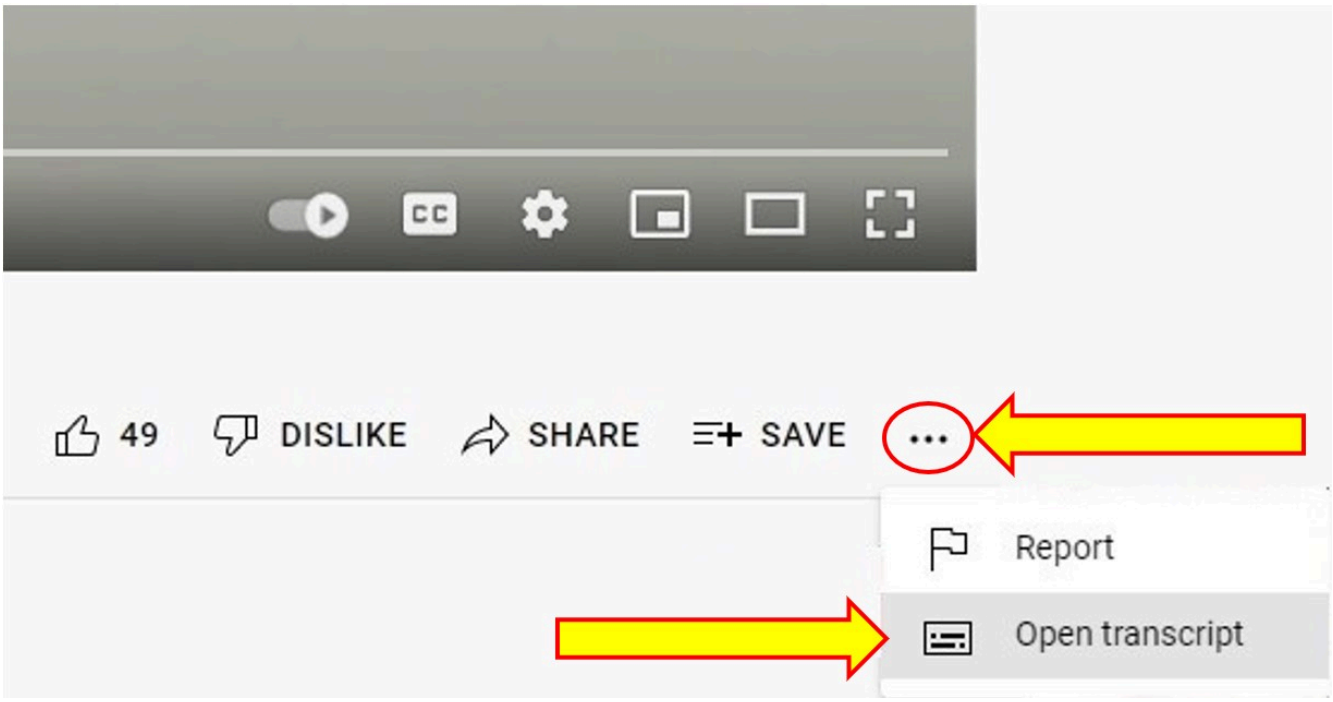

By integrating Trauma-Informed and Human Rights perspectives into all aspects of programming these makes monumental changes for agencies, clients and everyone.

> "Simply stated, trauma-informed practice is policy and practice based on what we know from research about the prevalence of trauma and about how it affects people. "

Nancy J. Smyth, Former Dean and Professor

The social work profession has given little attention to trauma-informed practice principles, and in promoting human rights in all areas of social work practice. These perspectives are related and incredibly meaningful. Through ongoing work it is important to gain in-depth knowledge and practice, theory and research methods — the trauma-informed and human rights lenses complement this by helping social workers better understand the work they do.

Figure 3.4.2 Photo by Priscilla Du Preez on Unsplash

By including clients' rights we take into account the potential role of traumatic life events and development of individuals using service delivery systems. We can then recognize the staggering prevalence of traumatic experiences in the histories of many clients. We change how we ask clients and ask "What happened to you?" rather than "What is wrong with you?"

Looking at being trauma-informed and human rights perspective is a game changer in so many ways.

Human Rights

Trauma Informed and Trauma Specific Services

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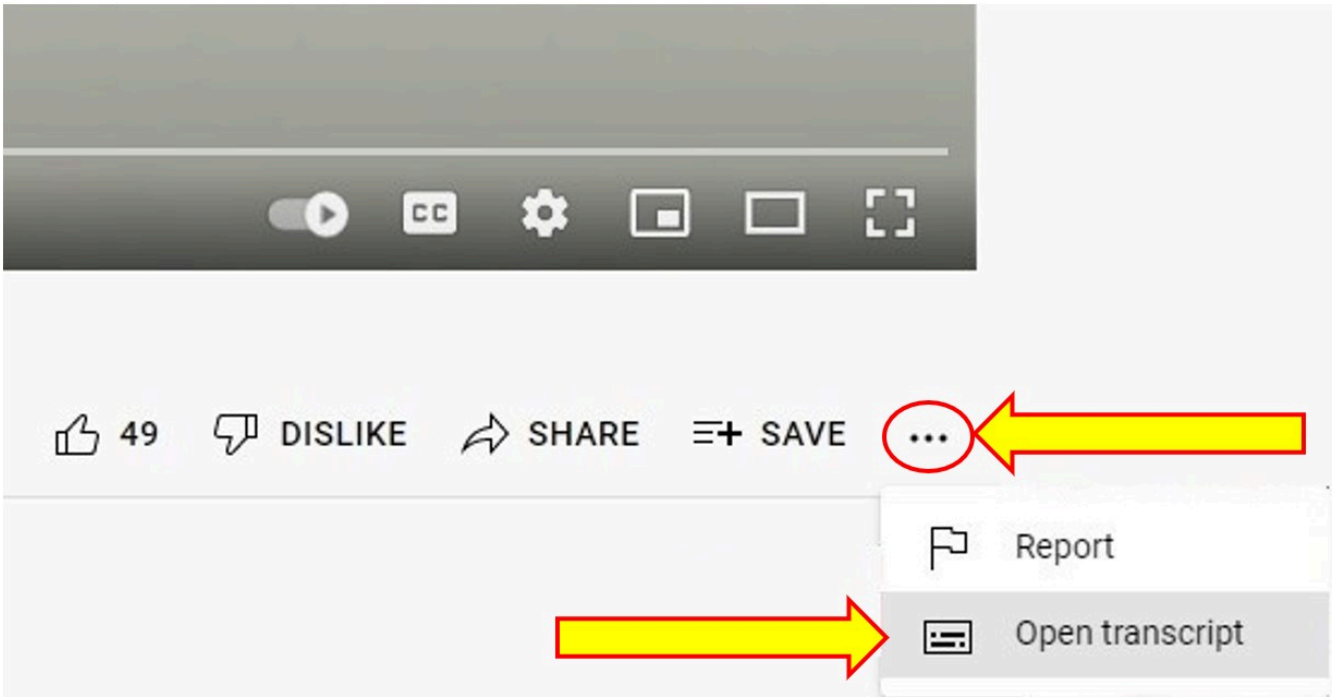

Often trauma and human rights violations frequently go hand in hand, so we need to seek and explore the intersection of traumatic experiences with human rights violations, from local to global.

We are committed to promoting social and economic justice. A human rights perspective entails a focus on the need for social action for community change — a key part of the recovery process for trauma survivors.

Difference between Trauma-Informed Care vs Trauma-Informed Specific Services

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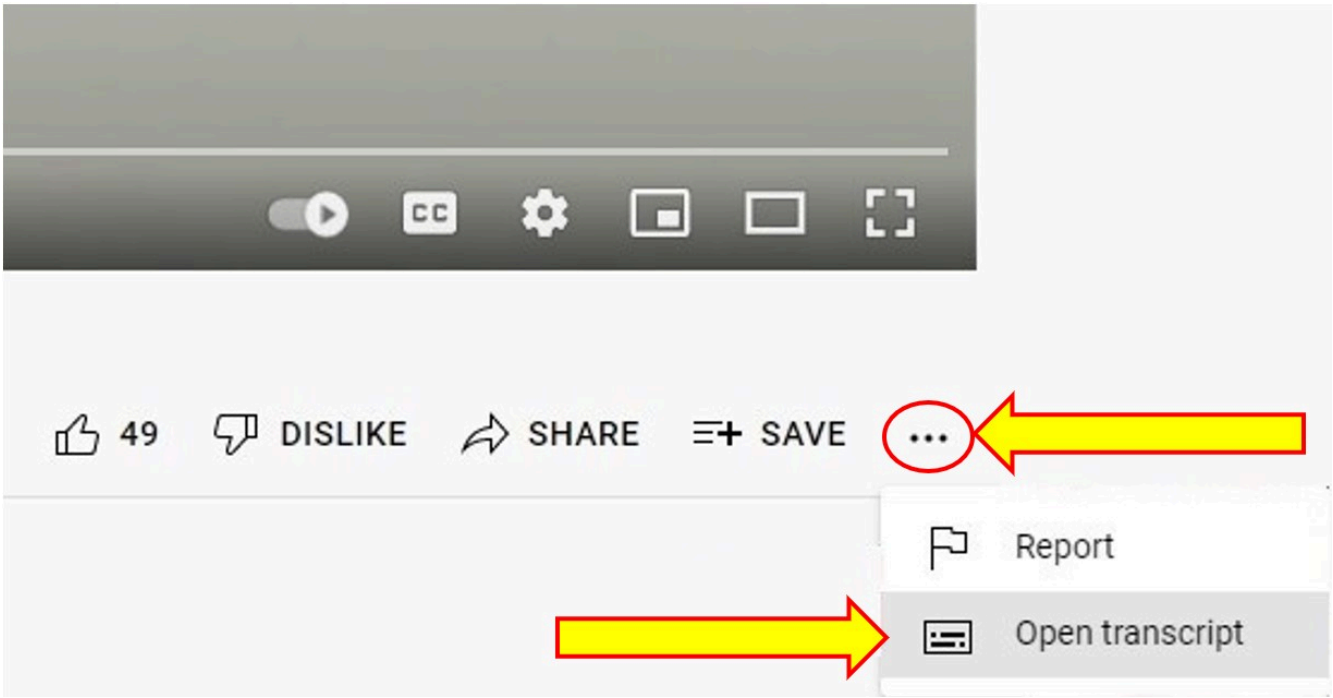

There are many trauma facilities across Canada, using evidence-based treatment programs and services to give hope to survivors of abuse, illness, or injury and military, veterans, first responders or anyone who has suffered from trauma.

Changes are happening but we still need to focus on looking not only through the trauma lens but also the intersectionality of Clients' human rights lens.

For More Information on Specific Services:

- Trauma Specific Services – Family Services of Peel
- Homewood – Specific Services
- EHN Canada – Your Trauma, Your Treatment, Your Chance for Recovery
- Canadian Centre for Victims of Torture

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3.5 TRAUMA INFORMED FOR DIVERSE CLIENTS' GROUPS

Figure 3.5.1 – Photo by Brittani Burns on Unsplash

When we work with Diversity, Equity and Inclusion it's important to apply this in all areas, but especially when we are working through a Trauma Informed Lens. We will touch on a few of these Diverse Communities but

there are more that we will have an opportunity to discuss. Learning and working with Diverse Communities is like working on Cultural Competence, it is an ongoing journey, one that we will be continually learning and adding to our knowledge.

10 Tips to Work Effectively with Diverse Clients

1. Stretch your understanding of diversity

2. Reflect on your own biases, stereotypes, and assumptions

3. Listen to your clients' / customers' stories

4. Take a holistic approach

5. Understand the process of transition

6. Recognize systemic barriers/challenges

7. Choose appropriate tools and resources

8. Know when and where to refer

9. Advocate

10. Take a "hope-centered" approach.

10 Tips to Work with Diverse Clients – Lifestragies.ca

There are many diverse communities in Canada – we will touch base on a few of them. This information continues to grow and part of the work with Diverse Clients' is us looking and finding the necessary supports for the communities that we work in.

Gender Bias Through Meeting Culture

We need to be aware of our gender bias especially in regards to culture. There are so many different

components when we are discussing culture we need to be aware to always be respective and teachable. Trauma is individual and is perceived through every individuals eyes differently.

Interrupting gender bias through meeting culture

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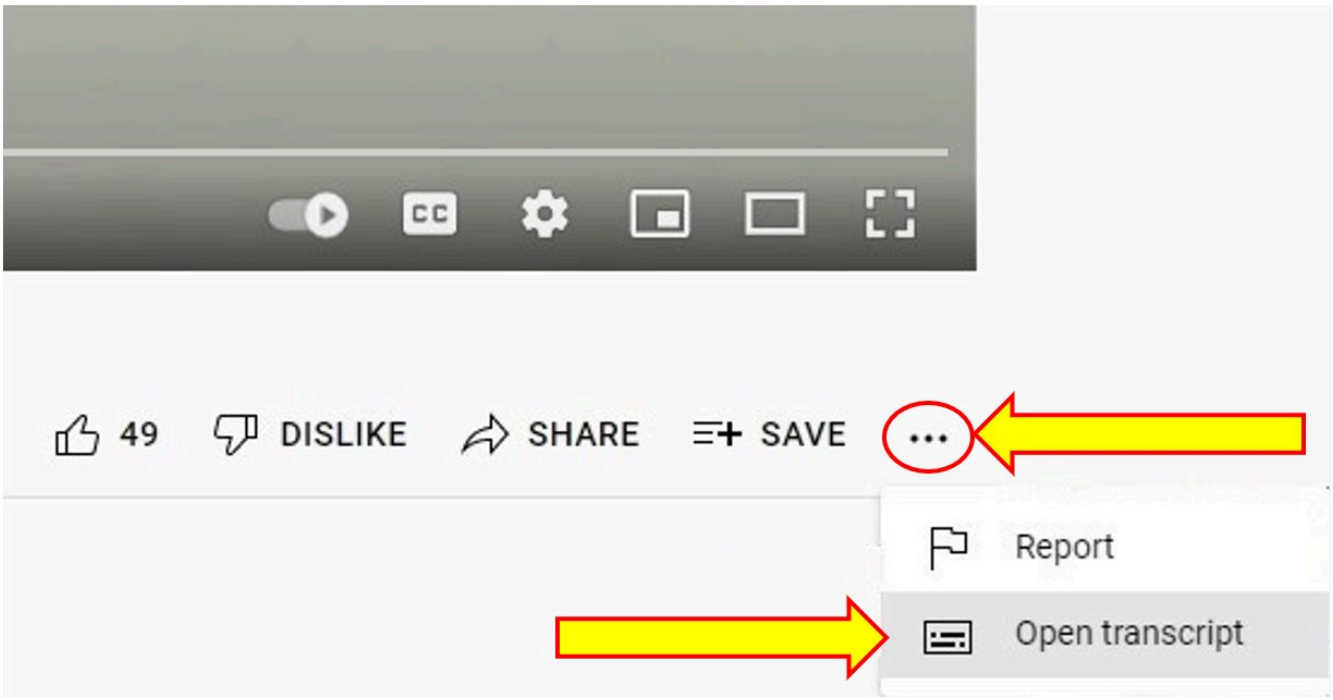

Trauma Informed with those who are Gender Fluid

Gender Fluidity: Gabriel Burton at TedxColumbus

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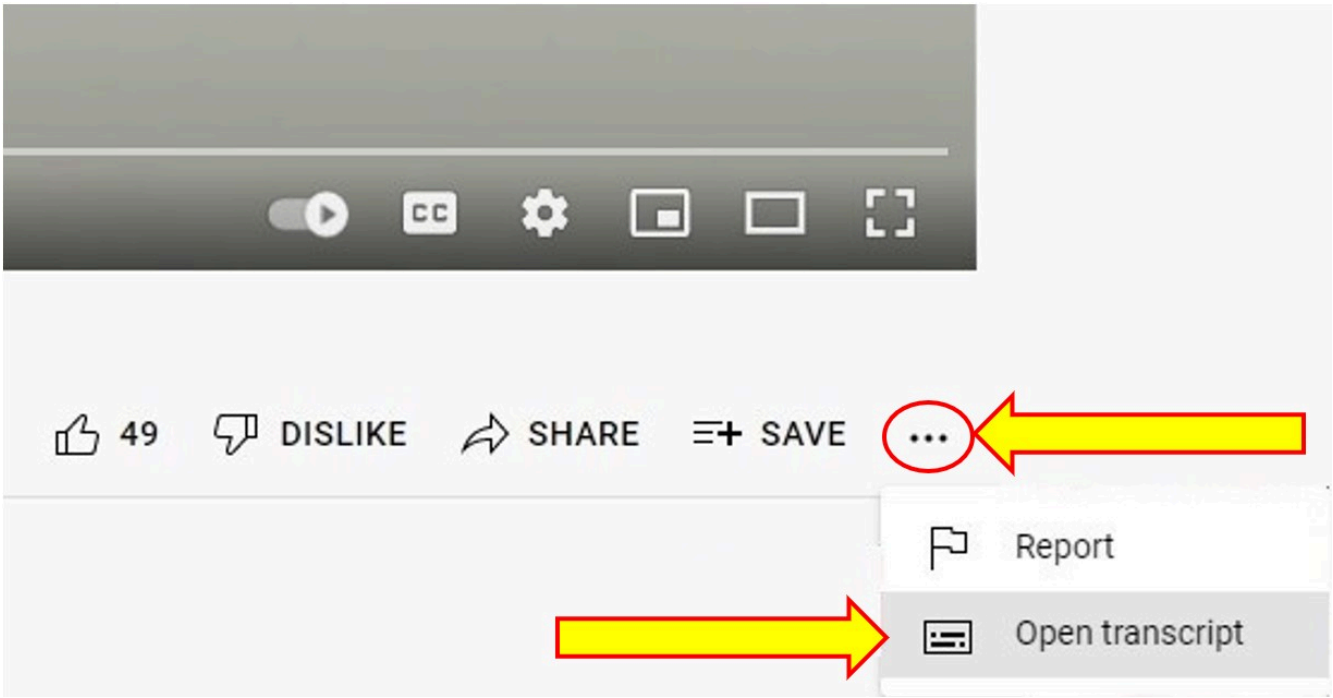

Trauma-Informed with LGBTQ

A trauma-informed approach is driven by a set of core principles that reflect the fundamental attitudes, values, and beliefs needed to provide adequate support for all youth exposed to trauma, including LGBTQ youth.

It is important to have those who are Trauma-Informed with LGBTQ & LGBTQ youth to support and assist in their Trauma. Many LGBTQ do not feel safe in their own environment, schools or communities, due to their sexual orientation or identity.

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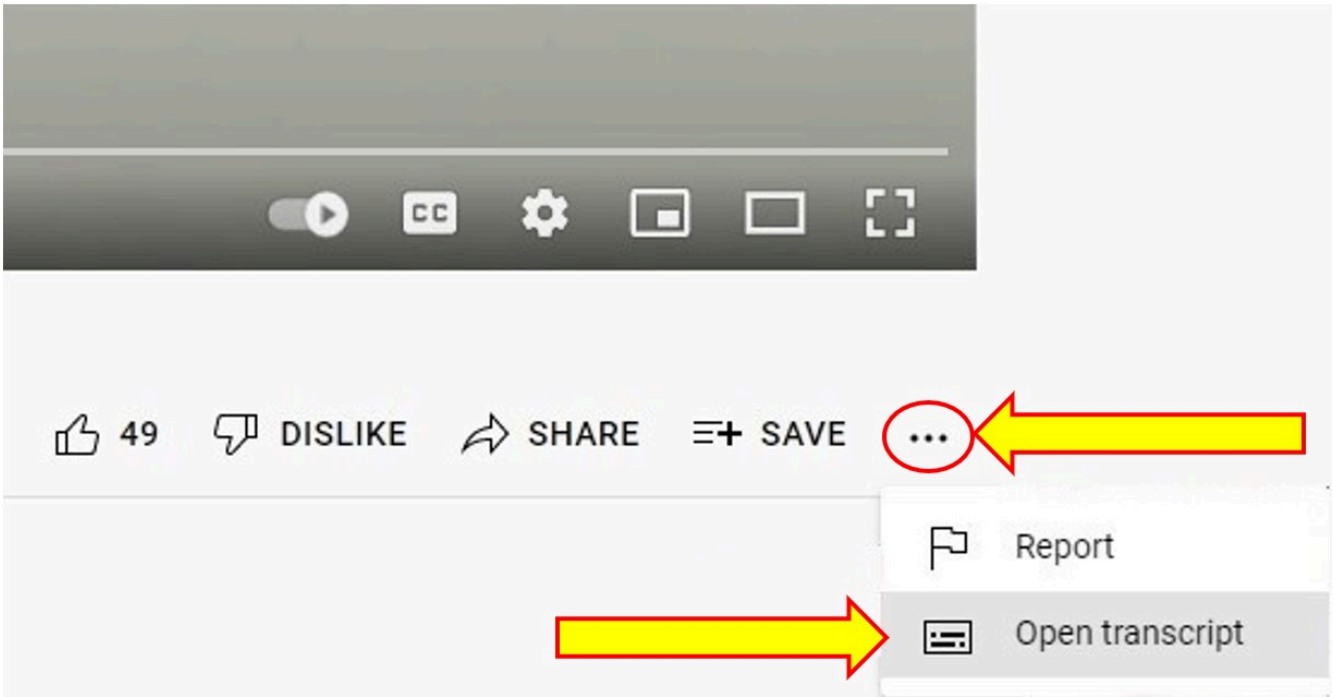

More Information: LGBT

- Building Competence, Building Capacity: 2SLGBTQ2+ Focused Trauma-Informed Care – CAMH
- Trauma Informed for LGBT Youth – Healthy Safe Children

Trauma-Informed with Youth

Trauma informed is a strengths based framework that emphasizes physical, psychological, and emotional safety for both providers and survivors. There are many agencies who work specifically in this community as well as through schools. It is important to have Services tailored for youth so that it is easier to start a conversation around the trauma they are encountering.

Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control.

Trauma-Informed with Seniors

McMaster University – Faculty of Health Sciences

Nearly two-thirds of middle-aged and older adults in Canada report adverse childhood experiences – March 15, 2021

Figure 3.5.2 – Photo by Artyom Kabajev on Unsplash

New research from McMaster University has found that roughly three in every five Canadian adults aged 45 to 85 have been exposed to childhood abuse, neglect, intimate partner violence or other household adversity. Many seniors were taught not to discuss these issues. Often we hear "in my culture" or "in my generation". Breaking the cycle of silence to be able to support, assist, work with these seniors takes time and the right program.

Examples – Seniors

- Nearly 2/3 of Middle Aged Adult & Older Adults have Childhood Trauma – McMaster University

Figure 3.5.3 – Photo by Karsten Winegeart on Unsplash

Respond to Gender differences in Experiences of Violence and Trauma with Women

When we talk about Feminist Therapy it is Trauma-informed. Women have been oppressed and have suffered much abuse through generations worldwide. Feminist thinkers have brought light on the diagnosis and treatment of posttraumatic experiences, trauma treatment implicitly embodies the many feminist paradigms.

A trauma-informed lens must be aware of the many types of oppressive experiences that have been long-standing and far-reaching consequences that can be perceived as traumatizing. We will look at social structures, including but not limited to violence and abuse, in conceptualizing, investigating and developing clinical interventions for women's mental health.

When both the individual and societal levels are looked at we can promote a more nuanced understanding of trauma-related challenges and interventions that would assist.

The areas we will cover will include:

- gender role socialization
- women's mental health
- gender role oppression
- women's well-being

When we're looking at being trauma-informed for Women there are still many different pieces that need to be in place. There are many different cultures that women are involved with, heritage, age, knowledge, awareness, and support to name just a few.

Accessibility, availability and diversity in this community is all a necessary component to deal with trauma informed.

For More Information

- Outcomes of Trauma-Informed Interventions for Incarcerated Women: A Review – SAGE Journal
- Trauma Informed Care for Indigenous Women – Ontario Women's Native Association
- Exposure to Trauma – Incarcerated women – Correctional Service Canada

Videos:

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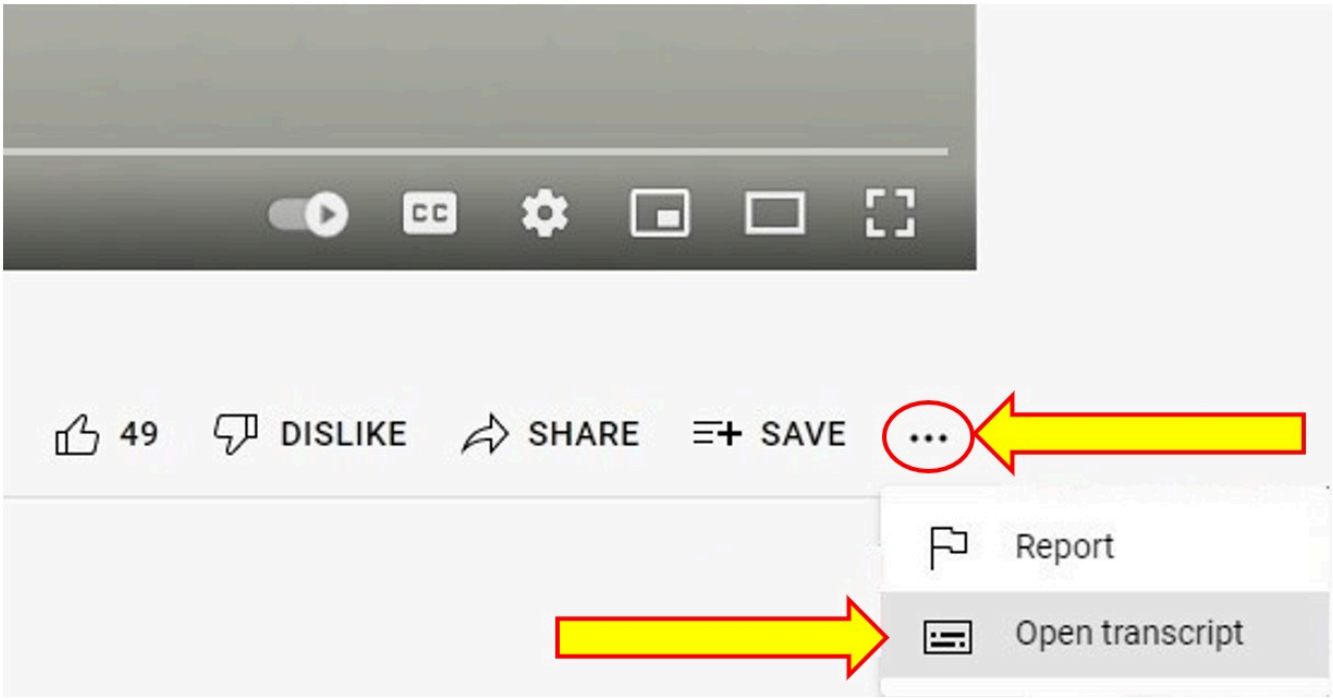

For More Information:

- PTSD – CAMH
- Gender Identity Clinic (Adult) – CAMH
- Trauma-informed Services for LGBTQ2S Communities – The 519
- Trauma and violence-informed approaches to policy and practice -Government of Canada
- Cultural Diversity and the Treatment of Trauma – University of Toronto
- History of Equity, Diversity, and Inclusion in Trauma Surgery: for Our Patients, for Our Profession, and for Ourselves
- The Traumatizing Impact of Racism in Canadians of Colour

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3.6 TRAUMA INFORMED OF CHILDHOOD TRAUMA

Figure 3.6.1 Photo by David Clarke on Unsplash

Trauma

Every traumatic experience is different, and each child's response depends on their coping skills and resources and on the context and circumstances in which the stressful event occurs. Whether a child develops a trauma reaction that increases in severity, becomes chronic, and is less responsive to intervention or has a reaction that is moderate, manageable, and time limited depends on several factors. These include the nature of the experience, the characteristics of the child, and the way the family, school, and community respond. For example, chronic or repetitive traumatic experiences, especially those perpetrated intentionally by a caregiver, are likely to result in a different set of symptoms than a single shocking traumatic event.

> Always be aware we are talking about being Trauma Informed, we are not Trauma Experts. In most agencies there is a specific person who works with those who have had Trauma or have a Professional the clients are referred to.

Determinants of Trauma Reactions

Trauma results from an event, series of events, or set circumstances that is experienced by individual as physically emotionally harmful life threatening and has lasting adverse effects on the individual's functioning mental, physical, social, emotional, spiritual wellbeing. The Substance Abuse and Mental Health Services Administration (SAMHSA) provide a useful 'The Three E' framework to understand how traumatic events impact on individuals (SAMHSA, 2013).

Events: The first 'E' of the framework refers to events – this is the circumstances surrounding the actual or extreme threat of physical or psychological harm (i.e., physical violence, natural disasters etc.) or severe, life threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time.

Experience: The individual's experience of these events or circumstances helps to determine whether it circumstances helps to determine whether it experienced as traumatic for one individual and not for another (e.g., a child removed from an abusive home experiences this differently than their sibling; one refugee may experience fleeing one's country differently from another refugee). How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic. Traumatic events by their very nature set up a power differential where one entity (whether an individual, an event or a force of nature) has power over another. They elicit a profound question of "why me?" The individual's experience of these events or circumstances is shaped in the context of this powerlessness and questioning.

Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. When someone experiences physical or sexual abuse, it is often accompanied by a sense of humiliation, which can lead the person to feel as though they are bad or dirty, leading to a sense of self-blame, shame and guilt. In cases of war or natural disasters, those who survived the traumatic event may blame themselves for surviving when others did not. Abuse by a trusted caregiver frequently gives rise to feelings of betrayal, shattering a person's trust and leaving them feeling alone. Often, abuse of children and domestic violence are accompanied by threats that lead to silencing and fear of reaching out for help. How the event is experienced may be linked to a range of factors, including the individual's cultural beliefs (e.g., the subjugation of women and the experience of domestic violence), availability of social supports (e.g., whether isolated or embedded in a supportive family or community structure) or to the developmental stage of the individual (i.e., an individual may understand and experience events differently at age five, 15 or 50).

Effects: The long-lasting adverse effects of the event are a critical component to trauma. These effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognize the connection between the traumatic events and the effects. Examples of adverse effects include an individual's inability to cope with normal stressors, and strains of daily living; to trust and benefit from relationships; to manage cognitive processes – such as memory, attention, thinking, to regulate behaviour; or to control the expression of emotions. In addition to these visible effects, there may be an altering of one's neurobiological make-up and ongoing health and wellbeing. Advances in neuroscience and an increased understanding of the interaction of neurobiological and environmental factors have documented the effects of such threatening events.

Traumatic effects, which may range from hyper-vigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down, physically, mentally and emotionally. Survivors of trauma also highlight the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences.

Child Development And Trauma Reactions

The following points give an essential perspective for using the information about childhood trauma and its impact on development across specific age groups:

- Children, even at birth, are not 'blank slates' – they are born with a certain neurological make- up and temperament. As children get older, these individual differences become greater as they are affected by their experiences and environment. This is particularly the case where the child is born either drug dependent or with fetal alcohol syndrome.
- Even young babies differ in temperament e.g., activity level, amount and intensity of crying, ability to adapt to changes, general mood, etc.
- From birth on, children play an active role in their own development and impact on others around them.
- Culture, family, home and community play an important role in children's development, as they impact on a child's experiences and opportunities. Cultural groups are likely to have particular values, priorities and practices in child rearing that will influence children's development and learning of particular skills and behaviours. The development of children from some cultural backgrounds will vary from traditional developmental norms, which usually reflect an Anglo-Western perspective.
- As children get older, it becomes increasingly difficult to list specific developmental milestones, as the achievement of many of these depends very much on the opportunities that the child has to practice them, and also, on the experiences available to the child. A child will not be able to ride a bicycle unless they have access to a bicycle.
- Development does not occur in a straight line or evenly. Development progresses in a sequential manner, although it is essential to note that while the path of development is somewhat predictable, there is variation in what is considered normal development. That is to say no two children develop in exactly the same way.
- The pace of development is more rapid in the early years than at any other time in life.
- Every area of development impacts on other areas. Developmental delays in one area will impact on the child's ability to consolidate skills and progress through to the next developmental stage.

Most experts now agree that both nature and nurture interact to influence almost every significant aspect of a child's development.

- General health affects development and behaviour. Minor illnesses will have short to medium term effects, while chronic health conditions can have long-term effects. Nutritional deficiencies will also have negative impacts on developmental progression. Specific characteristics and behaviours are indicative only. Many specific developmental characteristics should be seen as 'flags' of a child's behaviour, which may need to be looked at more closely, if a child is not meeting them. Teachers and education staff should refer to relevant specialist assessment guides in undertaking further assessments of child and family.

There has been an explosion of knowledge in regard to the detrimental impact of neglect and child abuse

trauma on the developing child, and particularly on the neurological development of infants. It is critical to have a good working knowledge of this growing evidence base so that we can be more helpful to families and child focused.

The following basic points are useful to keep in mind and to discuss with parents and young people:

- Children need stable, sensitive, loving, stimulating relationships and environments in order to reach their potential. They are particularly vulnerable to witnessing and experiencing violence, abuse and neglectful circumstances. Abuse and neglect at the hands of those who are meant to care is particularly distressing and harmful for infants, children and adolescents.
- Given that the infant's primary drive is towards attachment to a parent or caregiver, not safety, they will accommodate to the parenting style they experience. They have no choice given their age and vulnerability, and in more chronic and extreme circumstances, they will show a complex trauma response. They can eventually make meaning of their circumstances by believing that the abuse is their fault and that they are inherently bad.
- Infants, children and adults will adapt to frightening and overwhelming circumstances by the body's survival response, where the autonomic nervous system will become activated and switch on to the freeze/fight/flight response. Immediately the body is flooded with a biochemical response which includes adrenalin and cortisol, and the child feels agitated and hypervigilant. Infants may show a 'frozen watchfulness' and children and young people can dissociate and appear to be 'zoned out'.
- Prolonged exposure to these circumstances can lead to 'toxic stress' for a child which changes the child's brain development, sensitizes the child to further stress, leads to heightened activity levels and affects future learning and concentration. Most importantly, it impairs the child's ability to trust and relate to others. When children are traumatized, they find it very hard to regulate behaviour and soothe or calm themselves. They often attract the description of being 'hyperactive'.

Babies are particularly attuned to their primary carer and will sense their fear and traumatic stress. This is particularly the case where family violence is present. They will become unsettled and therefore more demanding of an already overwhelmed parent. The first task of any service is to support the non-offending parent and to engage the family in safety.

- Traumatic memories are stored differently in the brain compared to everyday memories. They are encoded in vivid images and sensations and lack a verbal narrative and context. As they are unprocessed and more primitive, they are likely to flood the child or adult when triggers like smells, sights, sounds or internal or external reminders present at a later stage.
- These flashbacks can be affective, i.e., intense feelings, that are often unspeakable; or cognitive, vivid memories or parts of memories, which seem to be actually occurring. Alcohol and drug abuse are the classic and usually most destructive attempts to numb out the pain and avoid these distressing and

intrusive experiences.

- Children are particularly vulnerable to flashbacks at quiet times or at bedtimes and will often avoid both, by acting out at school and bedtimes. They can experience severe sleep disruption and intrusive nightmares which add to their 'dysregulated' behaviour, and limits their capacity at school the next day. Adolescents will often stay up all night to avoid the nightmares and sleep in the safety of the daylight.

Now that we know about the impact of the risk factors and of childhood trauma we can begin thinking functionally about the needs of these students and begin by considering the factors depicted in the triangle, heart and speech bubble shapes in the figure below.

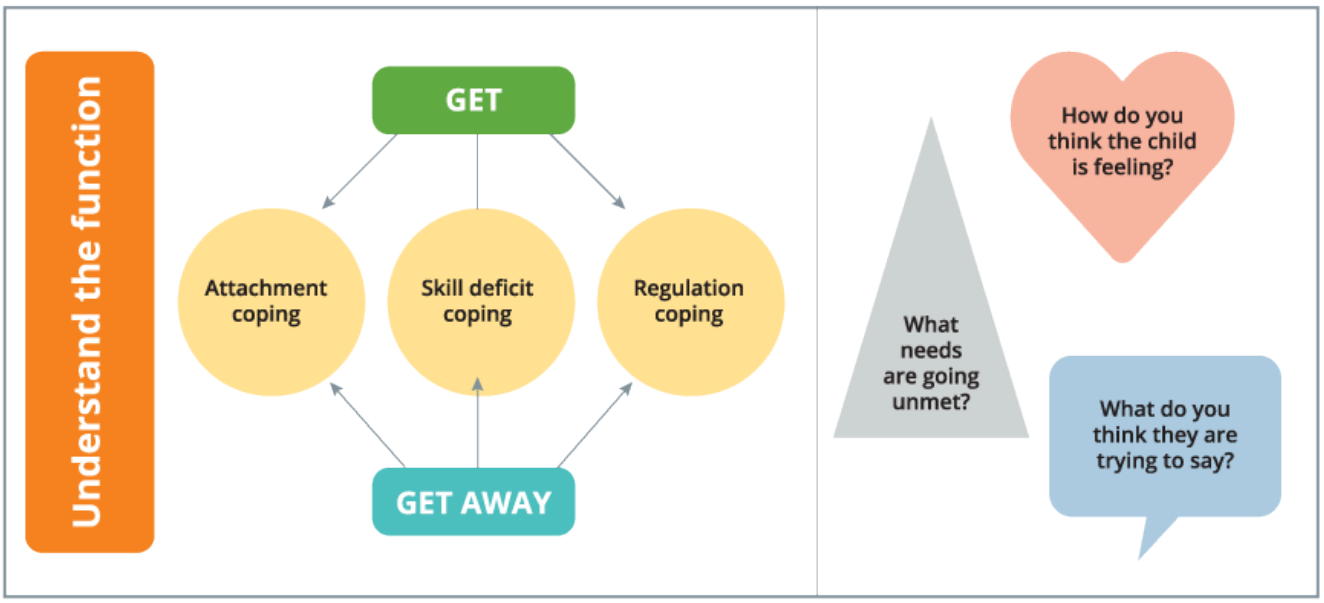

Figure 3.6.2 Understand the function by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

According to figure 3.6.2, the triangle represents the pyramid of needs (see Snowman et al., 2009 for Maslow's hierarchy of needs) starting with physiological needs, such as adequate food, hydration, clothing and physical health care. Examples of how this can be supported in the school environment include rest times, snack times built into learning time, water bottles on desks and available at all times throughout the day, and breakfast clubs.The heart represents the feelings of grief linked to the losses in the child's life that may impact their academic and social functioning at school. These losses may include the death of loved ones, separation from family and friends, and traumatic grief linked to experiences of abuse. Understanding these losses and their impact on the student can inform our expectations of the student's functioning, the management of the classroom and school environment to minimise triggers and the support for the student to build trusting relationships that can help them with these complex and painful feelings.The speech bubble shape represents the student's behaviour as communicating unmet needs and unprocessed feelings. The deprivation and abuse experienced by these children often leaves them with deficits in their skills to seek out appropriate support. Due to this, the child's misbehaviour may come across as deliberately defiant and oppositional, when in fact, it may the result of their inability to appropriately communicate the challenges that they are facing. It is then,

the job of the educators to understand the context of the child – both in and out of the school environment – to interpret the function and meaning of the misbehaviours and disengagement.

Childhood Adversity and Maltreatment

Child maltreatment refers to any non-accidental behaviour by parents, caregivers, other adults or older adolescents that are outside the norms of conduct and entail a substantial risk of causing physical or emotional harm to a child or young person. Such behaviours may be intentional or unintentional and can include acts of omission (i.e., neglect) and commission (i.e., abuse) (Bromfield, 2005; Christoffel et al., 1992). Child maltreatment is commonly divided into five main subtypes:

- physical abuse
- emotional maltreatment
- neglect
- sexual abuse and
- exposure to family violence

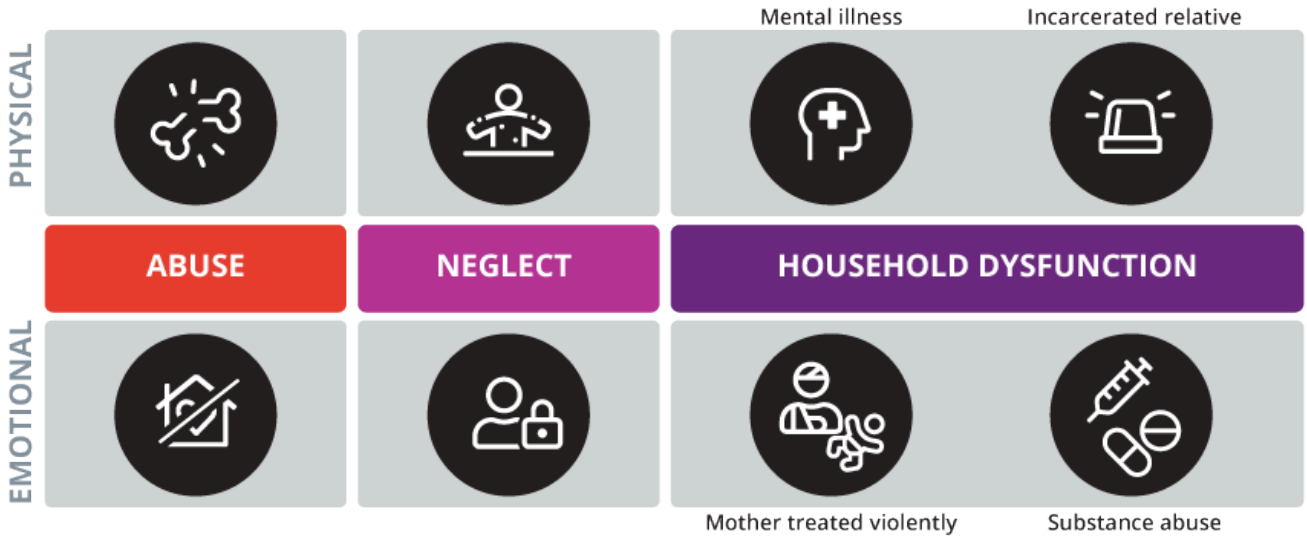

Figure 3.6.3 Childhood maltreatment sub-types

Watch the following video to understand some key statistics about children who have been maltreated. Please note that the clip contains themes and images that may be distressing to some. Please feel free to stop watching the video if you are distressed.

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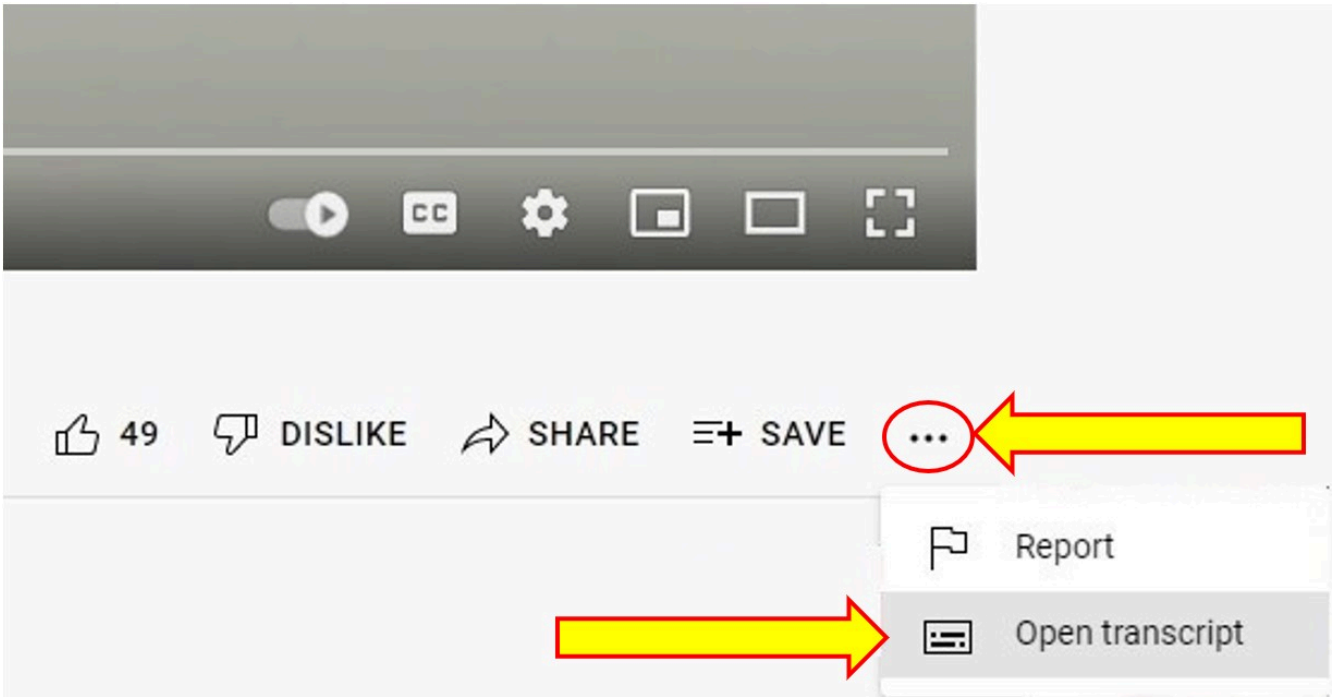

For More Information

- Childhood Trauma Toolkit – CAMH
- Childhood Trauma Toolkit Videos – CAMH

Key Term Study Guide – Trauma Informed of Childhood Trauma (a number of complex issues need to be considered when trying to define a form of maltreatment)

- Bronfenbrenner's Ecological Theory of Development
- Child Development and Trauma
- Childhood Adversity & Maltreatment
- Determinants of Trauma Reaction
- Etiology of Childhood Adversity and Maltreatment
- Three E Framework: **E**vents, **E**xperience & **E**ffects
- A number of complex issues need to be considered when trying to define a form of maltreatment. For example:
    - physical abuse
    - emotional maltreatment
    - Neglect
    - Sexual Abuse
    - Exposure to Family Violence
    - Other Forms of Child Maltreatment include: fetal abuse, bullying or peer abuse, sibling abuse, exposure to community violence, and organized exploitation

We Can Prevent Adverse Childhood Experiences (ACEs)

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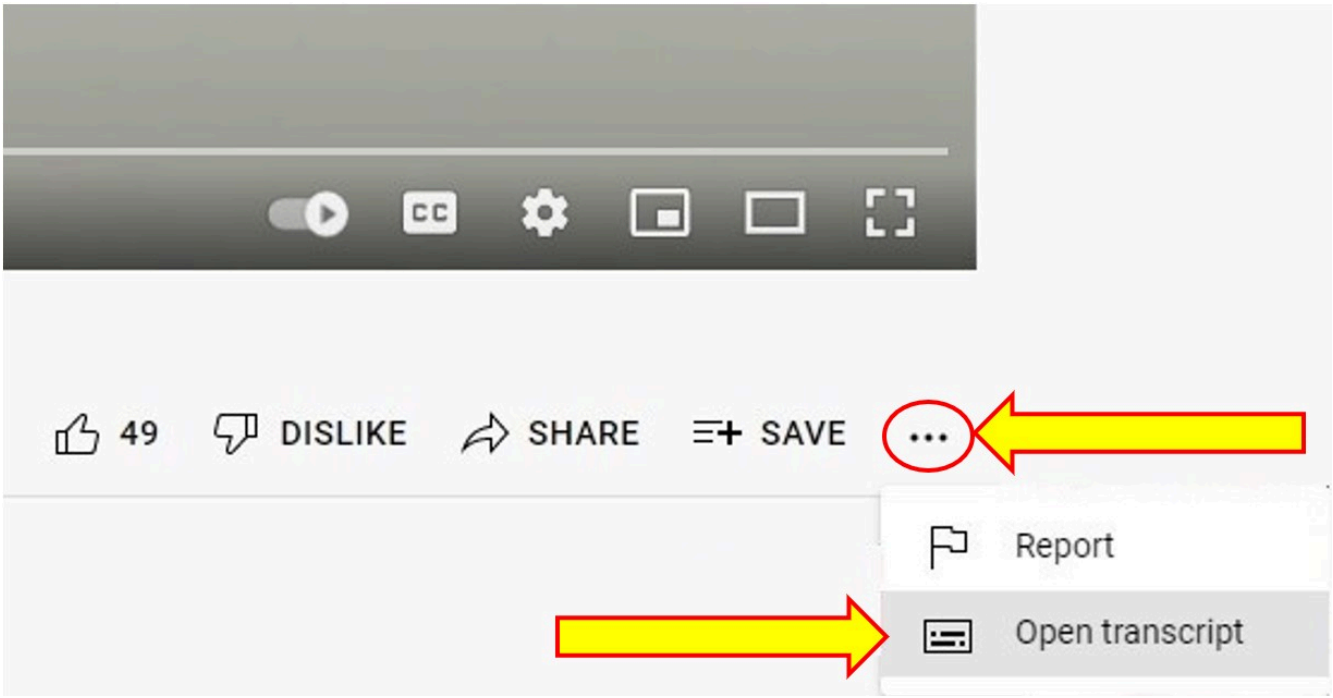

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Pictures:

- Figure: 3.6.1 – Unsplash License
- Figure: 3.6.2 – Understand the function by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA. Ayre, K., & Krishnamoorthy, G. (2020, November 25). *Trauma Informed Behaviour Support: A Practical Guide to Developing Resilient Learners – UniSQ Open Textbooks*. Pressbooks. Retrieved December 2, 2022, from https://usq.pressbooks.pub/traumainformedpractice/
- Figure 3.6.3 – Childhood maltreatment sub-types (Bromfield, L.M -2005) Ayre, K., & Krishnamoorthy, G. (2020, November 25). *Trauma Informed Behaviour Support: A Practical Guide to Developing Resilient Learners – UniSQ Open Textbooks*. Pressbooks. Retrieved December 2, 2022, from https://usq.pressbooks.pub/traumainformedpractice/

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3.7 TRAUMA INFORMED PRACTICE FOR INDIGENOUS PEOPLES

Figure 3.7.1 Photo by Galen Crout on Unsplash

Important to Increase Awareness about Trauma Informed Practice for Indigenous People

8th Fire Wab Kinew – 500 Years in 2 minutes

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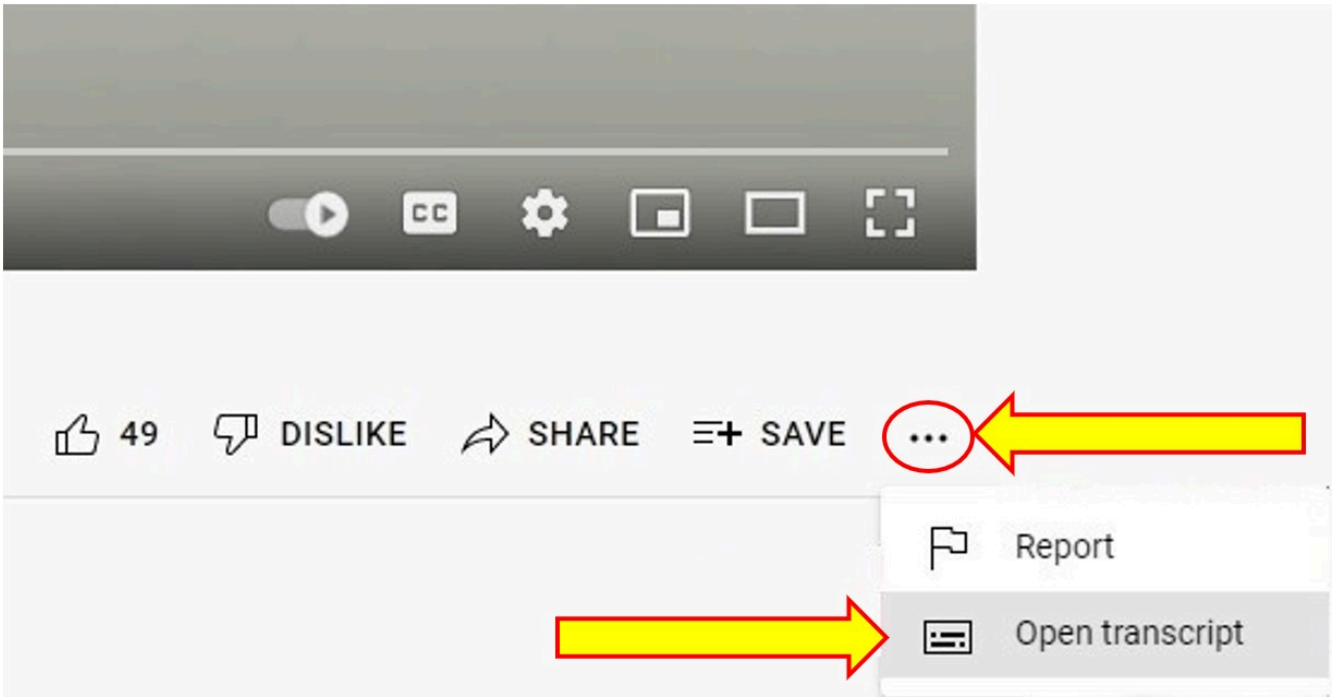

Wabanakwut "Wab" Kinew (/wɑːb kɪˈnuː/; born December 31, 1981), is the Leader of the Manitoba New Democratic Party and Leader of the Opposition in the Legislative Assembly of Manitoba.

July 15, 2021 Wab Kinew challenges new Indigenous Minister's defence of residential schools

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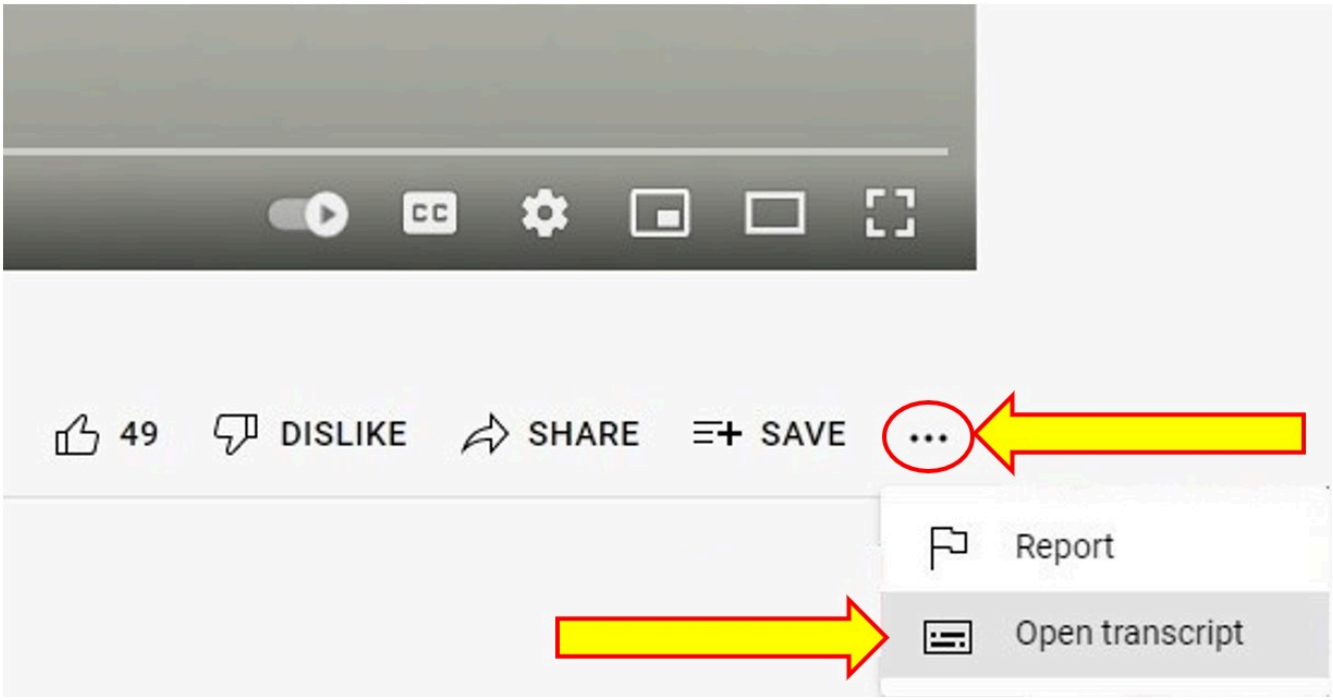

Why is the Past Important

It is important to have awareness of the negative impact of psychological trauma on a person's health and wellbeing. Understanding the journey that belongs to the Indigenous person/people/community we are working with, and what that journey was for them. Colonialism is defined as "control by one power over a dependent area or people." (Merriam Webster).

Historical or intergenerational trauma occurs when trauma caused by historical oppression is passed down through generations. For more than 100 years, the Canadian government supported residential school

programs that isolated Indigenous children from their families and communities (*see* Residential Schools in Canada).

This impacts parenting skills, experience, families, culture, communities, experiences, education and relationships to just name a few.

Indian Residential School System

> The Whole part of the residential school was a part of a bigger scheme of colonization. There was intent; the schools were there with the intent to change people, to make them like others and to make them not it. And today, you know, we have to learn to decolonize. Shirley Flowers (quoted in TRC, 2015)

Understanding Intergenerational Trauma

Intergenerational Trauma: Residential Schools

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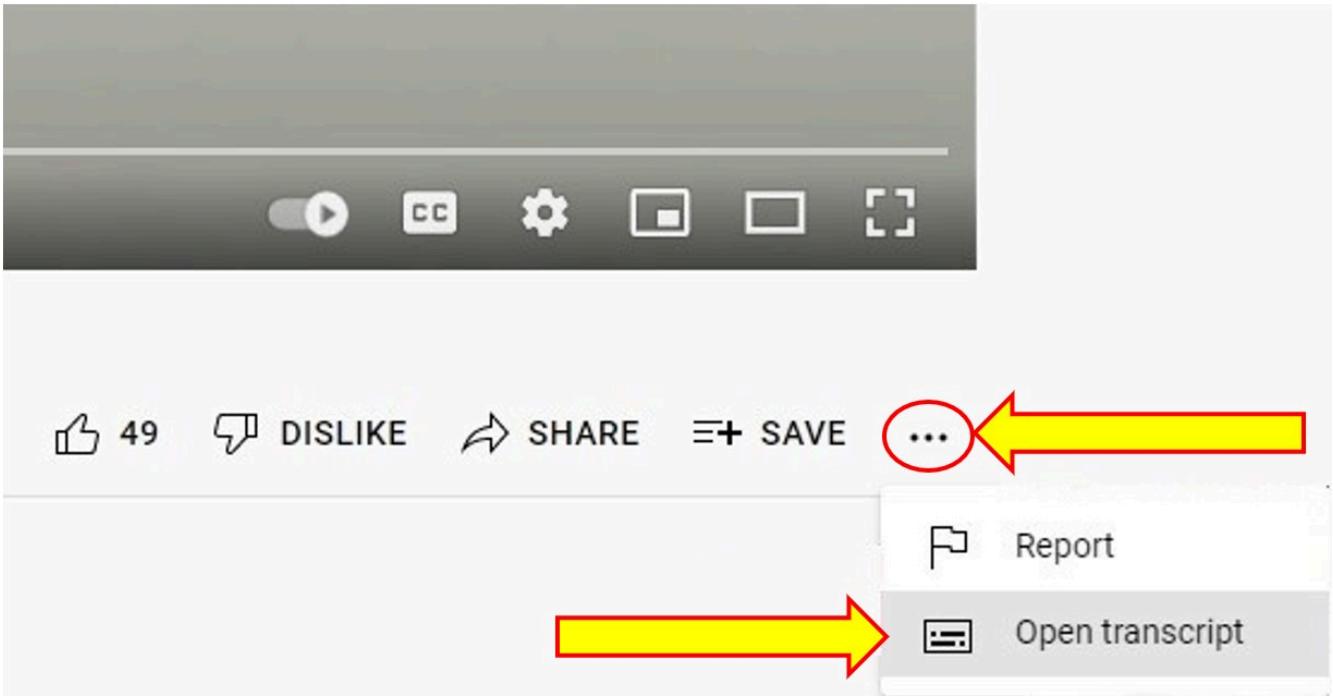

Intergenerational trauma may begin with a traumatic event affecting an individual, traumatic events affecting multiple family members, or collective trauma affecting larger community, cultural, racial, ethnic, or other groups/populations (historical trauma). Intergenerational trauma (sometimes referred to as trans – or multigenerational trauma) is passed down from those who have the experience and the generations that follow them. It affects individuals, parents, elders, children, community, family members, cultural, racial, ethnic and more. (https://www.goodtherapy.org/blog/Understanding_Intergenerational_Trauma)

Figure 3.7.2 Photo by Manny Becerra on Unsplash

Indigenous Health Care Practitioners

Indigenous health care practitioners are an important component for the Indigenous community. These practitioners are both culturally and clinically competent, meaning that they understand, communicate and articulate the Indigenous healing methods that are the most therapeutic strategies to Indigenous Communities. They also have sufficient Western education to be able to dialogue with Indigenous

Communities on many different levels including psychiatry which allows them to have an understanding of wholistic health and their philosophies towards mental health. (Decolonizing Trauma Work)

This assists with recognizing the many layers of Intergenerational trauma that has occurred in this community. They are trained and understand the meanings, purpose, ceremonies, culture and most importantly trauma and how it affects them on so many different levels.

Stolen Children

Stolen Children / Residential Students Speak Out – CBC (Residential School Survivors share their stories)

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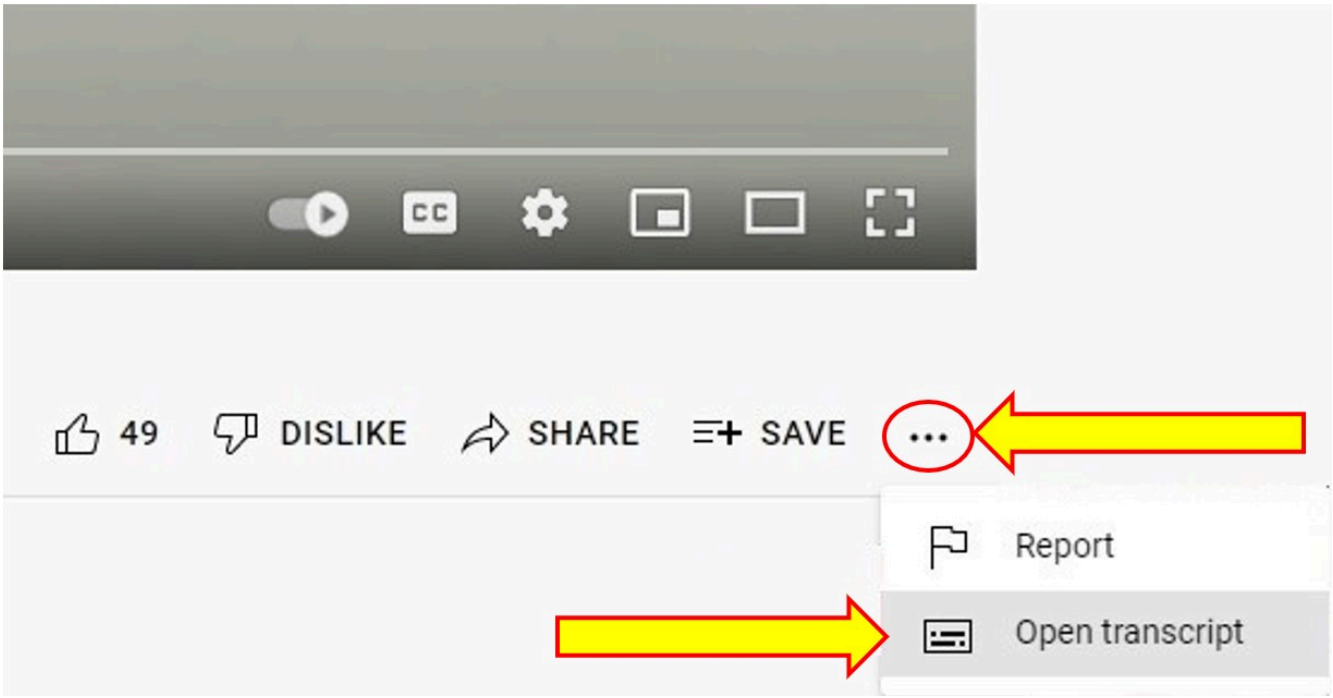

Indigenous Strategies for Helping and Healing

Wholistic health is important in the Indigenous Communities, the philosophies are derived from traditional Indigenous perspectives. It is important to understand what wellness means in the Indigenous Communities. This understanding includes: balance and harmony (understanding the connection between good health, balance and harmony), Being in Creation (a strong relationship with Creation), care and compassion (that a person has for his/herself and their community) and the challenge Indigenous communities contend with in the pursuit of wellness (kindness and respect for others in their community/world).

There are specific Indigenous Strategies for Helping and Healing for individuals, families and communities. These include: helping with trauma, prayer, Spiritual Connection, Love, Relationships, Cultural and Ceremonial Resources, Cultural Assessment, Cultural Identity and Decolonization, Assistance with Depression, Cultural specific approaches, Help with parallel and multiple realities (replace the psychiatric classification of psychoses and psychotic episodes), experiencing Spirit, being open to a different reality (keeping an open mind), and connections with family and community.

Truth and Reconciliation

Truth and Reconciliation has had a long journey to be heard. We are more aware but still have so far to go. It will take many generations.

The NCTR (National Centre for Truth and Reconciliation) is a place of learning and dialogue where the truths of the residential school experience will be honoured and kept safe for future generations. It was created

as part of the mandate of the Truth and Reconciliation Commission of Canada (TRC). The TRC was charged to listen to Survivors, their families, communities and others affected by the residential school system and educate Canadians about their experiences. The resulting collection of statements, documents and other materials now forms the sacred heart of the NCTR.

Wab Kinew – Understanding Reconciliations: Mere co-existence, New Foundation, or Mutual Celebration?

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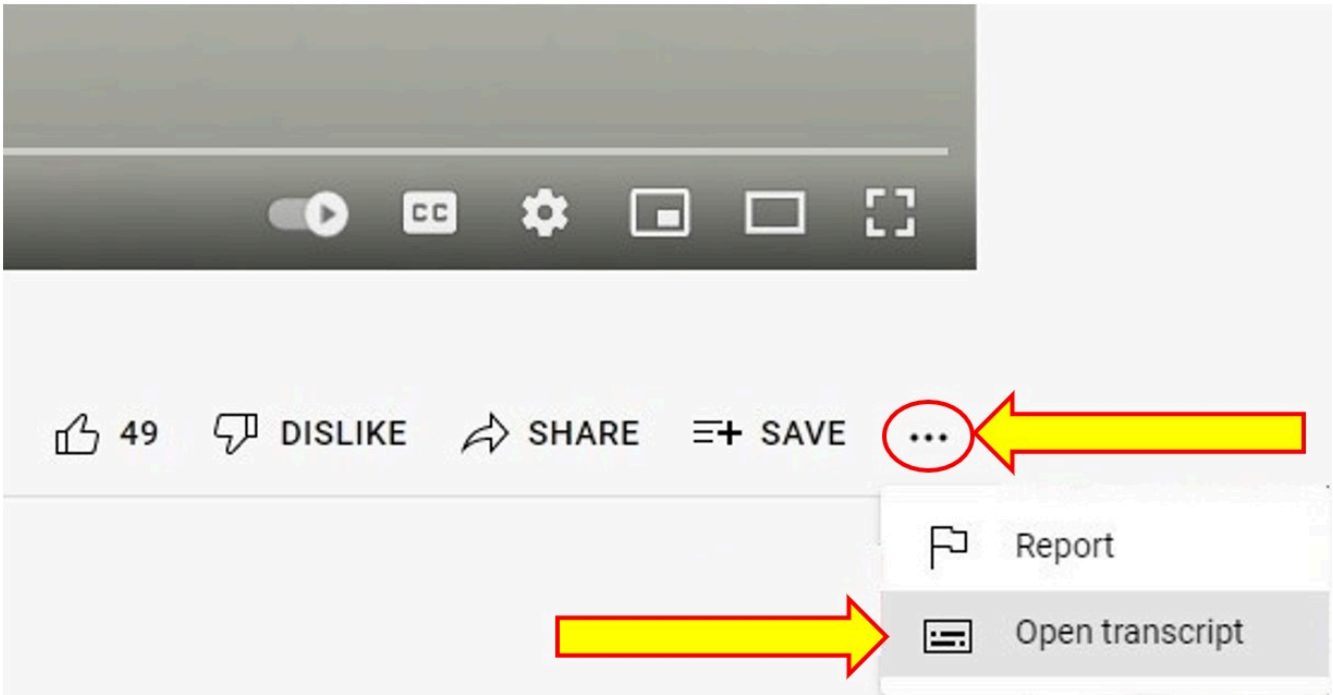

It's not just a part of who we are as Survivors – it's a part of who we are as a nation.

– *The Honourable Murray Sinclair*

Activities

- What did you learn about Intergenerational Trauma?
- Why do you think it's important to consider the impact of Intergenerational Trauma when working with the Indigenous Community?
- What steps do we need to take to be more supportive?

The importance of Indigenous Education & Services

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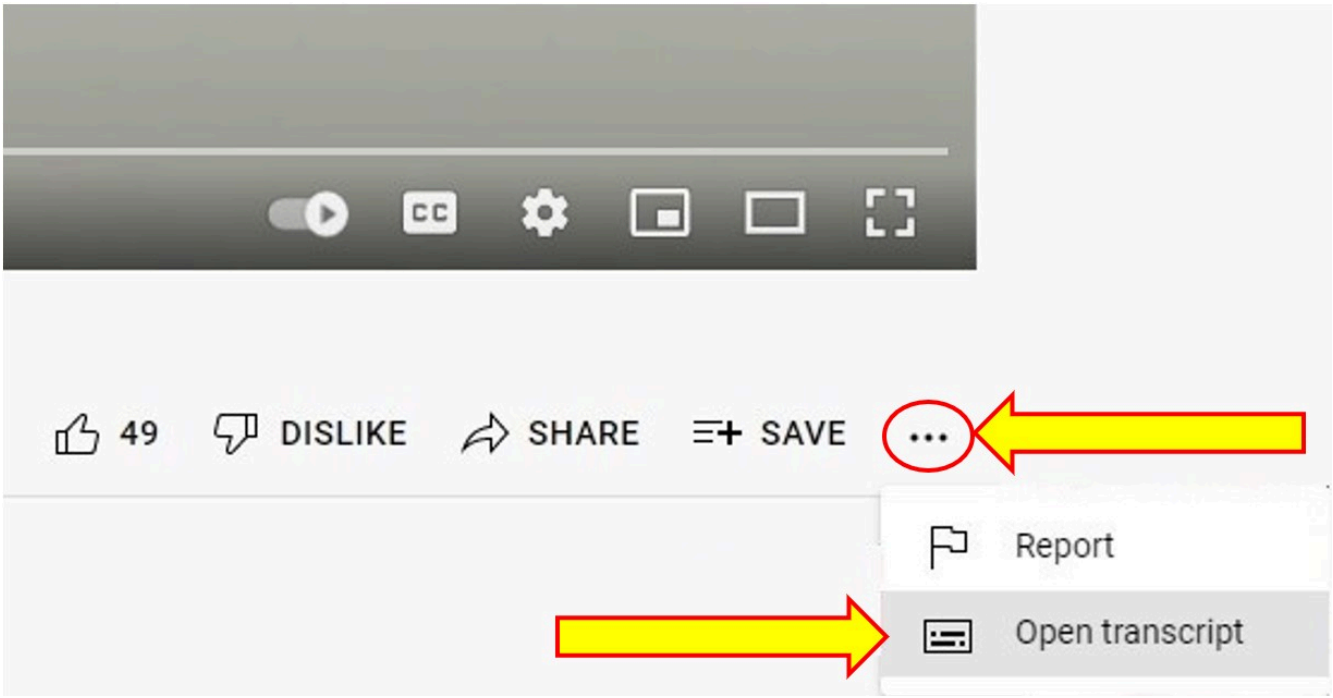

Introducing the Red Fish Healing Centre for Mental Health and Addiction

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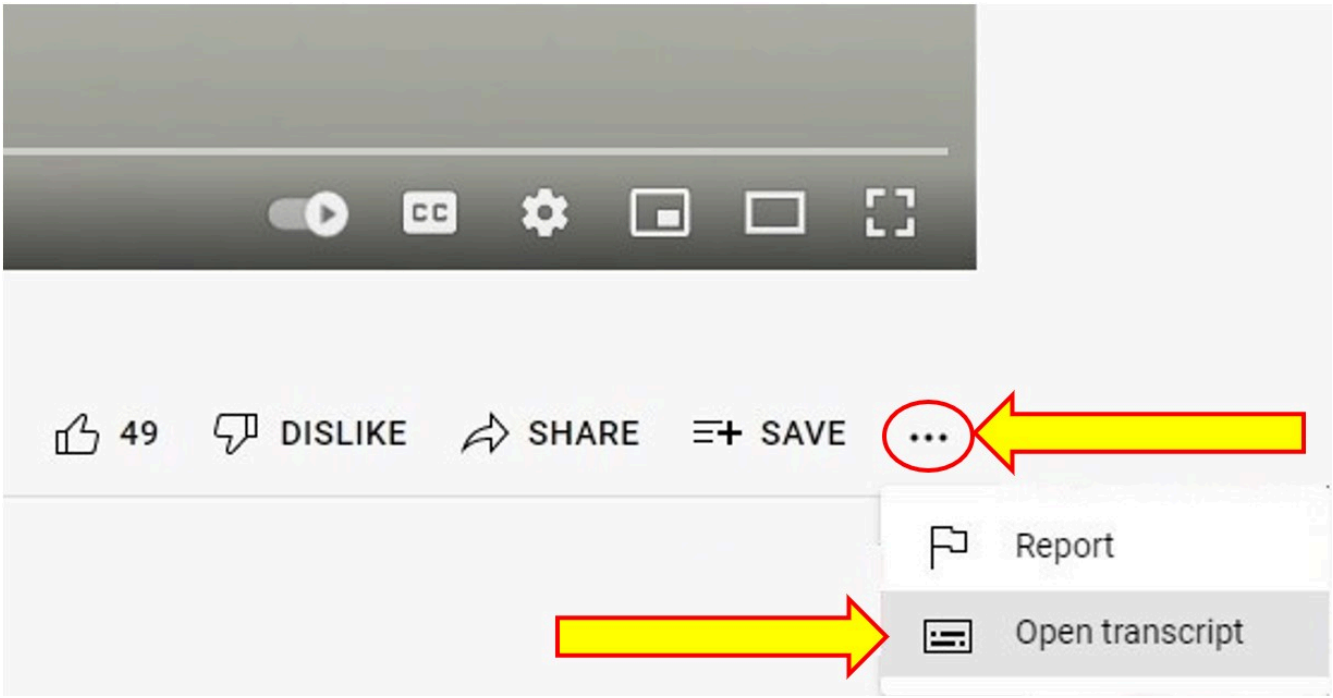

Explore Further (Books and Articles)

- Our Stories – First peoples in Canada – Centennial College
- Dedication – Our Indigenous etextbook is dedicated to the memory of Reva Jewell – Clan Mother/advocate/social innovator/service provider of the Haudenosaunee.
- Indian Residential Schools System – Our Stories
- Lost Generations
- CBC News Interactive – Stolen Children
- Healing Families, Helping Systems: A Trauma-Informed Practice Guide for Working with Children, Youth and Families
- San'yas Indigenous Cultural Safety Training (Anti-Racism Indigenous Cultural Safety Training Program)
- Red Fish Healing Centre for Mental Health and Addiction
- Decolonizing Trauma Work (Indigenous Stories and Strategies)

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3.8 TRAUMA INFORMED FOR INCARCERATED

Figure 3.8.1 Photo by Devon Wilson on Unsplash

When we look at Trauma Informed for Incarcerated we need to be aware that this is the only initiative designed to challenge the culture of the justice system and the prison service. The goal/aim of this is about improving the support for prisoners and staff. There are many layers of standard practices (searches, seclusion, restraint) that create trauma or re-traumatize many.

Trauma-informed care in prisons does require looking at many changes such as organizational policies and practices and they pose a serious threat to an individual and can re-traumatize or trigger traumatic memories.

We've all got a big story "Experiences of a trauma informed intervention in prison"

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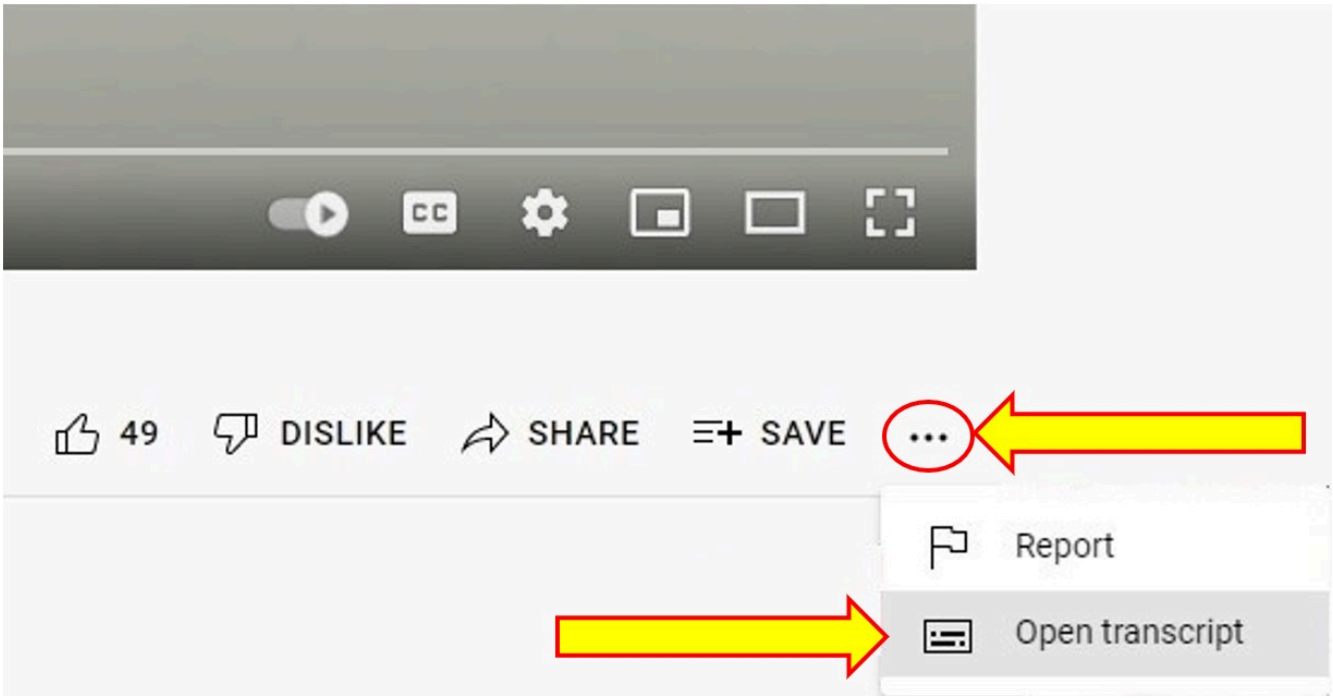

For more information:

- Trauma Informed Work with people with contact with the criminal justice system
- An Experimental Study of the Effectiveness of a Trauma- Specific Intervention for Incarcerated Men
- MENTAL HEALTH AND CRIMINAL JUSTICE POLICY – CAMH
- Canada's State of the Criminal Justice System – Government of Canada
- The Safe Return of Offenders to the Community Statistical Overview April 2005
- Outcomes of Trauma-Informed Interventions for Incarcerated Women: A Review

Drug Treatment Court – CAMH

Figure 3.8.2 – Photo by Tingey Injury Law Firm on Unsplash

An intervention model combining drug addiction treatment with supervision of a "problem-solving" court, as an alternative to incarceration for individuals facing charges from non-violent criminal activities related to substance abuse.

This program is meant for individuals facing charges from substance abuse related non-violent criminal activities. Those who are interested can self-refer (voluntary) through their lawyer and/or duty counsel. The DTC Crown attorney screens all applicants for eligibility.

Program is a structured outpatient program offering programs such as: random urine screens, frequent court appears, thorough assessments, extensive case management services and addressing social determinants of health and social reintegration. Program lasts minimum 1 year, upon successful completion of the program will receive a non-custodial sentence, rather than incarceration.

The DTC is a partnership between CAMH, the Ontario Court of Justice, the Ministry of the Attorney General and many community agencies.

There are many DTC across Canada.

For more information on Drug Treatment Court:

- CAMH Drug Treatment Court Services
- Beyond recidivism: changes in health and social service involvement following exposure to drug treatment court
- Steps to Justice – how to Participate in Drug Treatment Court
- Drug Treatment Court – CCSA / CCLAT
- Drug Treatment Court – Man missing who was active in Program
- Drug Treatment Court of Vancouver (BC)
- Calgary Drug Treatment Court
- Drug Treatment Court – Newfoundland & Labrador
- Drug Treatment Court – Saskatchewan
- Drug Treatment Courts – United Nations Office of Drug & Crime
- Drug Treatment Courts – Canadian Bar Association – Alberta – Supports
- CBC – Alberta man says 'drug treatment court' pulled him out of life of addiction and crime
- Mr. Justice Kofi Barnes – People, Places and Things: Inspirational Voices from Canada's Drug Treatment Courts (Book)

Gladue Court (Indigenous People's Court)

Figure 3.8.3 Hazelton Reserve (BC) Gitanmaxx Band – First Nations – by Denise Halsey

A Gladue report is **a written document that weaves together your story with information from interviews with family, Elders, and community members**. It can also include relevant documentation to support the judge in making an appropriate decision.Gladue Court is a special court for people charged with a crime and who self-identify as Indigenous, Métis, First Nations, or Inuit. Gladue Court is also called Indigenous Peoples Court.

Gladue Courts deal with all criminal offences. Usually they only handle bail hearings and sentencing hearings. Gladue Courts don't handle trials or preliminary hearings.

Gladue Courts are Canadian courts that apply Canadian law. They often try to incorporate Indigenous

cultural practices and understandings of justice. For example, a Gladue Court might start with a smudging ceremony or have Elders or Knowledge Keepers start with a song or prayer.

Some courthouses have only one day or a few days that Gladue Court is available each week. But **every** court must apply the Gladue principles even if it's not a Gladue Court.

Gladue principles

Even if you're not in a Gladue Court, the Gladue principles apply.

Gladue principles require all courts to take into account:

- your Indigenous background, and
- the impact and history of discrimination against Indigenous people by Canada and the criminal justice system, also called systemic discrimination.

This means at sentencing hearings, all alternatives to jail must be considered before a jail sentence is given. Jail is a last resort. And when a jail sentence is given, the court must apply Gladue principles to the length of the sentence.

And in Ontario, at bail hearings, all types of releases must be considered. Detention, or holding an accused without bail, is a last resort.

With your permission, your lawyer will tell the court about your Indigenous identity. Your background information is sometimes called Gladue factors. Your lawyer must also make arguments, called Gladue submissions, based on how the Gladue principles apply to your case.

Courthouses might have different practices in their Gladue Court. Speak to your lawyer, duty counsel, or an Indigenous court worker to find out more.

Participants from eight jurisdictions (Alberta, British Columbia, Nova Scotia, Nunavut, Ontario, Saskatchewan, Yukon, and Northwest Territories) stated that there was at least one specialized court for Aboriginal accused/offenders in their jurisdiction that satisfies the criteria established by the researchers.

Gladue Practices in the Provinces and Territories – Including names of the courts cited by the participants and their locations

For More Information on Gladue Courts

- A court of our own – More on the Gladue Courts
- Gladue Principals – Legal Aid BC
- Gladue Principles: Indigenous Peoples and the Canadian Criminal Justice System – Wilfred Laurier University
- Aboriginal Courts in Canada – The SCOW Institute
- What is Gladue – Native Women's Association of Canada (NWAC)

Elizabeth Fry Society

Figure 3.8.4 – Photo by Vonecia Carswell on Unsplash

Operates **regionally in communities throughout Canada and nationally** through the Canadian Association of Elizabeth Fry Societies. Each regional society is self-governing. Twenty-four affiliate societies exist in cities across Canada. They assist some of the most vulnerable populations – women, girls and children at risk, involved in or affected by the Justice System. The goal is through advocating, education and support to break the cycle of poverty, addiction, mental illness, homelessness and crime.

For more information: Elizabeth Fry Society – Canada

John Howard Society

Figure 3.8.5 – Photo by Nicholas Green on Unsplash

Operates **regionally in communities throughout Canada and nationally.** Currently there are branches and offices in over 60 communities across Canada, provincial offices in all 10 provinces and the Northwest Territories and a national office in Kingston.

Effective, just and humane responses to the causes and consequences of crime.

- works with people who have come into conflict with the law,
- reviews, evaluates and advocates for changes in the criminal justice process,
- engages in public education on matters relating to criminal law and its application
- promotes crime prevention through community and social development activities.

For more information: John Howard Society – Canada

New Initiatives

Incarcerated – Corrections Canada – Education

All Federal and Provincial Institutions offer High School Education. Each Institution runs their education system. Some offer college courses.

Grand Valley Institute for Women – is unique when it comes to post-secondary education in Canada. There are currently about 125 federally-incarcerated post-secondary students in all of Canada and 25 of those are at GVI. Typically they have 20-25% of the post-secondary students in Canada, even though they only have about 1% of the overall offender population. They offer the most substantial program. GVI's offerings should not be seen as "typical" for incarcerated people but more of a "best practices" situation (based on current funding/technological limitations).

They offer a few print-based correspondent program and University of Ottawa offers correspondence courses through a print/video hybrid model.

"Walls to Bridges (W2B) is an innovative educational program that brings together incarcerated ("Inside") and non-incarcerated ("Outside") students to study post-secondary courses in jails and prisons across Canada. The National Hub for the program is based out of the Lyle S. Hallman Faculty of Social Work, in partnership with **Grand Valley Institution for Women in Kitchener.**

Centennial College for the last 2 years in partnership with **Grand Valley Institution for Women** has been using an innovative educational program that brings the classroom into GVI by Internet, to work with the incarcerated students to do the Addictions Work Certificate program (5 courses). Many of the women when discharged have continued with the Addictions Work Continuing Education mainstream and completed the certificate course. There have been 15+ graduates complete the Certificate.

Amadeusz work with young people who are incarcerated to create positive change in their lives through access to education, community programs and supports, mentorship and exceptional care. They have 10+ incarcerated students that they work with Centennial College through print-based programs as well when they are no longer incarcerated. These students are in Vanier, Toronto South and Toronto East facilities.

A Canadian Prisoner's Perspective

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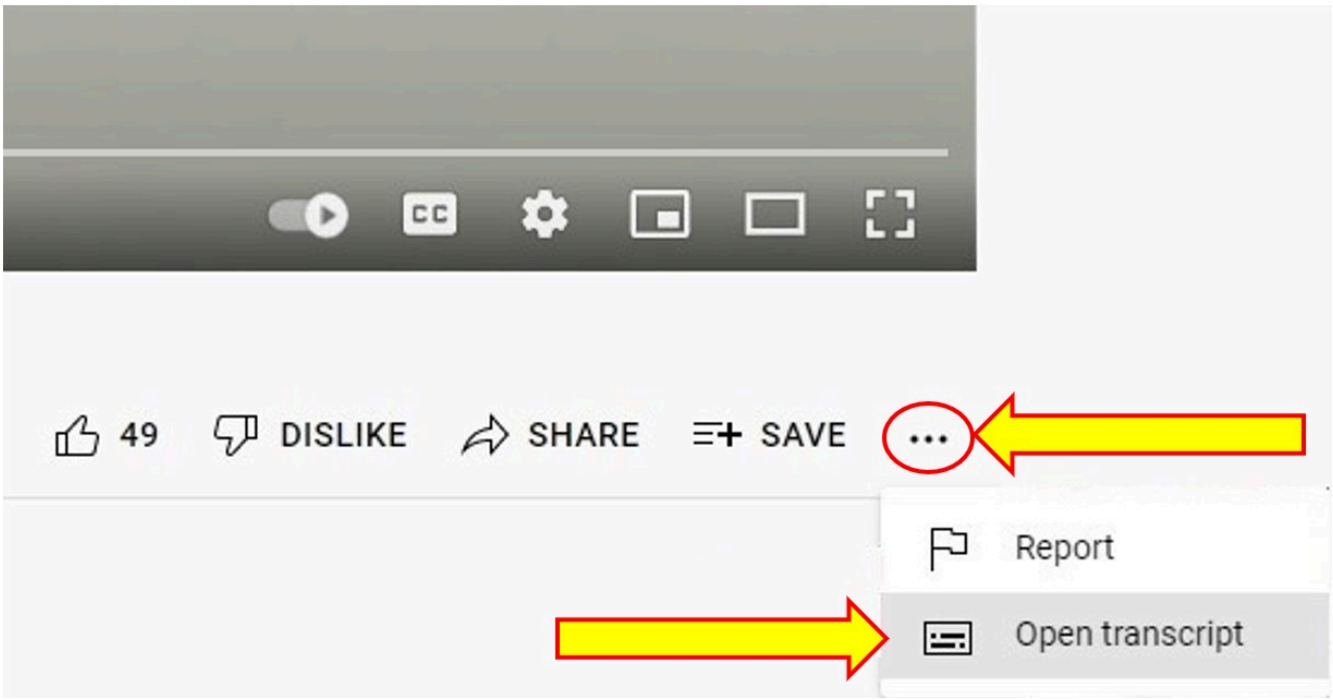

Food for thought

New Initiatives – Many programs over the last 3 years, during the ***Covid pandemic*** have gone through many changes. Some have expanded, some have closed, some have evolved into something new and some new ones were created in mainstream, but what about those who are incarcerated. Programs have had to look at meeting the changes and delivery of those services, but for those incarcerated it wasn't that simple.

Reflect on these questions for those who are incarcerated:

1. Reflect for a moment on how these COVID impacted those who are incarcerated?
2. What is the value/importance of expanding, evolving or creating changes for those who are incarcerated?
3. Can you think of any programs that you know of that are offered those who are incarcerated?
4. How could you help others understand the changes those who are incarcerated?
5. What training is involved in updating skills as a service provider who work with those who are incarcerated?

Gaps in the System

Figure 3.8.6 – Photo by Kristopher Roller on Unsplash

Food for Thought

Gaps in the System – there are many services that are needed and can't be found. Reflect on these questions. There have many changes over the last 3 years during the ***Covid pandemic.*** This has created a lot of changes. Some have expanded, some have closed, some have evolved into something new and some new ones were created. All programs have had to look at meeting the changes and delivery of those services.

Pieces to be aware of:

- Accessibility is **the practice of making your programs, websites, support, activities usable by as many people as possible**. It is not just about people with disabilities, but the practice of making programs accessible to everyone, online, in person, using mobile devices, or those with slow network connections or no network connections
- Stigma – **Refers to the discrediting, devaluing, and shaming of a person because of characteristics or attributes they possess which leads to reluctance to seek help or treatment**. – stigma leads to negative social experiences such as isolation, rejection, marginalization, and discrimination. Can affect individuals, families and communities. It can be influenced by cultural and contextual value systems that differ over time and across contexts.
- language – **is it offered in many languages.** Three types of languages are written, oral and nonverbal.
- culture awareness – **able to support cultural awareness –** being aware the cultural awareness is **the understanding that our own culture differs from one individual and group to the next, and specifically from our target language**. Understanding this enables us to communicate more effectively, beyond words and grammar, by understanding their culture.

Our awareness of these GAPS can make the difference between communicating and not communicating.

Street Voices

A social enterprise and media platform with an online directory that provides access to free and subsidized services in the Greater Toronto Area.

The organization was initially established as a magazine in 2014 to empower street-involved and at-risk youth. Over the past six years, the magazine has broadened into a digital media platform that publishes journalistic articles, podcasts, and visuals.

In November 2021, Street Voices expanded from a media platform to include a directory that offers a variety of programs and services throughout the GTA. The website also provides aggregated news of the trending stories.

Ultimately, our aim is to empower marginalized voices, no matter who they are. As we continue to increase our reach as a platform, we hope to expand the directory Canada-wide while telling the stories of our communities.

Amadeusz

Amadeusz offers a variety of programs and supports with a focus on education, community support, research and case management.

The Amadeusz education program supports young people aged 18 to 35 in working towards their educational goals. The goal of this program is to provide young people who are incarcerated with the opportunity, resources, and support to complete their high school education and to explore, prepare for, and attend post-secondary schooling.

For more information on agencies

- Amadeusz – supports young people who are incarcerated to create positive change in their lives through education, community programs and supports
- Oasis – Addiction Recovery and Employment Services
- Street Voices – is a social enterprise and media platform with an online directory that provides access to free and subsidized services to empower street-involved and at-risk youth

Food for thought

New Initiatives – Many programs over the last 3 years, during the ***Covid pandemic*** have gone through many changes. Some have expanded, some have closed, some have evolved into something new and some new ones were created. All programs have had to look at meeting the changes and delivery of those services.

Reflect on these changes:

1. Reflect for a moment on how these changes impacted the community you work with?
2. What is the value of expanding, evolving or creating changes to agencies?
3. Can you think of any programs that you know of that have expanded, evolved, changed or closed?
4. What are some examples?
5. How could you help others understand the changes?
6. What training is involved in updating skills as a service provider?Gaps in the System

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3.9 INTEGRATED SCREENING, ASSESSMENT AND TRAINING IN TRAUMA INFORMED CARE

Figure 3.9.1 Photo by Külli Kittus on Unsplash

All service agencies need to begin by screening everyone who enters their programs for trauma histories, as well as for substance use and mental health issues. This screening needs to be brief and non-threatening, with a sensitive, trauma-informed and culturally competent process.

When consumers come in for an intake to access these services, we need to be aware that the questions that we are asking might be sensitive and a challenge. Letting the consumers know that if they do not want to answer specific questions, they have the option to let us know that they are not comfortable answering that question or that they prefer not to answer that question.

Our consumers have multiple layers of challenges and issues, and when we make them uncomfortable or insist on answers quite often they may shut down or lie about their situations, to get assistance or into a specific program which is counterproductive.

Figure 3.9.2 Photo by David Clode on Unsplash

Being trauma-informed means that we are aware of the challenges and try to support and by assisting them to feel safe and respected. Using Integrated Screening, Assessment and Training in Trauma Informed Care we are able to assist in getting a clear picture of the person's situation and get them options that are the best fit for them. If they choose to disclose then it's important that we validate the disclosure and express empathy and caring.

There are times when this means the best option is an integrated or stepped program, where certain components get addressed initially (i.e. roof over their head or safe place to be) and others a little later, or however the options can be integrated. Certain agencies have different options, that could be a great fit, but that is not always that simplistic.

There are various screening tools depending on where you work, and what the issues are. The screening tools are through a trauma-informed process to assist in in finding the best services for you. If there are co-occurring issues, health issues, critical life threatening issues or other challenges this will be reflected in the screening and assessment process.

Different issues, agencies, communities, provinces and countries have various programs to support through the trauma-informed process. There will be questions around mental health, substance use, or trauma/domestic violence. Depending on the answers the options / solutions could be different.

Figure 3.9.3 Photo by Brett Jordan on Unsplash

When working in a 6 month residential treatment agency, one of the clients who had been with us for 4 months and was enjoying his health and wellness, came back from a specialist appointment to tell us he had been diagnosed with cancer. His plan was to complete the 6 months and then begin cancer treatment. We began a conversation around what exactly he had and the stage it was at. Once all the medical information/documentation was compiled (which was done in a timely fashion) it was decided that this client needed to pause his stay in the 6 month residential treatment as his current health issue with cancer was very serious, and postponing addressing the cancer treatment could cost him his life. A plan was created (which included the client, all of his counsellors, supports, professionals and doctors) which included a integrated program that was the best fit for him and including him returning to complete the residential treatment when he was in a better state of health and the cancer had been addressed.

Denise Halsey

Trauma Informed Care Screening and Assessment

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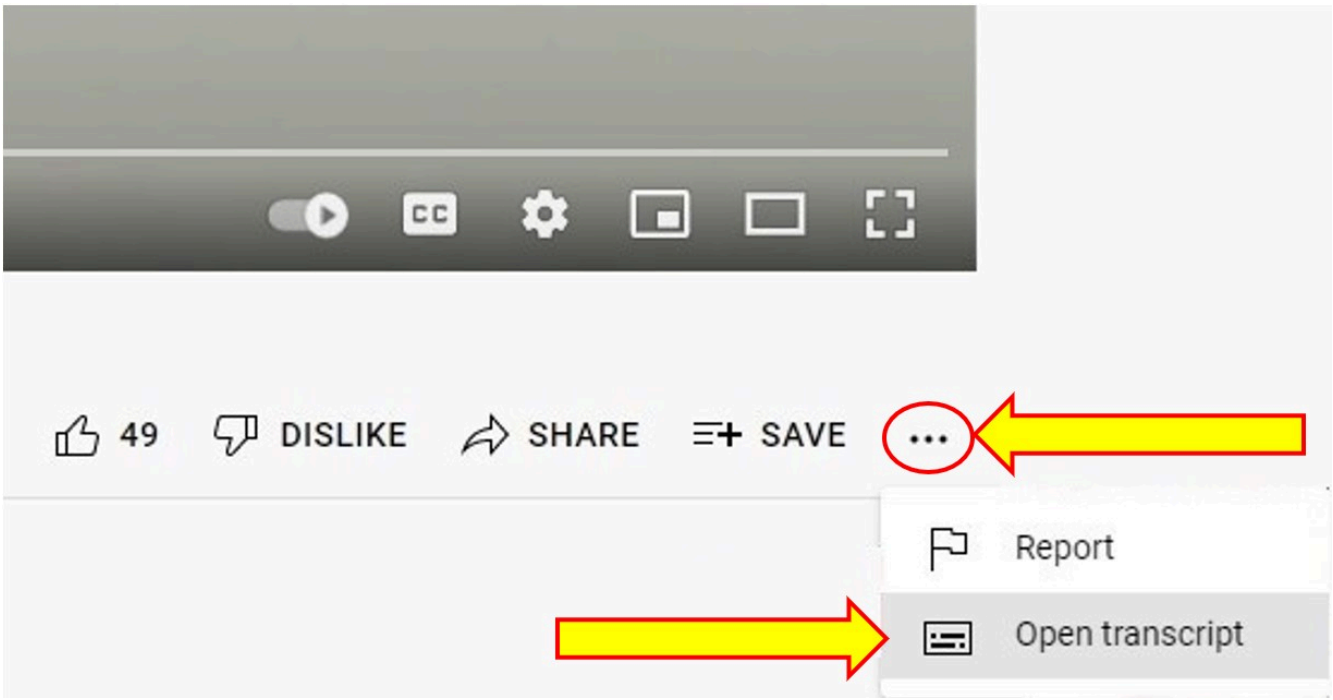

For More Information:

- Integrated Treatment Planning – Alberta Health Services
- Family Services of Peel
- Trauma Informed Screening and Assessment – Homeless Hub

References:

- Figure 3.9.1, 3.9.2, 3.8.3 –Unsplash License
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3.10 VICARIOUS TRAUMA

What is Vicarious Trauma?

Figure 3.10.1 Photo by Priscilla Du Preez on Unsplash

Vicarious trauma is **a process of change resulting from empathetic engagement with trauma survivors**. Anyone who engages empathetically with survivors of traumatic incidents, torture, and material relating to their trauma, is potentially affected, including doctors and other health professionals. (British Medical Association 2022)

There is a difference between trauma and vicarious trauma. **Vicarious traumatization is a negative reaction to trauma exposure and includes a range of psychosocial symptoms**. There are many signs of vicarious trauma and it can present differently for everyone.

It's important to understand that as professionals who work in the helping field vicarious trauma is an occupational hazard. Quite often we normalize challenging situations and don't recognize how strongly things affect us.

For helping professionals who work with victims of trauma, their reaction to a client can be similar to the post-traumatic stress symptoms of a victim. It is important to be aware.

What is Vicarious Trauma?

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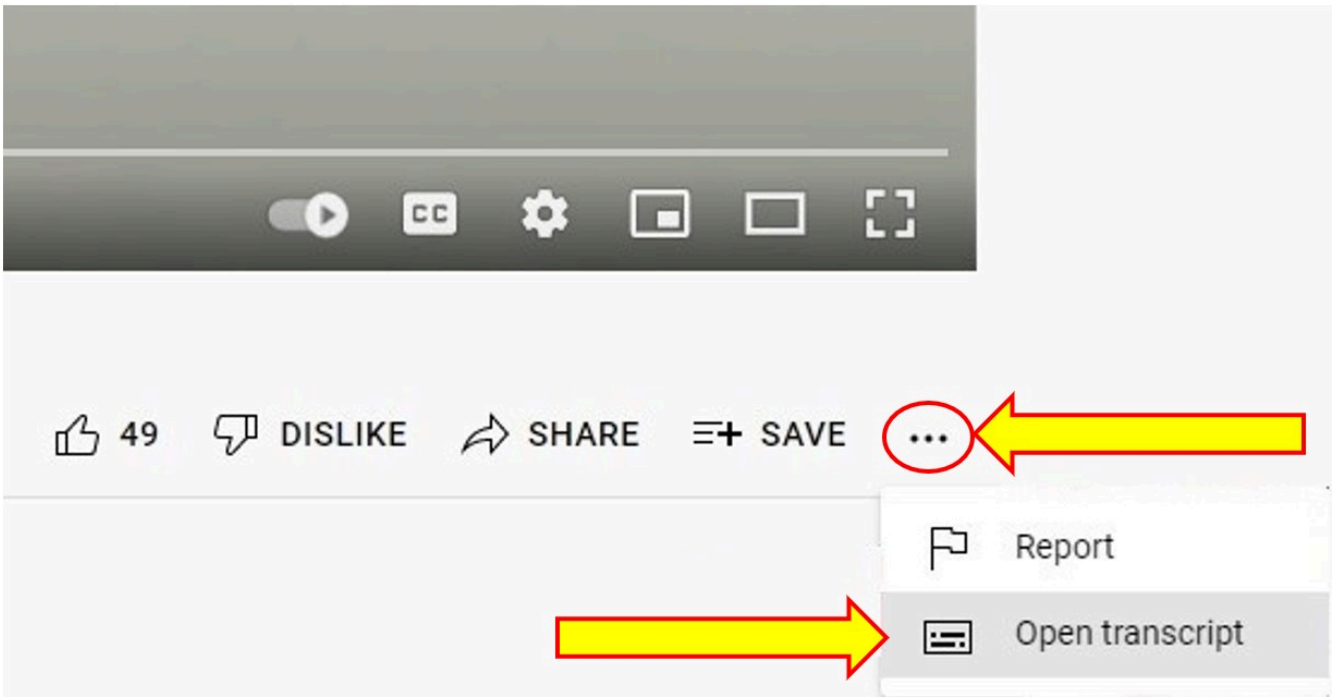

How can you recognize vicarious trauma?

Visible changes include:

- becoming cynical or losing hope
- avoiding social or work contact
- becoming fearful and overprotective because the world is seen to be dangerous
- setting rigid boundaries in relationships or, displaying a lack of boundaries and rescuing others
- abandoning spiritual beliefs

Drowning in Empathy: The Cost of Vicarious Trauma

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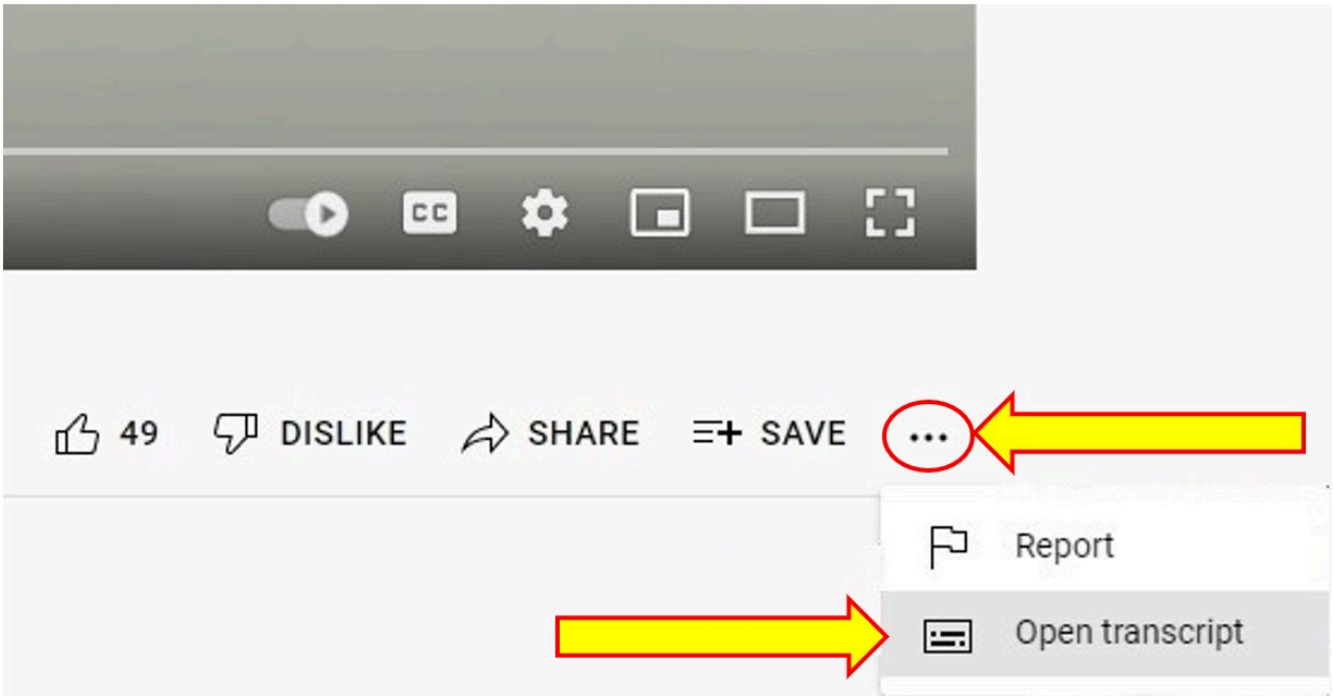

Key Takeaways

- Helping professionals who work in the social field experience Vicarious trauma
- When working with others with trauma, vicarious trauma can occur
- There are many signs of vicarious trauma and it can present differently for everyone

For More Information:

- Vicarious trauma: signs and strategies for coping
- Vicarious Traumatization – Here to Help
- Vicarious trauma: Signs and strategies for coping
- VICARIOUS TRAUMA & SELF-CARE TOOLKIT – City of Toronto
- Guidebook on vicarious trauma : recommended solutions for anti-violence workers – Government of Canada

Post-Traumatic Growth: Healing from Trauma and Vicarious Trauma

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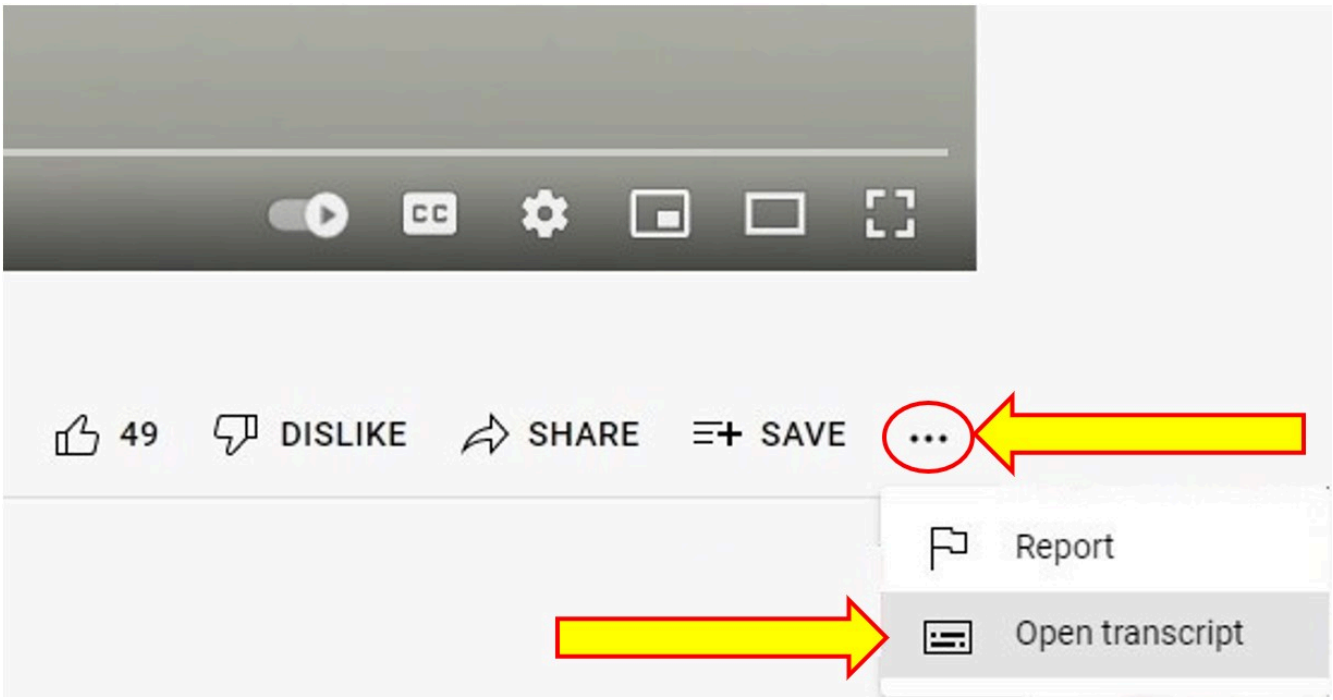

Activity

Here is a quizlet activity on Vicarious Trauma:

- Vicarious Trauma Flashcards

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3.11 KEY TERMS STUDY GUIDE

Figure 3.11.1 Photo by Luis Villasmil on Unsplash

The material in this chapter are the core of being **Trauma Informed**. Once you understand the importance of the many areas necessary to be trauma informed you will be more effective. You may be familiar with these terms, but If you are not familiar with the terms below, I recommend you download this study sheet, add more

spaces to write in definitions and relevant information (or make flashcards) as you read the chapter and watch videos.

1. A3n I c s T r e g l d o g a n m a f h o f v s u f a n e n a a C a n t g e l9o V a s c n r e r a d e T e7l T u f a r o a r o e ' m o t f o f c I h u f i e s r i u s a t e s a u C n r n s r m o I e r v t r r G a r e o r o t n i m o d l8n T m c m e r e e s i m a e a 6t S a a r l1n T m h2i T m s r I I d r y r i f l a r e o r e a a s c g n m n a r r u i c 9i T m f r e o r e e o n l4n T l5m T m c d l7d T m f u a d r s e r i e i I e a m a r n r e o a d u a d C u f c r e r e e r h r e o s u R i m r a n n n 4n I t a l e i a d r u f r u f l p o a a d a l6d T m o a d r P m i o e a t g t g f n 5i R S e n l0u T m m o S m o i s r r u i u i r e o u P I e a g u n t e , a i o t o e c n g m r e a r u a n l3e T m c m n m n a d d m r n o I h s t e d A n n r e n s h 8i T a a d I B p i D n r e e a T a P u o T a a d p n t T
2. I d S s d T m r a i o n r I u C n e p n i t a d r I h I r m f r I c i l f s r

References

3.11.1 Unsplash License

3.12 SELF CARE

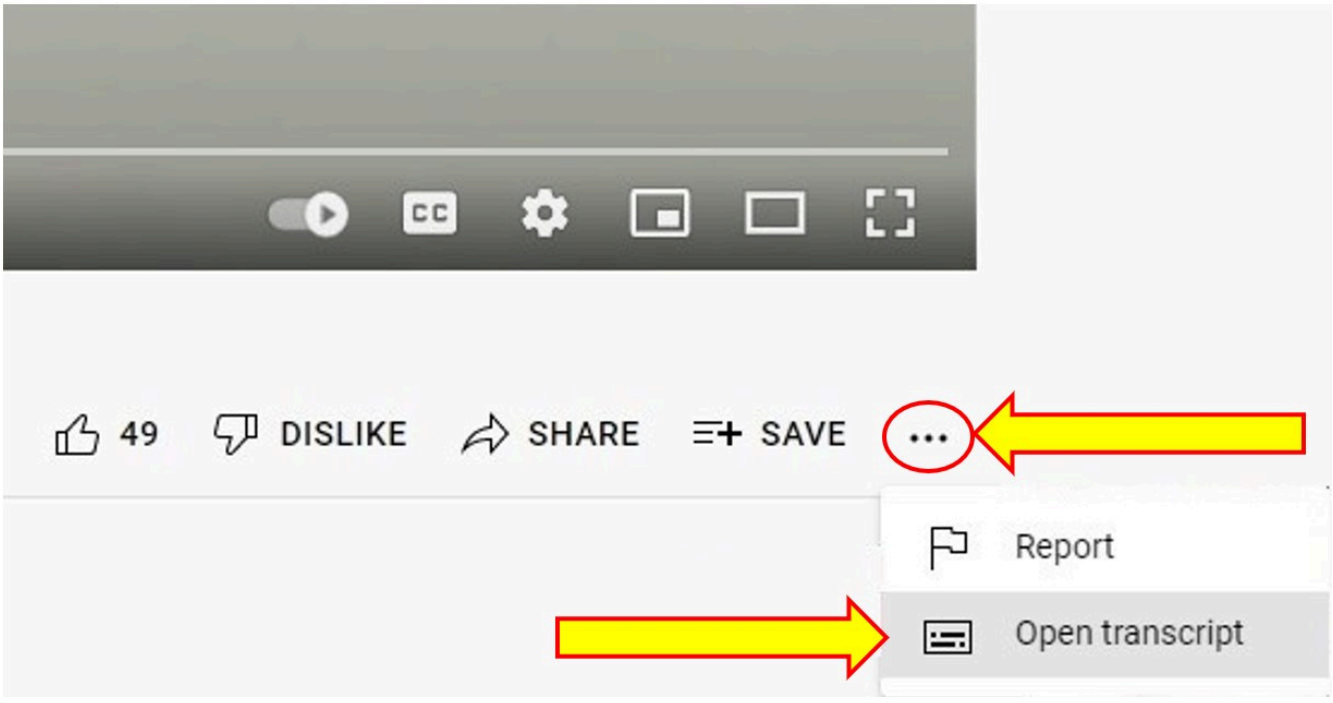
This module's self care continues to explore mindfulness. This week for mindfulness, please listen to the guided meditation with Tara Brach. This activity takes approximately 20 minutes. Ensure that you have the time and space to engage in this activity.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=681#oembed-1

Transcript

To Access the Video Transcript:

1. Click on **"YouTube"** on the bottom-right of the video. This will take you directly to the YouTube video.
2. Click on the **More Actions** icon (represented by three horizontal dots)
3. Click on **"Open Transcript"**



References

- Brach, T. (2019, February 26). *Tara Brach leads a Guided Meditation: The Practice of RAIN* [Video]. YouTube. https://www.youtube.com/watch?v=W8e_tAEM80k

ADDITIONAL RESOURCES - TRAUMA INFORMED

What Trauma Taught Me About Resilience

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Transcript

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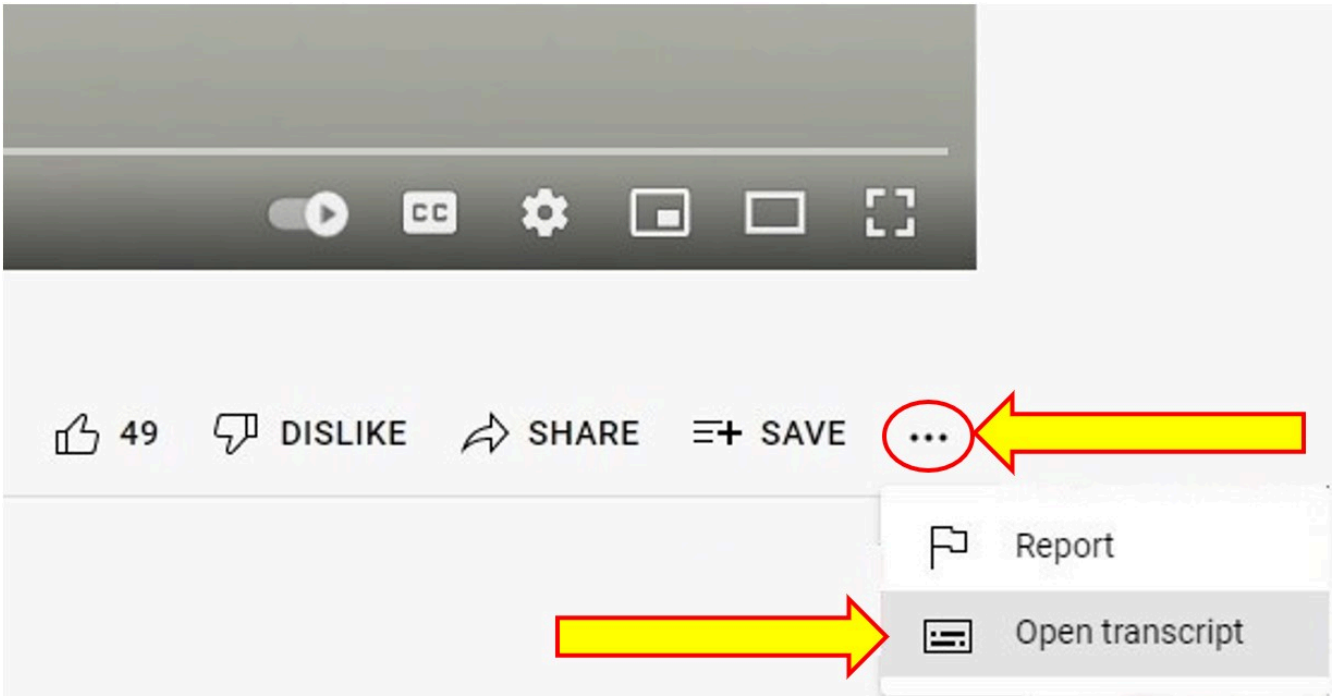

The paradox of Trauma Informed Care

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Transcript

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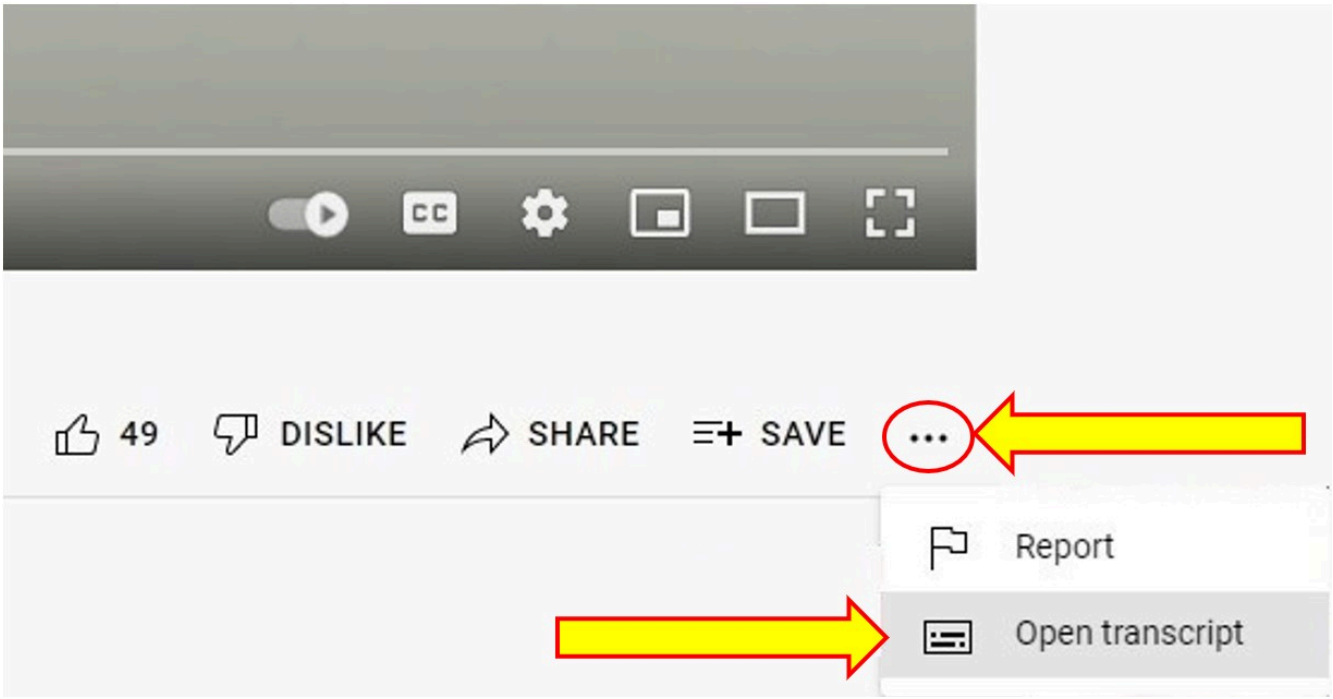
3. Click on **"Open Transcript"**



How Childhood Trauma affects Health across a Lifetime

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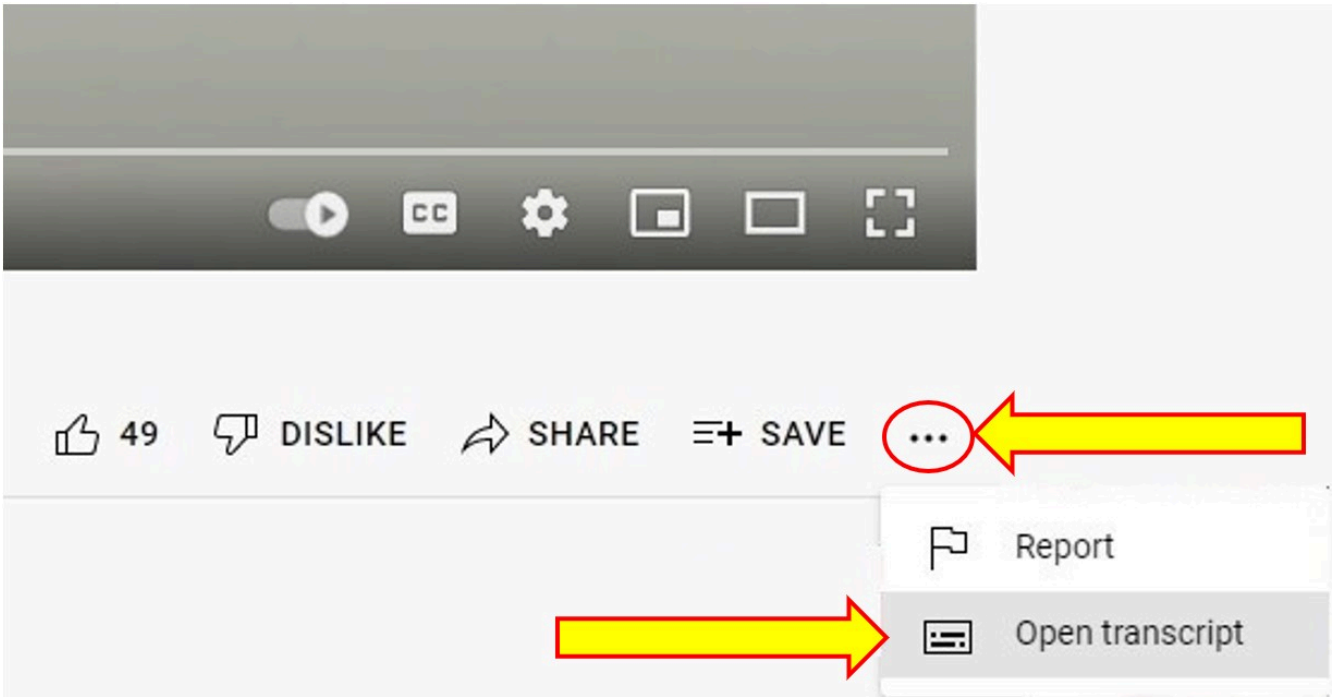
them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=96#oembed-3

Transcript

To Access the Video Transcript:

1. Click on **"YouTube"** on the bottom-right of the video. This will take you directly to the YouTube video.
2. Click on the **More Actions** icon (represented by three horizontal dots)
3. Click on **"Open Transcript"**



For More Information on Trauma-Informed

- Trauma-Informed Toolkit – Manitoba Trauma Informed and Education Centre

- CAMH – Trauma Resources
- CAMH – How a northern community is becoming trauma-informed
- PSSP Aboriginal Engagement and Outreach page – CAMH
- CAMH – 5Qs with PSSP's Aboriginal Engagement and Outreach Team

References

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- TEDx Talks. (2014, September 8). *The paradox of trauma-informed care | Vicky Kelly | TEDxWilmington* [Video]. YouTube. https://www.youtube.com/watch?v=jFdn9479U3s
- *What Trauma Taught Me About Resilience | Charles Hunt | TEDxCharlotte*. (2016, November 18). [Video]. YouTube. https://www.youtube.com/watch?v=3qELiw_1Ddg&list=RDLV3qELiw_1Ddg&start_radio=1&t=851s

CHAPTER 4: ADDICTIONS CASE MANAGEMENT

CHAPTER 4 - INTRODUCTION

Figure 4.1 – Photo by DocuSign on Unsplash

We will explore the areas of Case Management and all that it includes: definitions, responsibilities, different models of Case Management. The practice of case management extends across **all settings of the health and human services continuum.** This can include but is not limited to: client's home environment, worker's compensation, independent, private, employer, government, provider, payor or community.
Depending on the agency it will look slightly different to the community that is being served. This can include:

- A i i s u s i r F i e m g n I a e t I i n s d i a 2 G Q Mt H r S i s u We d c o A r C l e a l s m r t n r r e n g o I i d l S B I e a e t e o Y t o n d t n d t h d n m r I i a s c c a d d e u n v u s L T + n l a h n r o h m

We will define each of these areas and discuss how case management approaches can help clients reduce the impact of challenges in their lives. We will see effective case management is in improving the quality of life of people struggling with different issues.

LEARNING OBJECTIVES

Learning Objectives

By the end of this chapter you should be able to:

1. Understand the Case Management role and understand the Definitions and Responsibilities
2. Recognize Cultural Competence & how it applies to Different Populations
3. Explain the importance of Indigenous Approaches
4. Describe Interviewing Skills and how they apply in all Work Environments
5. Apply Screen & Assessment / Assessment Tools
6. Explain the Importance of all components of Case Management: Assessment, Social Histories, Developing a Service Plan & Monitoring, Closure & Terminating the Case
7. Discuss Current Prevention Programs, New Initiatives and Food for Thought

4.1 CASE MANAGEMENT: DEFINITIONS AND RESPONSIBILITIES

The Fundamentals – Case Management

Case management is a goal-oriented approach that aims to help employees remain at work and facilitate a safe and timely return to work. It is best accomplished with a multidisciplinary team. (The Fundamentals – Case Management – Canada.ca, n.d.-b)

When you work as a **Case Manager** in Human Services the goal is to work with the whole person in front of you. Case management does not only focus on one challenge but also take into consideration the person's strengths, interest, needs, challenges, personal concerns, their environment, family, knowledge and many other pieces that the person in front of you is experiencing. A primary purpose for case management is to improve the quality of life for your client. There is a process for case management for assessing the individual and through that **assessment** discover the needs, challenges, the many problems that they are experiencing in all areas of their life.

This takes many different skills which include: knowledge, skills, and guidelines that you will focus on there is a knowledge base skills and guidelines specific to case management.

Case Management is a **collaborative process of assessment**, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost effective outcomes.

Figure 4.1.1 Photo by Gabriella Clare Marino on Unsplash

Case management is a multi-step process to ensure timely access to and coordination of whatever services are needed which could include: medical, psychosocial services, finances, housing, counselling or many other options needed for their support system.

Case management includes the following processes: intake, assessment of needs, service planning, service plan implementation, service coordination, monitoring and follow-up, reassessment, case conferencing, crisis intervention, and case closure.

The client is the expert in their life. We are on the journey with them because they have invited us along for the journey or to be part of the team.

In Case Management, through a collaboration in conversation and information gathering we can then create an **individualized service plan** and then through ongoing **monitoring** can make sure it's effective and what works for the client as well as adjust as needed.

Figure 4.1.2 Photo by Dylan Gillis on Unsplash

Skills that are needed to be an effective Case Manager include: working *effectively with people* to assist in their growth, organization, communication, delegation, time management skills, conflict resolution skillls, computer and technology skills, approachable and team player.

There are many different skills needed to be a Case Manager. These will include:

- **Intake: Client Indentification and Eligibility** (make sure the program is a fit for the client)
- **Assessment** (gathering information to create a plan)
- **Service Planning** (action putting options forward for the plan)
- **Implementation of Plan** (applying the plan)
- **Service Coordination** (could include other specialists or agencies if needed)
- **Evaluation/monitoring/follow-up** (to see if current plan is working or needs adjusting)
- **Transition** (supports closure or changes to a different program offered)

Different types of Case Management

There are many different areas that Case Management is used. These include private practice, treatment centres, shelters, medical offices, hospitals, housing, ODSP, OW, MMT, incarcerated, mental health, short-term, long-term, in-house, outreach, community, hospital, clinics, police services and internet services (phone or video).

Depending on what services you access you could be called Client, Patient, Consumer, Resident, inmate or a number of others depending on the agency.

Different Agencies offer different options for Case Management which can include individual, family, couples, seniors, youth, specific communities or group. This can include accessibility and various office hours. Some will have a drop-in, make appointments, some are set hours for walk ins, some will have regular appointments or other options as well.

For more Information on Case Management

- Canadian Standards of Practice for Case Management
- Effectiveness of Different Models of Case Management for Substance-Abusing Populations
- TCAT – Toronto Community Addiction Team
- Major Case Management – Ontario's Police Services
- Abilities – Case Management
- Homeless Hub – Case Management
- Case Management for Indigenous Adults

Case Management for Canadian Armed Forces (CAF)

The Case Management (CM) program provides professional guidance to Canadian Armed Forces (CAF) members following illness or injury with the goal of facilitating the achievement of optimal health and wellness. Nurse Case Managers in the program work together with the Primary Care teams and key partners such as CAF TG, VAC and SISIP in order to ensure continued access to health services and benefits as they return to duty or transition from the CAF to civilian life. (National Defence, Government of Canada)

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4.2 ECOLOGICAL SYSTEMS THEORY

An Introduction to the Ecological Model in Public Health

Ecological Systems Theory (EST), also known as human ecology, is an ecological/ system framework developed in 1979 by Urie Bronfenbrenner (Harkonen, 2007). Harkonen notes that this theory was influenced by Vygotsky's socio-cultural theory and Lewin's behaviorism theory. Bronfenbrenner's research focused on the impact of social interaction on child development. Bronfenbrenner believed that a person's development was influenced by everything in the surrounding environment and social interactions within it. EST emphasizes that children are shaped by their interaction with others and the context. The theory has four complex layers called systems, commonly used in research. At first, ecological theory was most used in psychological research; however, several studies have used it in other fields such as law, business, management, teaching and learning, and education.

Figure 4.2.1 – Created by Denise Halsey

Previous Studies

EST has been used in many different fields, however, commonly, it is used in health and psychology, especially in child development (e.g., Heather, 2016; Esolage, 2014; Matinello, 2020). For instance, Walker et al. (2019) used an EST framework to examine risk factors for overweight and obese children with disabilities. The study focused on how layers of an ecological system or environment can negatively affect children with special needs in terms of weight and obesity. They found that microsystem such as school, family home, and extracurricular activities can impact overall health through physical activities and food selectivity. Furthermore, the second layer, mesosystem (e.g., family dynamic and parental employment), also can lead to an increase in children's weight because of a lack of money to buy nutritious food. In addition, children may be socially isolated and excluded in ways that cause stress, and their parents might use food to reinforce or comfort them. The third layer the study adopted was the macrosystem. For example, some

cultures discriminate against children with disabilities so that they face more difficulty gaining access to health services.

In the field of language teaching, Mohammadabadi et al. (2019) researched factors influencing language teaching cognition. They used an ecological framework to explore the factors influencing language teachers at different levels. They adopted the four systems from Bronfenbrenner's theory for studying the issue. This study found that the ecological systems affect language teaching. For example, the microsystem included a direct influence on teachers' immediate surroundings, such as facilities, emotional mood, teachers' job satisfaction, and linguistic proficiency. The mesosystem defined interconnections between teachers' collaboration and their prior learning experience. The exosystem included the teaching program and curriculum and teachers' evaluation criteria, while the macrosystem addressed the government's rules, culture, and religious beliefs. In other words, researchers use EST to guide the design of their studies and to interpret the results.

Model of EST

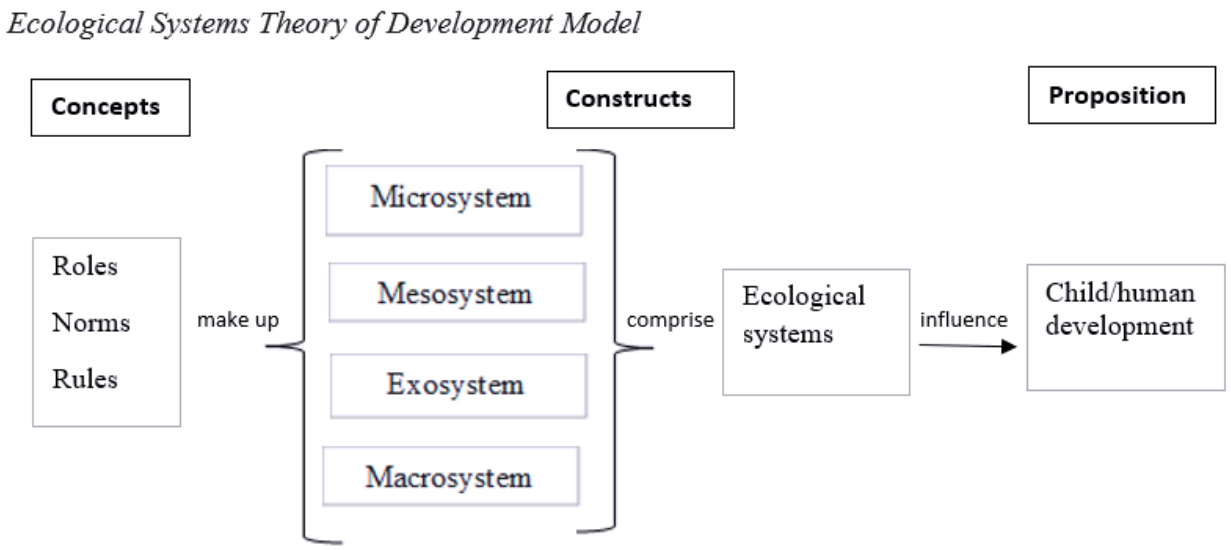

Figure 4.2.2 – Model of EST – Ecological Systems Theory of Development by Samsu Alam, contributor to Theoretical Models for Teaching and Research, edited by Joy Egbert and Mary Roe, CC-BY-NC.

Concepts, Constructs, and Propositions

The four systems that Brofenbrenner proposed are constructed by roles, norm and rules (see Figure 4.2.2). The first system is the microsystem. The microsystem as the innermost system is defined as the most proximal setting in which a person is situated or where children directly interact face to face with others. This system includes the home and child-care (e.g., parents, teacher, and peers). The second is the mesosystem. The

mesosystem is an interaction among two or more microsystems where children actively participate in a new setting; for instance, the relationship between the family and school teachers. The third is the exosystem. This system does not directly influence children, but it can affect the microsystem. The effect is indirect. However, it still may positively or negatively affect children's development through the parent's workplace, the neighborhood, and financial difficulties. The outermost system is the macrosystem. Like the exosystem, the macrosystem does not influence children directly; however, it can impact all the systems such as economic, social, and political systems. The influence of the macrosystem is reflected in how other systems, such as family, schools, and the neighborhood, function (Kitchen et al., 2019). These four systems construct the EST which considers their influences on child or human development.

Bronfenbrenner (cited in Harkonen, 2007) noted that those environments (contexts) could influence children's development constructively or destructively. As the proposition, the system influences children or human development in many aspects, such as how they act and interact, their physical maturity, personal characteristics, health and growth, behavior, leadership skills, and others. At the end of the ecological system improvement phase, Bronfenbrenner also added time (the chronosystem) that focuses on socio-history or events associated with time (Schunk, 2016). In summary, the views of this ecological paradigm is that environment, social interaction, and time play essential roles in human development.

Using the Model

There are many possible ways to use the model as teachers and parents. For teaching purposes, teachers can use the model to create personalized learning experiences for students. The systems support teachers and school administrators to develop school environments that are suitable to students' needs, characteristics, culture, and family background (Taylor & Gebre, 2016). Because the model focuses on the context (Schunk, 2016), teachers and school administration can use the model to increase students' academic achievement and education attainment by involving parents and observing other contextual factors (e.g., students' peers, extra-curricular activities, and neighbor) that may help or inhibit their learning.

Furthermore, the EST model can support parents to educate and guide their children. It can prompt parents to assist their children in choosing their friends and finding good neighborhoods and schools. Additionally, they can build close connections to teachers, so they know their children' skills and abilities. By involving themselves in schools, parents can positively influence their children's educational context (Hoover & Sandler, 1997).

For research purposes, researchers can test and modify or refine the EST proposition, or they can find additional ways to measure it. Researchers also can develop questionnaires from the components or concepts and construct of EST. Additionally, the four levels of EST can be used by researchers to frame qualitative, quantitative, and mixed research (Onwuegbuzie, et.al., 2013).

Conclusion

We all begin as blank puzzle pieces, who we become is influenced by those around us, such as: family, parents, teachers, people, places, things, community, society, political systems, education and environment.

Figure 4.2.3 Photo by Mel Poole on Unsplash

At first, EST was used in children's development studies to describe their development in their early stages influenced by the person, social, and political systems. Currently, EST is broadly applied in many fields. Schools or educational institutions can use EST to improve students' achievement and well-being. Interaction between the family, parents, teachers, community, and political system will determine students' development outcomes.

For More Information – Videos:

- SocioEcological Theory of Addiction

- SocioEcological Theory of Addiction – Doc Snipes
- Bronfenbrenner's Ecological Systems: 5 Forces Impacting Our Lives
- Bronfenbrenner's Ecological Systems Theory

References

- Figure 4.2.1 – Wordart created by Denise Halsey
- Figure 4.2.2 – Model of EST – Roe, J. E. A. M. (n.d.). *Ecological Systems Theory – Theoretical Models for Teaching and Research*. https://opentext.wsu.edu/theoreticalmodelsforteachingandresearch/chapter/ecological-systems-theory/
- Figure 4.2.3 – Photo by Unsplash License
- *SocioEcological Theory of Addiction*. (2016, March 11). [Video]. YouTube. https://www.youtube.com/watch?v=RoSjNZbTixk
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4.3 THEORIES, APPROACHES AND FRAMEWORK

Topics:

1. Why Is Theory Important in Community Work?
2. Systems Theory
3. Anti-Oppressive Practice
4. Anti-Racism
5. Cultural Humility and Cultural Safety
6. Indigenous Worldviews

Introduction

This chapter focuses on theories and why theories are required in community development practice. There are many theories in social work; however, we will discuss four main theories that community workers should integrate into their practice. These theories are Systems Theory, Anti-Oppressive Practice, Cultural Humility and Safety, and Indigenous Worldviews.

1. Why Is Theory Important In Community Work?

Theories help us make sense of the world – and communities – around us. They allow us to explore problems and solutions with evidence and research to support our practice, instead of grasping at straws. This is particularly important as community workers need to be aware of personal assumptions and biases that may interfere with effective community practice.

Theories may also help us avoid doing **harm**, *unintentionally*. **Good intentions are not enough for community development work.** As social service professionals, it is critical for us to be aware of the ways that our work can perpetuate harm and oppression – and *intentionally* take steps to disrupt harmful systems

and practices today. In order for us to avoid repeating harmful mistakes of the past, community work must be grounded in anti-oppressive, anti-racist, and decolonizing practices and relations.

In order for us to explore different theoretical frameworks for working with communities, we must first understand what exactly we mean by *community*. At the most fundamental level, a **community** is based on relationships, identity, and a sense of belonging.

How can theories support our practice with diverse communities? What can they offer to community development work?

We will be introducing the following theoretical frameworks for community work:

- **Systems Theory**
- **Anti-Oppressive Practice**
- **Cultural Humility and Safety**
- **Indigenous Worldviews**
- **Anti Racism**

Note: *Keep in mind that this is not an exhaustive list. Continually evolving our practice, drawing on multiple theories from our toolbox, allows for deeper and broader understanding and engagement with diverse communities.*

2. Systems Theory

Like every *ecosystem*, individuals require ongoing input (e.g. food, energy, relationships) in order to survive – and hopefully thrive. When a system's needs are not met, we may feel out of balance, which prompts action. Preserving a state of balance (or *equilibrium*) is critical for systems to survive.

According to systems theory (Healy, 2005) :

- Individuals do not live in silos (or isolation).
- We are constantly interacting with multiple systems (e.g. family, neighbourhood, city, globe) across different levels.
- Our interactions, whether big or small, have an inevitable ripple effect throughout the entire system.
- All systems operate in relationships with other systems.

This perspective allows us to develop a **holistic** view of individuals and communities in our practice.

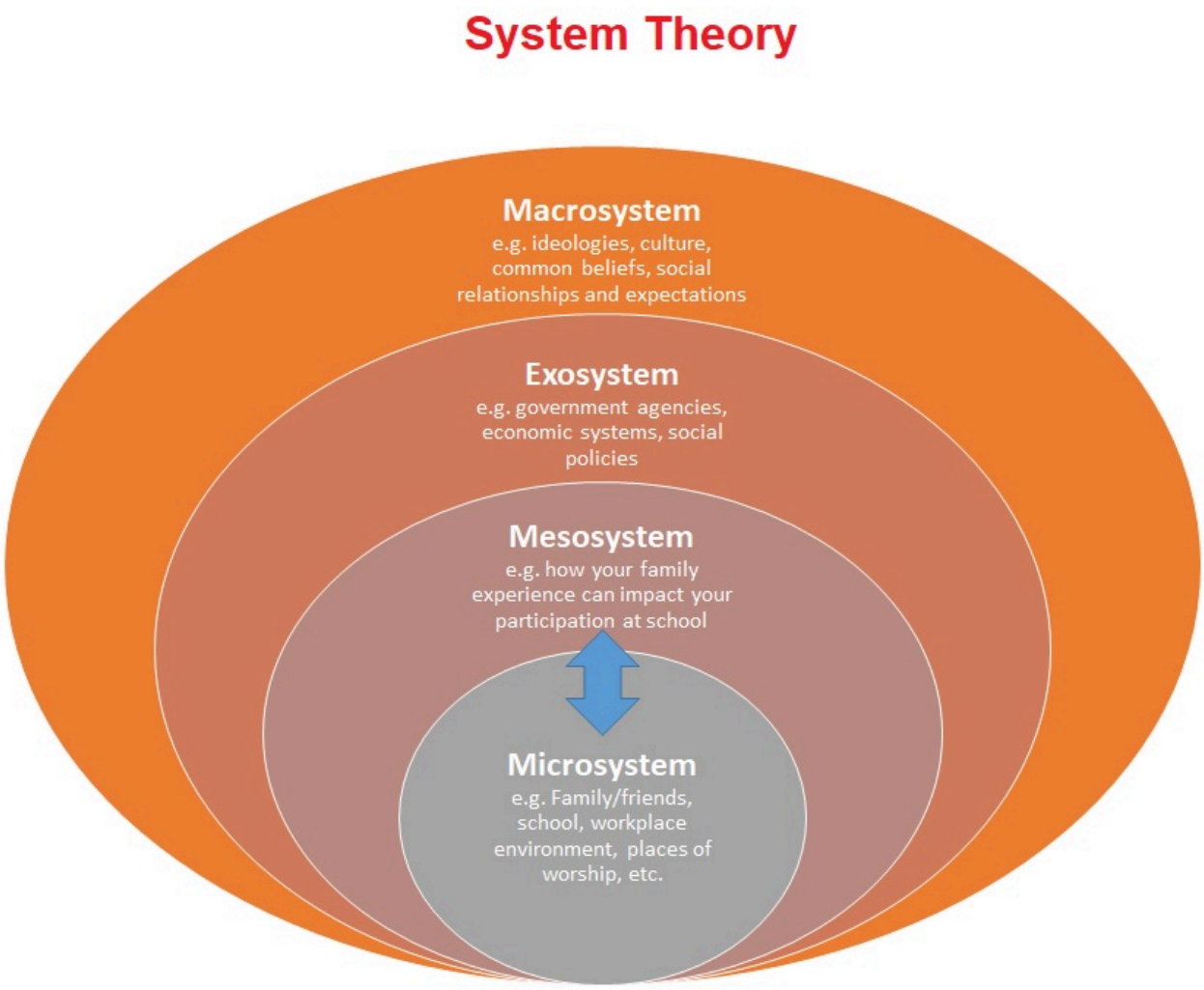

Figure created by Author based on Healy, 2005.

Figure 4.3.1 by System Theory by Sama Bassidj and Dr. Mahbub Hasan in Community Development Practice: From Canadian and Global Practices, CC-BY-NC-SA

Healy (2005) suggests that in addition to your *self* as the primary system, reflect on some of the following systems you interact with (from smallest to largest):

- ***Microsystem*** – the small immediate systems in your day-to-day life (e.g. family/friends, workplace environment, classrooms, places of worship, etc.)
- ***Mesosystem*** – the network of interactions between your immediate systems (e.g. how your family experience can impact your participation at school)
- ***Exosystem*** – the larger institutions in society that impact your personal systems and networks (e.g.

government agencies, economic systems, social policies, etc.)

- ***Macrosystem*** – the *intangible* influences in society (e.g. ideologies, culture, common beliefs, social relationships and expectations, etc.)

3. Anti-Oppressive Practice

Q – What is the difference between more mainstream approaches and anti-oppressive practice (AOP)? How does AOP help communities understand problems as linked to social inequality?

Part of this section is adapted from: Canadian Settlement in Action: History and Future by NorQuest College is licensed under a Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License, except where otherwise noted.

Oppression can be defined as the experience of widespread, systemic injustice (Deutch, 2011). It is embedded in the underlying assumptions of institutions and rules, and the collective consequences of following those rules. Oppression is often a consequence of unconscious assumptions and biases and the reactions of well-meaning people in ordinary interactions (Khan, 2018).

The following are some of the ways oppression can manifest itself:

- Ableism: Oppression that assumes that differently abled people require "fixing" and that their personhood is defined by their disability (Eisenmenger, 2019).
- Ageism: Oppression based on negative attitudes about a person based on their age (or perceived age), and the default orientation of access to public services towards people who are younger (Ontario Human Rights Commission, n.d.a).
- Classism: Oppression that discriminates based on a person's socio-economic class or caste (or perceived socio-economic class or caste) (Class Action, 2021).
- Homophobia: Systemic discrimination against individuals based on their sexual identity or preference (Planned Parenthood, 2021a).
- Racism: Systemic discrimination against individuals as a result of their real or perceived ethnicity (Ontario Human Rights Commission, n.d.b).
- Sexism: Oppression that occurs via through expression of the idea that certain individuals are inferior solely because of their gender; it is similar to the concept of misogyny (the systemic hatred of women) (Illing, 2020).
- Sizeism: Oppression based on a person's body size and shape (Bergland, 2017).
- Transphobia: Widespread antagonistic and systemic practices that target transgender individuals (people whose biological sex does not match the gender identity they have assumed) (Planned Parenthood, 2021b).

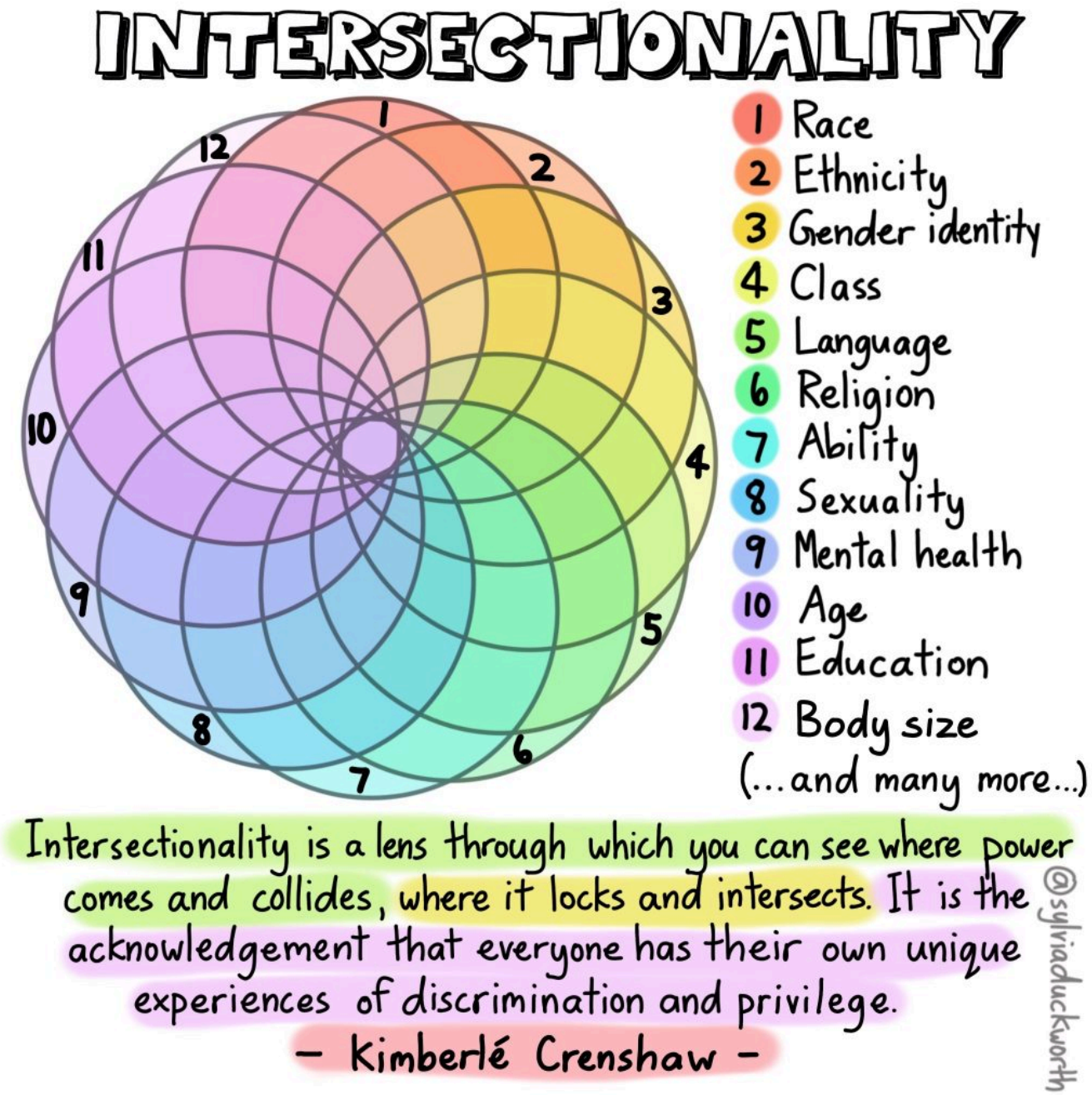

Figure 4.3.2 – Intersectionality Venn diagram by SylviaDuckworth is licensed under a CC BY-NC-ND 2.0 Generic license

Intersectionality is a core concept in the discussion of oppression. Crenshaw (1989) pioneered the term "intersectionality" to refer to instances in which individuals simultaneously experience many intersecting forms of oppression. Since individuals don't exist solely as "woman", "Black", or "working class", among others, these identities intersect in complex ways, and are determined by a set of interlocked social hierarchies.

Video: The urgency of intersectionality | Kimberlé Crenshaw. Ted Talk.

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Source: YouTube. https://youtu.be/akOe5-UsQ2o

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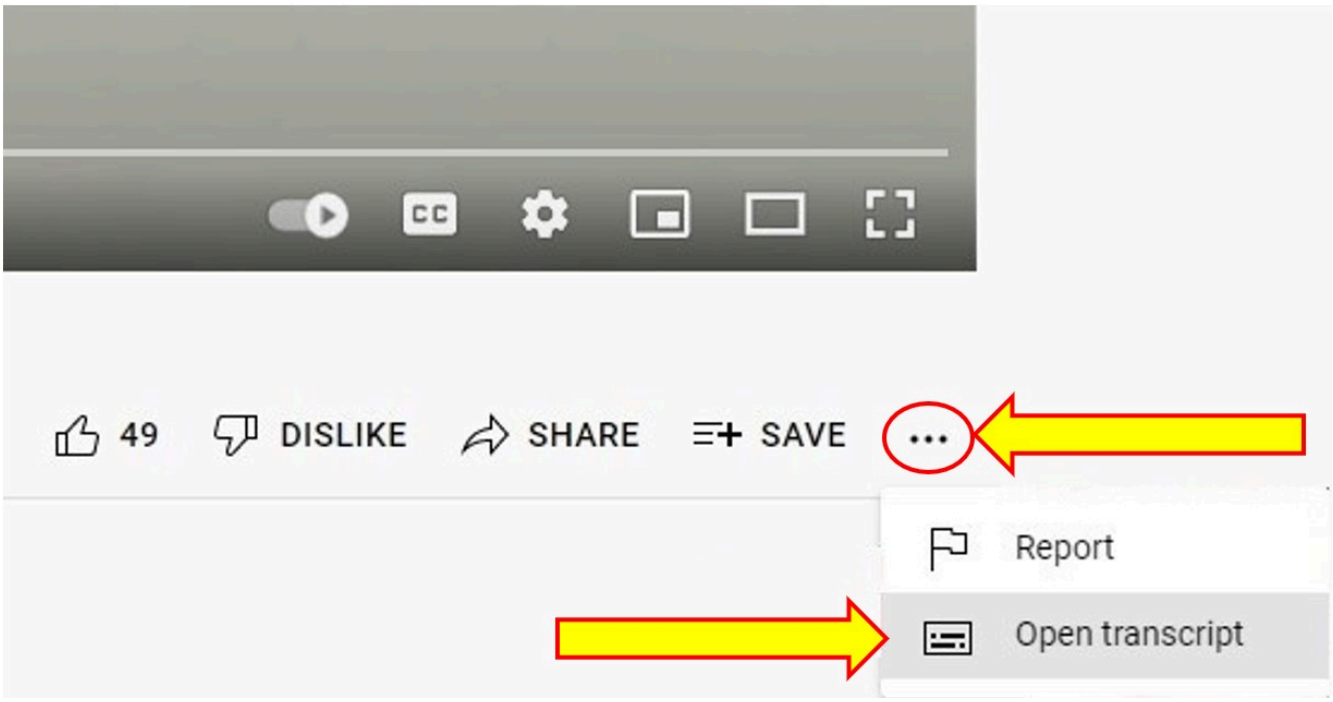

Therefore, **all our oppressions are interconnected and overlapping**. Intersectionality rejects the idea of "ranking" social struggles (sometimes referred to as "*Oppression Olympics*"), as this is divisive and unnecessary, undermining solidarity (the willingness of different individuals or communities to work together to achieve common goals).

In an intersectional analysis, a person's identity is layered, and the presence (or absence) of oppression is context-specific. The same person could feasibly be oppressed in one situation, and the oppressor in another

(for example, a Black man who experiences racism in the workplace but is domestically abusive). What is important is to look at the social forces that are at play and to remember that ***"the personal is always political".***

It would be difficult to discuss the importance of understanding **oppression** without understanding **privilege**. Garcia (2018) describes privilege as unearned social benefits or advantages that a person receives by virtue of who they are, not what they have done. Much like oppression, privilege can also be intersectional; however, because privilege is unearned, it is often invisible because those who benefit from it have been conditioned to not even be aware of its existence. **Privilege is thus a very important concept because the relationship that community workers have with communities is often a privileged standing, as they have** power over the lives of the communities they work with.

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Video: What is Privilege ? AS/IS

Transcript

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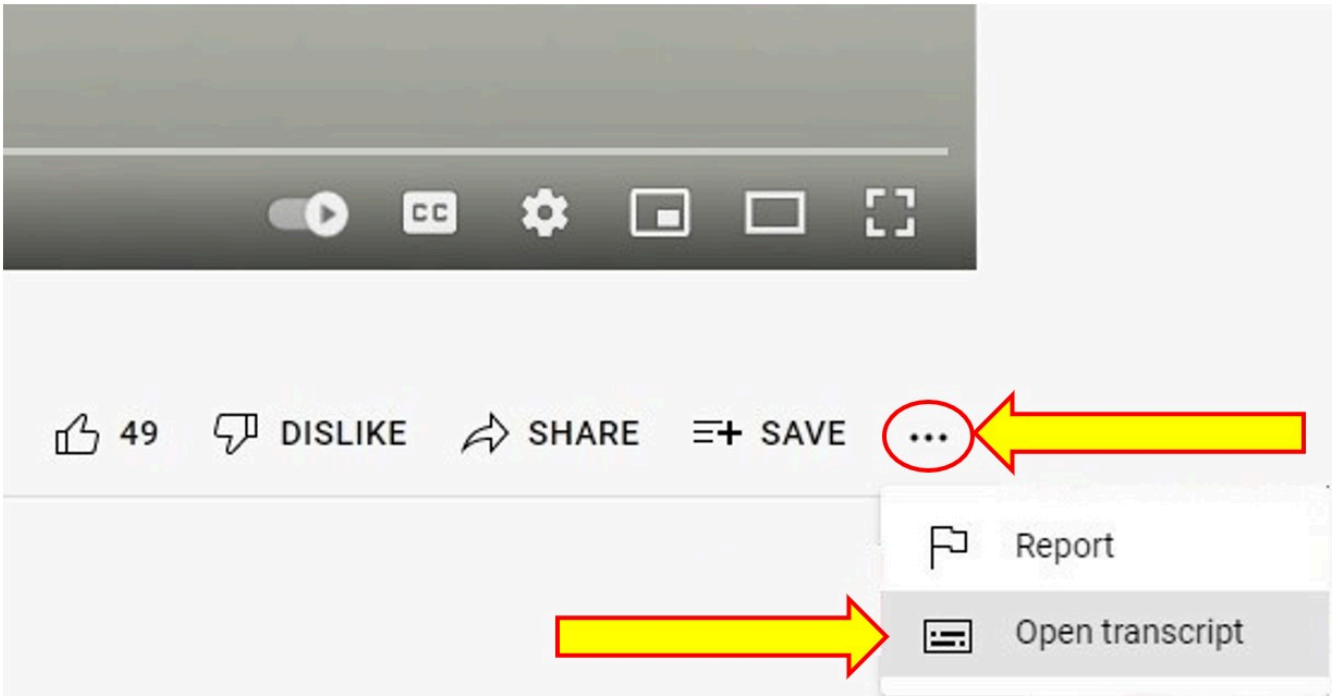

Among the most important roles that can be played by a community worker is that of an ally – when a person with privilege attempts to work and live in solidarity with marginalized peoples and communities. Allies take responsibility for their own education on the lived realities of oppressed individuals and communities and are willing to openly acknowledge and discuss their privileges and the biases they produce (Lamont, n.d.).

A thorough understanding of ***power, privilege, and oppression*** can help community workers develop an anti-oppressive approach to their practice. Being able to engage in anti-oppressive practice requires community workers to be able to deconstruct and challenge the Great Canadian Myth and expressions of Canadian exceptionalism, and to be able to discuss the often-complicated role played by social service professionals in the perpetuation and execution of harmful government policies towards racialized communities (Clarke, 2016, p. 119). As such, an anti-oppressive approach requires community workers to continually and critically reflect on their work with communities and to challenge the status of "expert" assigned to them.

Anti-oppressive practice is also a **strengths-based approach** in that the starting point of a conversation with communities is what they *can* do, not what they *cannot* do or are *lacking*. Strengths-based approaches separate people from their problems and focus more on the circumstances that prevent a person from leading the life they want to lead (Hammond & Zimmerman, 2012, p. 3).

Anti oppression approach addresses the prejudicial and inequitable relations that communities experience (Parada et al. 2011). Anti-oppressive social workers and community workers help communities understand that their problems are linked to social inequality and why they are oppressed and how to fight for change (Baines, 2011). Anti oppression practice addresses root causes of poverty and marginalization and promote collective actions by community.

4. Anti-Racism

Anti-Racism Framework

In this episode of Podcasting Social Work, Dr. Valerie Borum, Professor and Director, School of Social Work, Toronto Metropolitan University, discussed about anti-racism framework, roots of racism, and its impact on communities, and how can we integrate anti-racism framework in social work and community development practice. If you have any questions, please contact us at mhasan@centennialcollege.ca. Podcasting Social Work" by Mahbub Hasan is licensed under CC BY-NC-SA 4.0

5. Cultural Humility And Cultural Safety

5.1 Cultural humility

Cultural humility is the ability to remain open to learning about other cultures while acknowledging one's own lack of competence and recognizing power dynamics that impact the relationship.

Within cultural humility it is important to:

- engage in continuous and critical self-reflection
- recognize the impact of power dynamics on individuals and communities
- embrace a perspective of "not knowing"
- commit to lifelong learning

This approach to diversity encourages a curious spirit and the ability to openly engage with others in the process of learning about a different culture. As a result, it is important to address **power imbalances** and develop meaningful relationships with community members in order to create positive change. A guide to cultural humility is offered by Culturally Connected.

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them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=1020#oembed-3

Video: Cultural Humility (complete) by Vivian Chavez. "Cultural Humility: People, Principles and Practices," is a 30-minute documentary by San Francisco State professor Vivian Chávez, that mixes poetry with music, interviews, archival footage, and images of community, nature and dance to explain what Cultural Humility is and why we need it. The film describes a set of principles that guide the thinking, behaviour and actions of individuals and institutions to positively affect interpersonal relationships as well as systems change. These principles are: • Lifelong learning and critical self-reflection • Recognizing and changing power imbalances • Developing institutional accountability

Transcript

To Access the Video Transcript:

1. Click on **"YouTube"** on the bottom-right of the video. This will take you directly to the YouTube video.
2. Click on the **More Actions** icon (represented by three horizontal dots)
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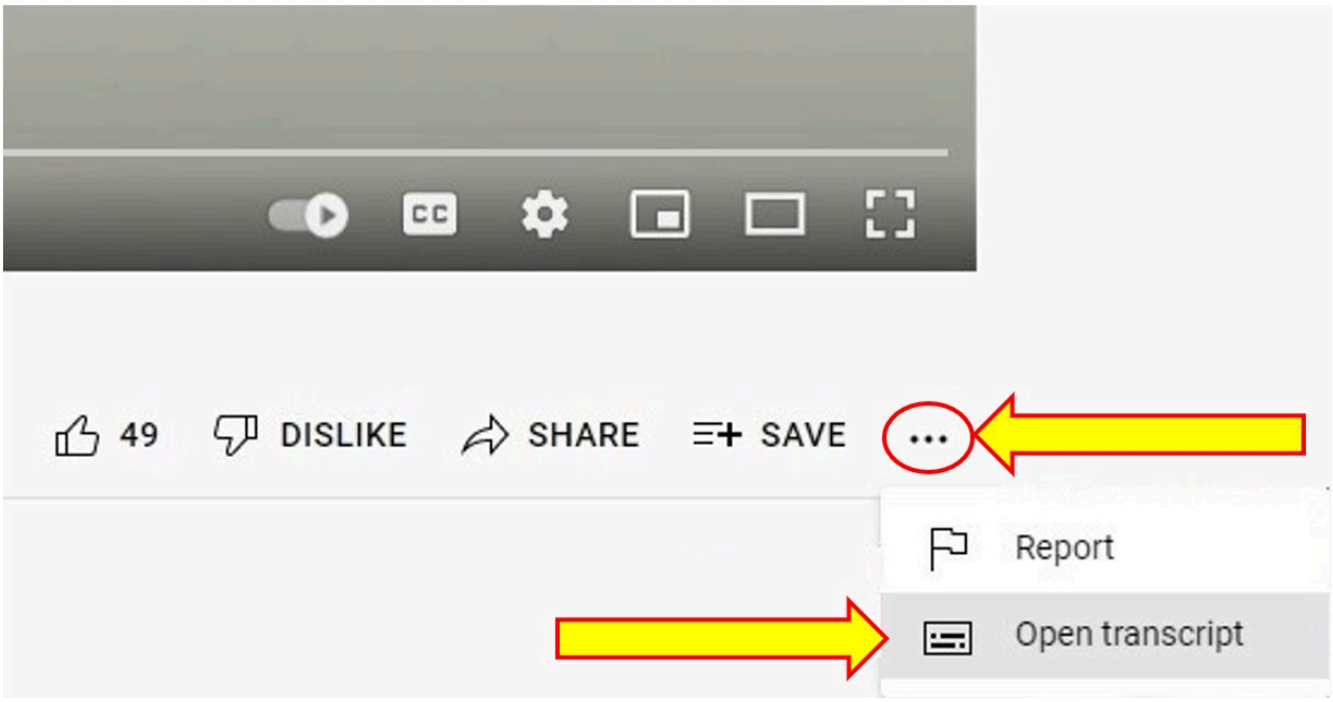

5.2 Cultural Safety

Culturally *unsafe* practices involve any actions that diminish, demean, or disempower the cultural identity and well-being of an individual.

According to Population Health Promotion and BC Women's Hospital:

> Culturally unsafe practices involve any actions that diminish, demean, or disempower the cultural identity and well-being of an individual. Creating a culturally safe practice involves working to create a safe space that is sensitive and responsive to a client's social, political, linguistic, economic, and spiritual realities. Ultimately, adopting a cultural humility perspective is one of the most effective ways to enable cultural safety – one that will help clients feel safe receiving and accessing care.

Indigenous Cultural Safety and Cultural Humility

As a result of Canada's legacy of colonization with Indigenous Peoples, working towards cultural safety and trust requires humility, dedication, and respectful engagement. Indigenous Cultural Safety is when Indigenous Peoples feel safer in relationships and communities.

According to BC Patient Safety and Quality Council, working towards **culturally safe engagement** with Indigenous communities requires:

- Acknowledgement of the **history of colonialism** in Canada and the impacts of **systemic racism.**
- A level of **cultural awareness and sensitivity**. (e.g. *Provide a meaningful land acknowledgement. Get to know Indigenous Peoples from the Land you work and live on. Be a lifelong learner.*)
- Deep **humility** and an **openness to learning**. (e.g. *Research local cultural practices and protocols. Read the Truth and Reconciliation Recommendations.*)
- Time for **relationship building, connection**, **collaboration, and cultivating trust**. (*e.g. Work towards balancing power dynamics. Be mindful of experiences of intergenerational trauma in building relationships. Integrate* ***trauma-informed community practices.***)

According to San'yas Anti-Racism Indigenous Cultural Safety Training Program a commitment to Indigenous Cultural Safety recognizes that:

- cultural humility aims to build mutual trust and respect and enables cultural safety
- cultural safety is defined by each individual's unique experience and social location
- cultural safety must be understood, embraced, and practiced at all levels of community practice
- working towards cultural safety is everyone's responsibility

6. Indigenous Worldviews

Community development practice owes much of its ways of knowing, doing, and being to Indigenous communities worldwide. Indigenous values of *interdependence* and *caring for all* are at the heart of this practice.

According to activist and academic Jim Silver (2006), who is non-Indigenous:

The process of people's healing, of their rebuilding or recreating themselves, is rooted in a revived sense of community and a revitalization of [Indigenous] cultures...The process of reclaiming an [Indigenous] identity takes place, therefore, at an individual, community, organizational, and ultimately political level. This is a process of **decolonization** that, if it can continue to be rooted in traditional [Indigenous] values of sharing and community, will be the foundation upon which healing and rebuilding are based. (p. 133)

Many Indigenous authors acknowledge one's **identity** as intricately connected to **community** (Carriere, 2008). In fact, family, kinship, and community are viewed as a significant determinant of well-being (Kral, 2003). This community identity is often **place-based**, connected to the Land and one's place of origin.

Baskin (2016) shares an example of an Indigenous community program that emphasizes the well-being of the community and family above that of the individual:

[At] Mino-Yaa-Daa (meaning "Healing Together" in the Anishnawbe language), [t]he individual is seen in the context of the family, which is seen in the context of the community... when an individual is harmed, it is believed that this affects all other individuals in that person's family and community... By coming together in a circle, women learned that they were not alone, and that their situations and feelings were similar to those of other women... [building relationships and a community of empowered women] can only be achieved by individuals coming together in a circle. This kind of community-building cannot happen through individual counselling or therapy (pp. 164-165).

Key Takeaways And Feedback

We want to learn your key takeaways and feedback on this chapter.

Your participation is highly appreciated. It will help us to enhance the quality of Community Development Practice and connect with you to offer support. To write your feedback, please click on Your Feedback Matters.

Thank you!

Attribution

AN INTRODUCTION TO THE ECOLOGICAL MODEL

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The Women and Children Health Policy Center (WCHPC). (2014, September 11). *An Introduction to the Ecological Model in Public Health* [Video]. YouTube. https://www.youtube.com/watch?v=Rm00AzC-gEU

Ecological Systems Theory

Ecological Systems Theory (EST), also known as human ecology, is an ecological/ system framework developed in 1979 by Urie Bronfenbrenner (Harkonen, 2007). Harkonen notes that this theory was influenced by Vygotsky's socio-cultural theory and Lewin's behaviorism theory.

Bronfenbrenner's research focused on the impact of social interaction on child development. Bronfenbrenner believed that a person's development was influenced by everything in the surrounding environment and social interactions within it. EST emphasizes that children are shaped by their interaction with others and the context. The theory has four complex layers called systems, commonly used in research. At first, ecological theory was most used in psychological research; however, several studies have used it in other fields such as law, business, management, teaching and learning, and education.

Previous Studies

EST has been used in many different fields, however, commonly, it is used in health and psychology, especially in child development (e.g., Heather, 2016; Esolage, 2014; Matinello, 2020). For instance, Walker et al. (2019) used an EST framework to examine risk factors for overweight and obese children with disabilities. The study focused on how layers of an ecological system or environment can negatively affect children with special needs in terms of weight and obesity. They found that microsystem such as school, family home, and extracurricular activities can impact overall health through physical activities and food selectivity. Furthermore, the second layer, mesosystem (e.g., family dynamic and parental employment), also can lead to an increase in children's weight because of a lack of money to buy nutritious food. In addition, children may be socially isolated and excluded in ways that cause stress, and their parents might use food to reinforce or comfort them. The third layer the study adopted was the macrosystem. For example, some cultures discriminate against children with disabilities so that they face more difficulty gaining access to health services.

In the field of language teaching, Mohammadabadi et al. (2019) researched factors influencing language teaching cognition. They used an ecological framework to explore the factors influencing language teachers at different levels. They adopted the four systems from Bronfenbrenner's theory for studying the issue. This study found that the ecological systems affect language teaching. For example, the microsystem included a direct influence on teachers' immediate surroundings, such as facilities, emotional mood, teachers' job satisfaction, and linguistic proficiency. The mesosystem defined interconnections between teachers' collaboration and their prior learning experience. The exosystem included the teaching program and curriculum and teachers' evaluation criteria, while the macrosystem addressed the government's rules, culture, and religious beliefs. In other words, researchers use EST to guide the design of their studies and to interpret the results.

Model of EST

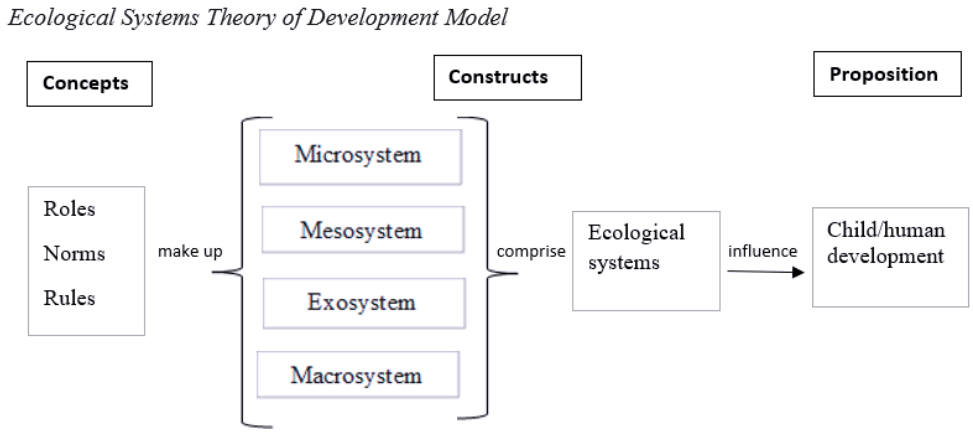

Figure 4.3.3 – Model of EST – Ecological Systems Theory of Development by Samsu Alam, contributor to Theoretical Models for Teaching and Research, edited by Joy Egbert and Mary Roe, CC-BY-NC.

Concepts, Constructs, and Propositions

The four systems that Brofenbrenner proposed are constructed by roles, norm and rules (see Figure 4.3.3). The first system is the microsystem. The microsystem as the innermost system is defined as the most proximal setting in which a person is situated or where children directly interact face to face with others. This system includes the home and child-care (e.g., parents, teacher, and peers). The second is the mesosystem. The mesosystem is an interaction among two or more microsystems where children actively participate in a new setting; for instance, the relationship between the family and school teachers. The third is the exosystem. This system does not directly influence children, but it can affect the microsystem. The effect is indirect. However, it still may positively or negatively affect children's development through the parent's workplace, the neighborhood, and financial difficulties. The outermost system is the macrosystem. Like the exosystem, the macrosystem does not influence children directly; however, it can impact all the systems such as economic, social, and political systems. The influence of the macrosystem is reflected in how other systems, such as family, schools, and the neighborhood, function (Kitchen et al., 2019). These four systems construct the EST which considers their influences on child or human development.

Bronfenbrenner (cited in Harkonen, 2007) noted that those environments (contexts) could influence children's development constructively or destructively. As the proposition, the system influences children or human development in many aspects, such as how they act and interact, their physical maturity, personal characteristics, health and growth, behavior, leadership skills, and others. At the end of the ecological system improvement phase, Bronfenbrenner also added time (the chronosystem) that focuses on socio-history or events associated with time (Schunk, 2016). In summary, the views of this ecological paradigm is that environment, social interaction, and time play essential roles in human development.

Using the Model

There are many possible ways to use the model as teachers and parents. For teaching purposes, teachers can use the model to create personalized learning experiences for students. The systems support teachers and school administrators to develop school environments that are suitable to students' needs, characteristics, culture, and family background (Taylor & Gebre, 2016). Because the model focuses on the context (Schunk, 2016), teachers and school administration can use the model to increase students' academic achievement and education attainment by involving parents and observing other contextual factors (e.g., students' peers, extra-curricular activities, and neighbor) that may help or inhibit their learning.

Furthermore, the EST model can support parents to educate and guide their children. It can prompt parents to assist their children in choosing their friends and finding good neighborhoods and schools. Additionally, they can build close connections to teachers, so they know their children' skills and abilities. By involving themselves in schools, parents can positively influence their children's educational context (Hoover & Sandler, 1997).

For research purposes, researchers can test and modify or refine the EST proposition, or they can find additional ways to measure it. Researchers also can develop questionnaires from the components or concepts and construct of EST. Additionally, the four levels of EST can be used by researchers to frame qualitative, quantitative, and mixed research (Onwuegbuzie, et.al., 2013).

Conclusion

At first, EST was used in children's development studies to describe their development in their early stages influenced by the person, social, and political systems. Currently, EST is broadly applied in many fields. Schools or educational institutions can use EST to improve students' achievement and well-being. Interaction between the family, parents, teachers, community, and political system will determine students' development outcomes.

For More Information – Videos:

- SocioEcological Theory of Addiction
- SocioEcological Theory of Addiction – Doc Snipes
- Bronfenbrenner's Ecological Systems: 5 Forces Impacting Our Lives
- Bronfenbrenner's Ecological Systems Theory

Social Theories

We live in a complex world with many factors that influence our behaviours. As discussed in psychological theories, we learn from many areas including individual, family, peer and community.[1] Substance use may be familial, a person may have watched a parent or caretaker use alcohol on special occasions or more frequently. Perhaps you had a parent who smoked tobacco, and this may have played a role in whether you smoke. These social connections that are critical for our development as babies, toddlers, youth and into adulthood play a role in what we do, how we act, and how we live.

Activities

1. Brainstorm a list of things you do each day, from morning until night.
2. Scratch out everything you do in a group. What is left?
3. How much of your daily interactions are with a group?

---

1. [2]
2. [1]

4. How did you learn to do each activity you do daily?

Social connections are also important for our health. Think back to the beginning days of the COVID-19 pandemic and how many people were negatively impacted by the social gathering restrictions. Some people increased their substance use to cope with the isolation.[3] Some people used technology to connect with family, friends, and even with their workplace.

Activities

1. Brainstorm a list of things you did to cope with the isolation from the pandemic.
2. Did you increase your substance use?
3. How important is social connection in your life?
4. Did technology help?

Social connection is an important factor in wellness and subsequently whether a person uses substances.[5]

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3. [4]
4. [2]
5. [6]
6. [3]

Social learning theory suggests behaviour is influenced by the interaction of personal, social, and environmental factors including intrapersonal factors, interpersonal factors, institutional or organizational factors, community factors, and public policy.[7] This is intersectionality. If you have been negatively impacted by one of these factors, are you susceptible to a substance use disorder? The research indicates yes; remembering it is one risk factor and does not mean it WILL lead to a substance use disorder. This theory is often used in counselling in supporting individuals with substance use disorders as it allows supporters to focus on individual, environmental, and societal factors.

Food For Thought

- Reflect on a happy memory from your childhood.
- Identify everyone who was involved.
- What were the factors that make this memory so wonderful?

The social factors that influence us are complex. Many of the treatment models use a social-ecological approach, identifying factors like trauma, adverse childhood experiences, mental health, racism, as well as self-efficacy.

FURTHER READING

Chapter 5.0: Social Context and Physical Environment Models of Substance Misuse in Introduction to Substance Use Disorders by Patricia Stoddard Dare and Audrey Begun.

7. [8]
8. [4]

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4.4 CULTURAL COMPETENCE & DIFFERENT POPULATIONS

Figure 4.4.1 – Photo by Christina @ wocintechchat.com on Unsplash

Video 1: What Is Cultural Competence?

University students talk about what cultural competence is and what cultural competence means to them personally.

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them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=839#oembed-1

What is Cultural Competence. Video by: Arkansas Open Educational Resources (OER)

Transcript

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1. Click on **"YouTube"** on the bottom-right of the video. This will take you directly to the YouTube video.
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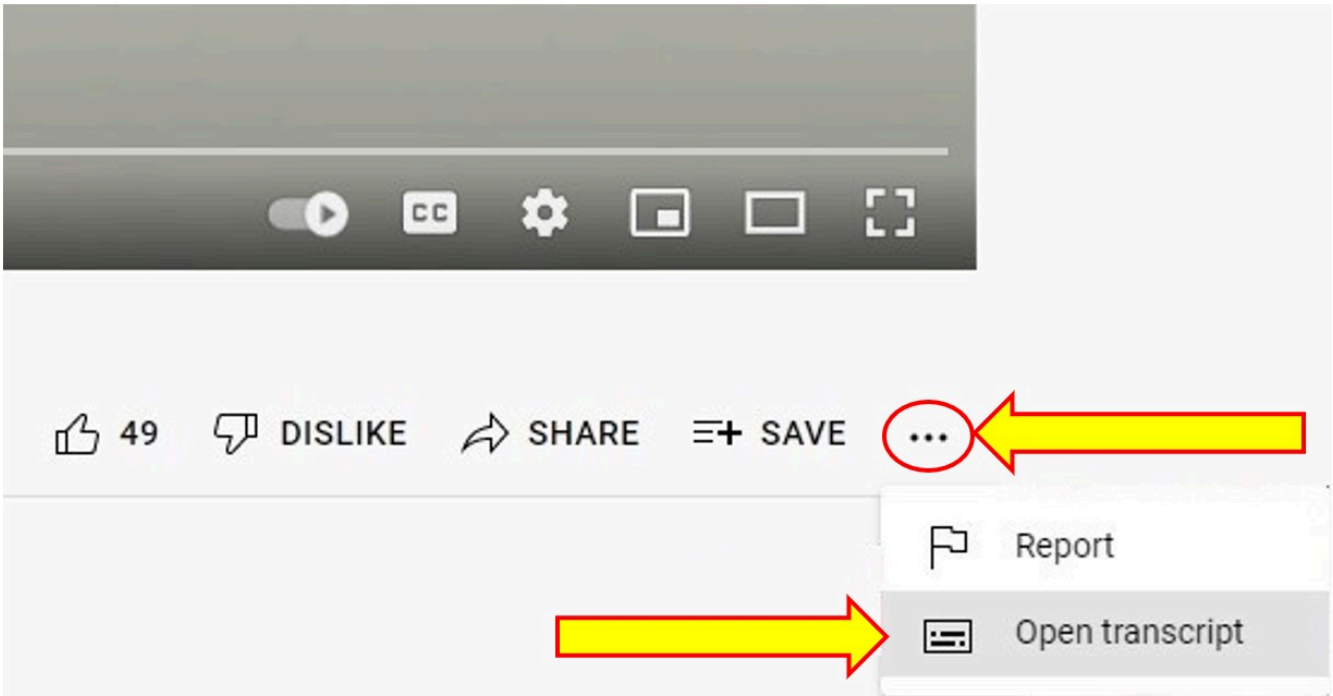

Video 2: Cultural Competence In Denial And Polarization

University students discuss what their experiences have been with either themselves or with others who have mindsets in Denial and Polarization in a monocultural mindset.

Denial is the first orientation in the IDI continuum and indicates a person is disinterested or avoidant of differences. Individuals in this orientation may avoid those who are different from themselves and view

their own cultural values and practices as preferable and may be critical of the cultural values and practices of others. Approximately 2% of people fall within Denial. The best strategy is for them to notice and recognize differences.

Next, Polarization (16%) is the "us vs. them" mindset, where people have a natural tendency to judge differences, and may become *Defensive* of their own way, identity, or culture; or they fall within *Reversal*, which is valuing others' cultures over one's own, and may report being embarrassed or ashamed of one's own culture. The best strategy for moving beyond these orientations is to start searching for commonalities among cultural groups.

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Video 2: Cultural Competence in Denial and Polarization; Video by: Arkansas Open Educational Resources (OER)

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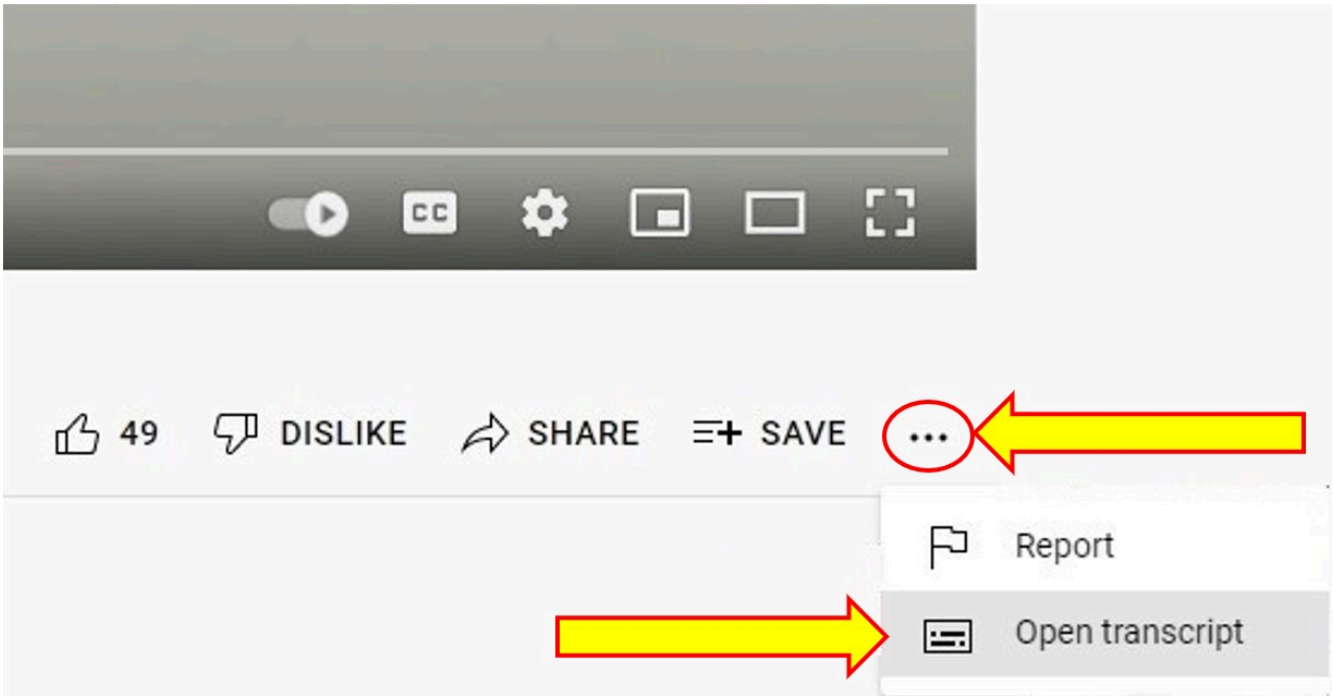

Video 3: Cultural Competence In Minimization

University students discuss what their experiences have been with either themselves or with others who have mindsets in Minimization.

Most people (65%) fall within Minimization, which is the tendency to focus too much on similarities and by ignoring differences; essentially, this orientation represents "colour-blindness," where people say, "I don't see colour, we're all the same" but takes away the value of individuality with which one identifies. This expectation of cultural commonality and universal values and principles may mask a deeper recognition of cultural differences. These individuals tend to have really "good hearts," believe in equality and humanity but have poor impact. The best strategy for moving beyond this orientation is to explore and focus on issues of power, privilege, and systemic differences.

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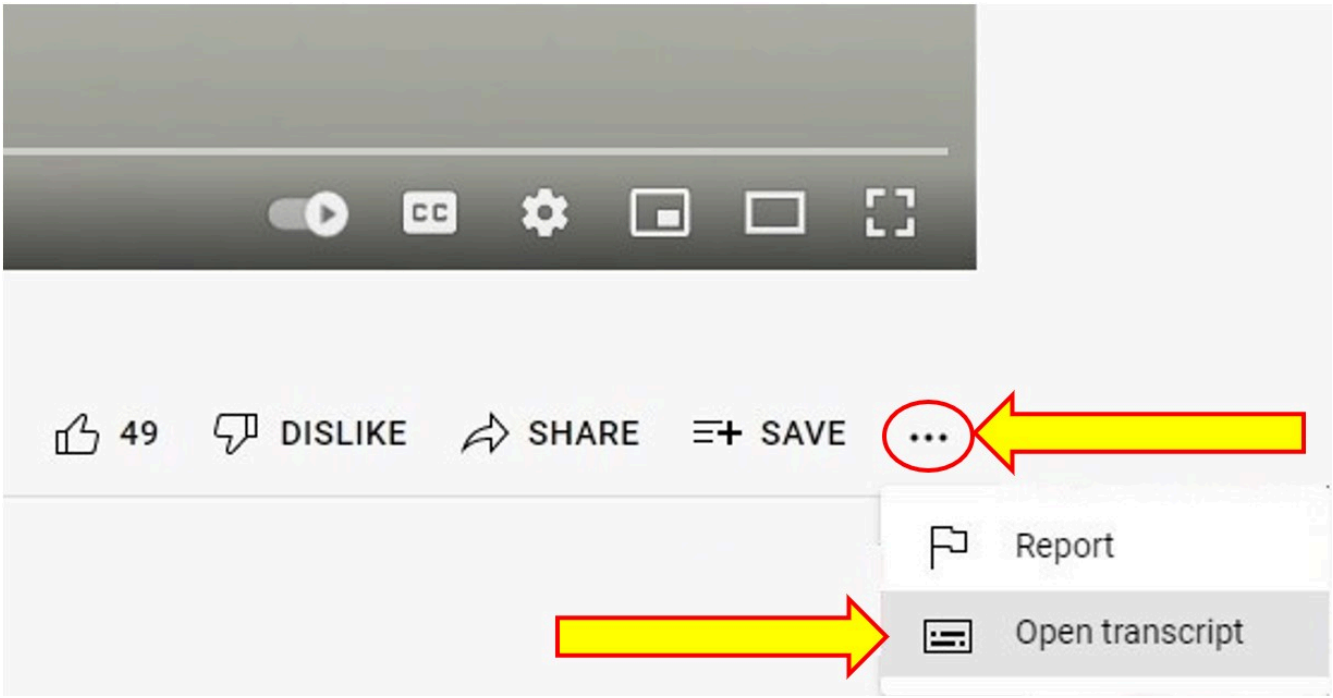

Video 4: Cultural Competence In Acceptance And Adaptation

University students discuss what their experiences have been with either themselves or with others who are oriented in Acceptance and Adaptation.

Moving toward a more intercultural mindset, individuals in Acceptance (15%) are those who recognize and appreciate cultural differences and similarities, but need additional experiences, as they are able to "talk the talk," but not quite able to "walk the walk." These individuals may recognize and appreciate culturally different patterns and commonalities in both their own and others' cultures but may not know how to advance toward a more intercultural mindset.

Adaptation (only 2% of people) is truly becoming able to "walk the walk" and to adapt one's behaviour within both cultural similarities and differences. Those who find themselves in the Adaptation orientation are capable of shifting cultural perspectives and altering their behaviour in ways that are both culturally appropriate and authentic. Cultural competence is a journey, not an event, and one must continue growing in their cultural competence to have an Adaptation mindset. Those who reach this orientation have a strong sense of cultural self-awareness and understanding and are able to "bridge" behaviours across cultural differences.

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Cultural Competence in Acceptance and Adaptation. Video by: Arkansas Open Educational Resources (OER)

Transcript

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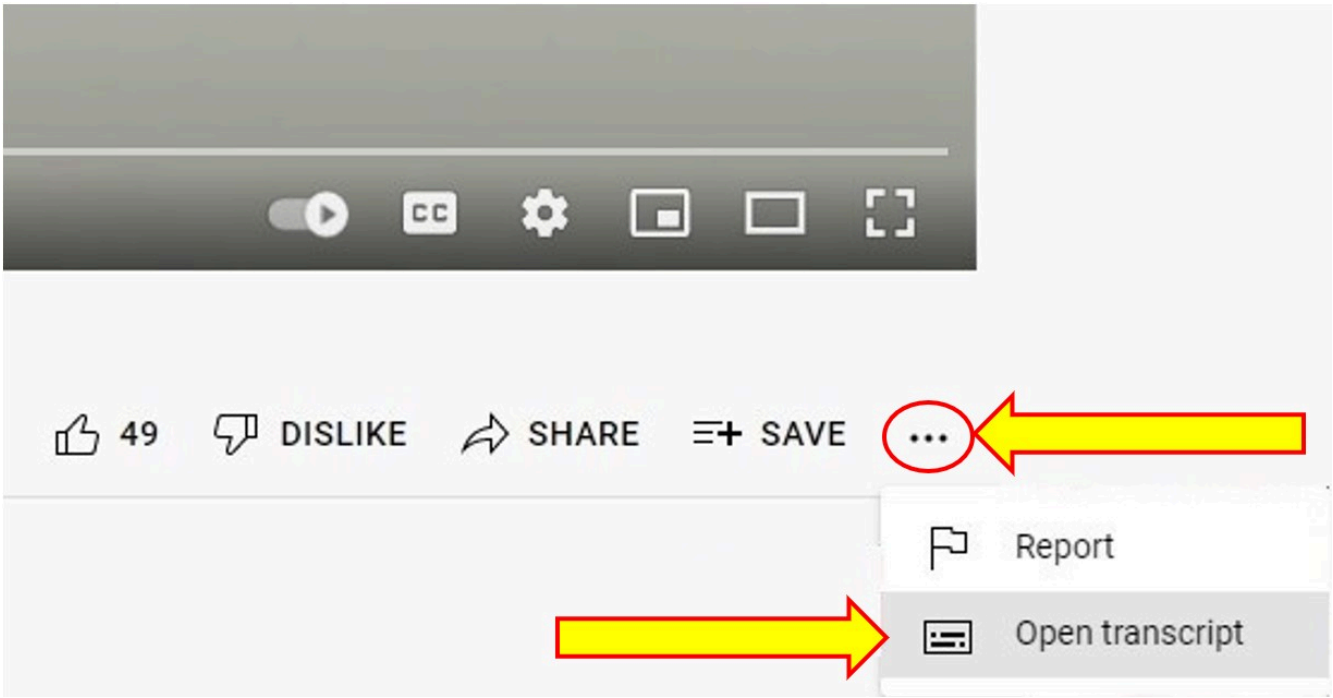

Video 5: Becoming Culturally Competent

University students discuss what it means to become culturally competent. They provide specific strategies that anyone can use to advance along the continuum.

Based on the IDI framework, three major steps are needed to grow in cultural competence:

1. Learning about your own self-identity and culture,
2. Learning about cultures that are different from your own, and
3. Having experiences where you can navigate cultural differences and similarities.

A deeper cultural self-understanding helps one to make sense of and respond to differences in cultural perspectives based on their own culturally learned perspectives, while a deeper cultural other-understanding helps individuals make sense of and respond to differences in culture as they are presented by other cultural groups.

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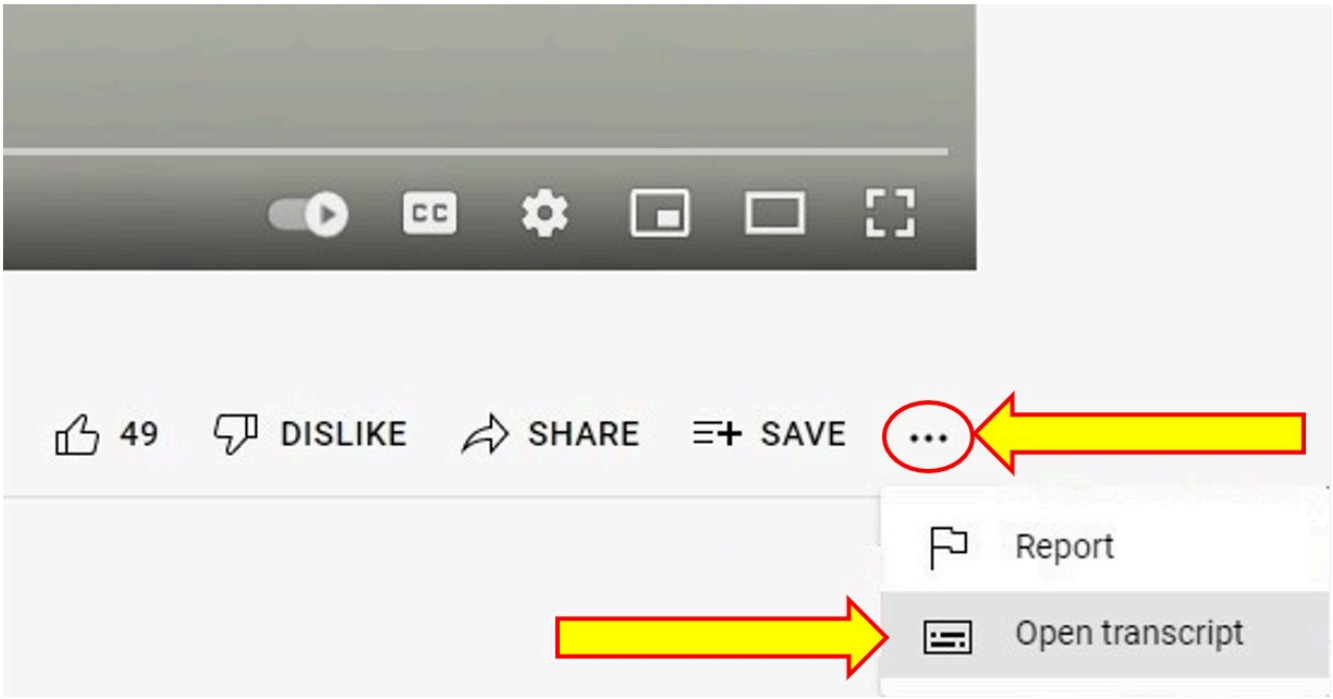

Don't Put People in Boxes

Quite often when we're looking at Cultural Competence, different populations or diverse communities we don't always take into consideration how diverse each culture can be.

We need:

- Value diversity
- Conducting cultural self-assessment
- Understand the dynamics of difference
- Institutionalizing cultural knowledge
- Adapt to diversity and individuality

Once size does not fit all. People are not a dichotomy (a division or contrast between two things that are or are represented as being opposed or entirely different). For example: Good/bad or yes/no.

Don't Put People in Boxes

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Video by: NewHope Church. (2017, May 22). *Don't Put People in Boxes* [Video]. When we label people and put them in different boxes, we don't see PEOPLE for who they truly are. This video proves that we have a lot more in common than we think and we should keep that in mind when we encounter anyone who might seem different than we are. Credit to TV2Danmark for inspiring us to make this.

Transcript

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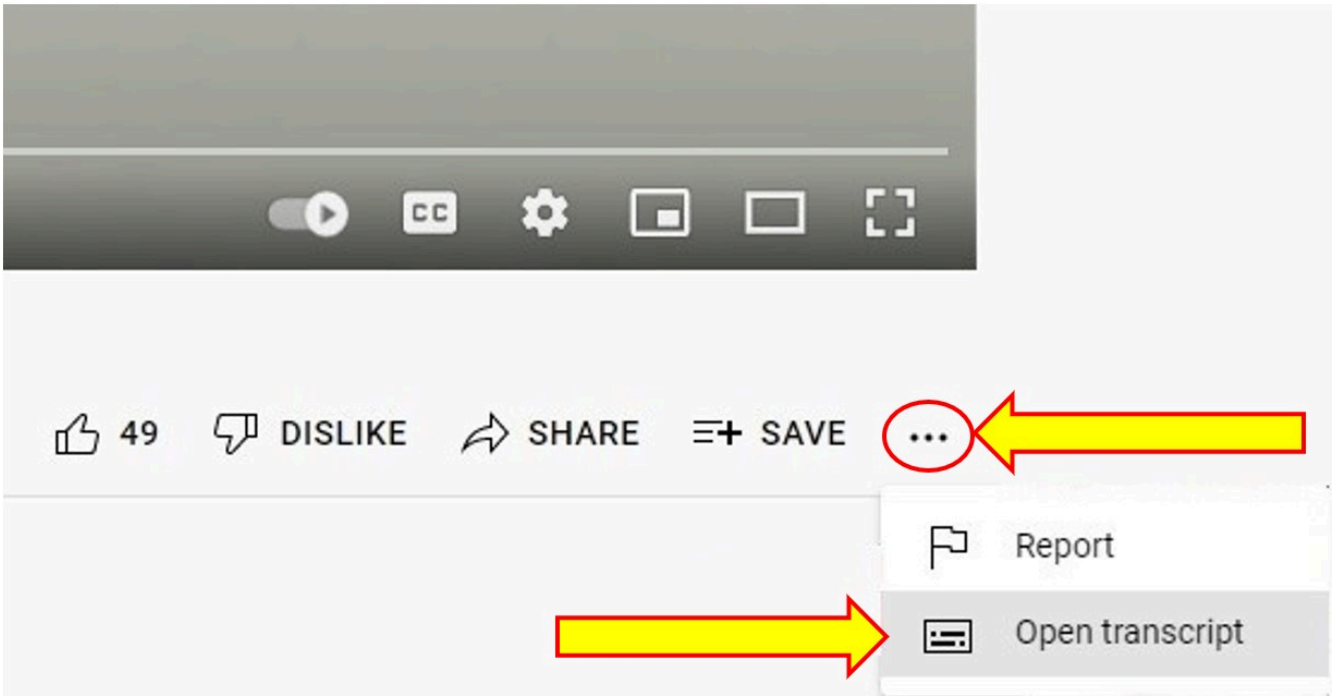

DIFFERENT POPULATION

Race & Privilege: A Social Experiment – We often say the words: diversity, culture, race, language or religion, and we don't realize how different it is for so many. We normalize certain behaviours which is not ok. There is privilege. Watch what happens in this experiment – and how participants react.

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Race & Privilege: A Social Experiment | Regardless Of Race | CNA Insider. We say the words, "Regardless of race, language or religion." But majority privilege may be more real in Singapore than some would like to think. Watch what happens in this experiment – and how participants react.

Transcript

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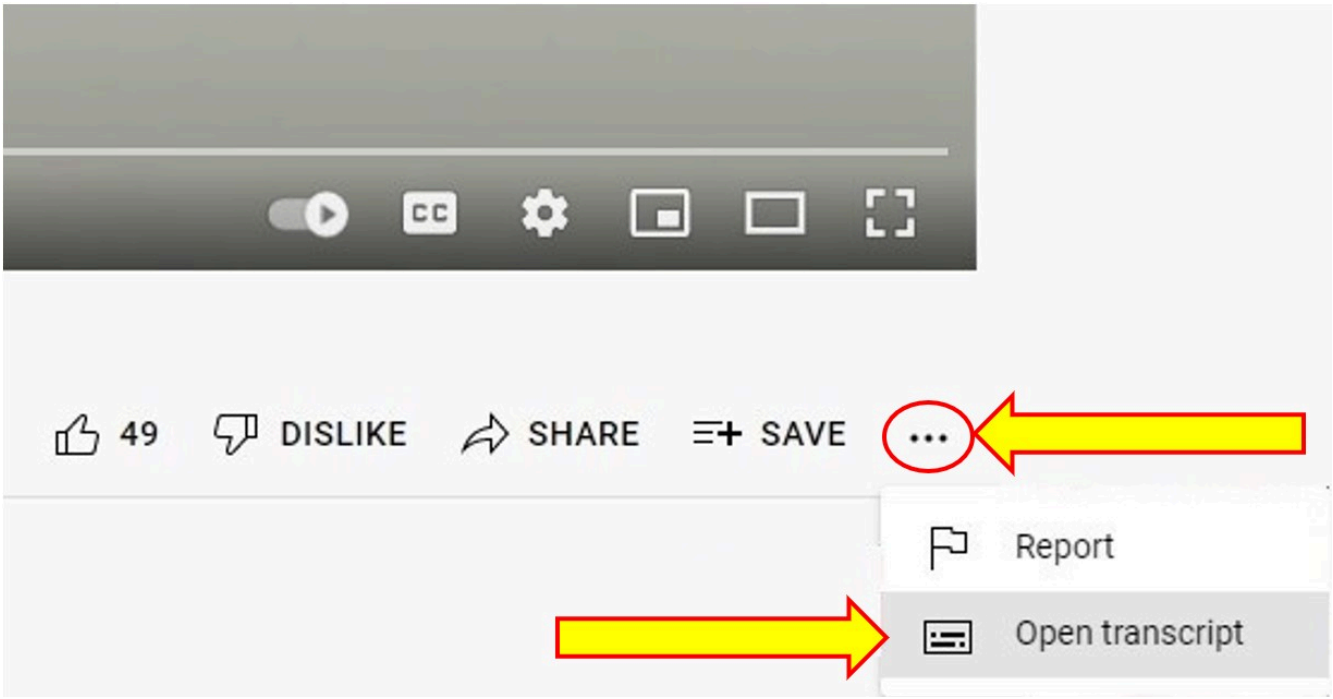

It is important when working with cultural competence and different populations that

we are aware of diversity, inclusion, individuality, whenever we are working through a Case Management Lens. It will look different for each individual person, even if they have similarities. It can also be applied differently depending on what agency you work for.

References

- NewHope Church. (2017, May 22). *Don't Put People in Boxes* [Video]. YouTube. https://www.youtube.com/watch?v=zRwt25M5nGw
- CNA Insider. (2016, August 14). *Race & Privilege: A Social Experiment | Regardless Of Race | CNA Insider* [Video]. YouTube. https://www.youtube.com/watch?v=F2hvibGdg4w

4.5 INDIGENOUS CASE MANAGEMENT

Figure 4.5.1 – Photo by Stéfano Girardelli on Unsplash

When we are looking at Indigenous Case Management we need to consider the challenges and barriers that *Indigenous* communities have experienced through their journey and intergenerational trauma. Case Managers are responsible for assisting the Indigenous communities in accessing services by way of holistic wellness planning, counselling, service coordination / navigation.

Decolonizing Community

Topics:

1. What Is Decolonization? Why Does It Matter?
2. Indigenization

1. WHAT IS DECOLONIZATION? WHY DOES IT MATTER?

Material in this section is adapted from:

If we want to challenge social injustice and contribute to systemic change, we need to understand and integrate concepts of *decolonization* and *Indigenization* in community practice in an intentional and ongoing way.

Decolonization is the process of deconstructing colonial ideologies that claim the superiority and privilege of Western thought and approaches (Cull et al., 2018). On the one hand, decolonization involves dismantling structures that perpetuate the status quo and address unbalanced power dynamics. On the other hand, decolonization involves valuing and revitalizing Indigenous knowledges and approaches, and challenging settler biases and assumptions that have impacted Indigenous ways of being (Cull et al., 2018).

"**Decolonization** doesn't have a synonym" (Tuck & Yang, 2012, p. 3). While unquestionably connected to *human rights* and *social justice*, it is not a substitute for these concepts (Ritskes, 2012). Specifically, decolonizing demands a centering of Indigenous ways of knowing and being, Indigenous Land, and Indigenous sovereignty.

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centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=115#oembed-1

Video: DECOLONIZED EDUCATION EXPLAINED IN SIMPLE TERMS By: Real Talk. "There is no discipline that is immune from this call of decolonisation" Dr Lwazi Lushaba

Transcript

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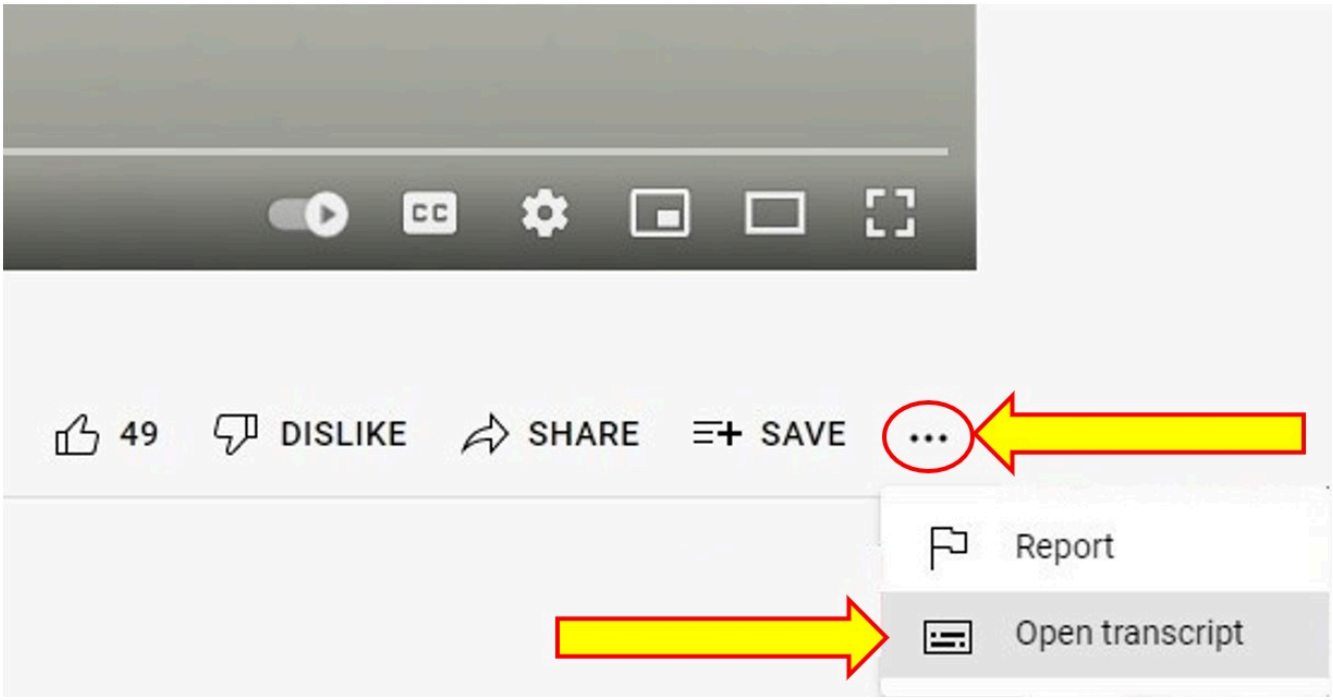

The physical and mental aspects of decolonization apply equally to Indigenous and non-Indigenous communities (Gray, Coates, Yellow Bird, & Hetherington, 2016).

For non-Indigenous people, decolonization is the process of critically examining your beliefs about Indigenous Peoples and cultures by learning about yourself in relationship to the Land and communities where you live and the people with whom you interact.

We work in **systems** that perpetuate colonial ideals and privilege Western ways of being and doing. For example, many community services use forms and procedures instead of first initiating relationships with

community members. This is a colonial process that tends to create environments of exclusion rather than inclusion.

Q – What other community practices and approaches can you think of that are rooted in colonial ways of thinking and doing?

Decolonization is an ongoing process that requires all of us to be collectively involved and responsible. Decolonizing our institutions means we create spaces that are inclusive, respectful, and honour Indigenous Peoples.

(Adapted from Decolonization and Indigenization)

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=115#oembed-2

Video: Ted Talk – Decolonization is for Everyone. "This history is not your fault, but it is absolutely your responsibility." A history of colonization exists and persists all around us. Nikki discusses what colonization looks like and how it can be addressed through decolonization. An equitable and just future depends on the courage we show today. "Let's make our grandchildren proud".

Transcript

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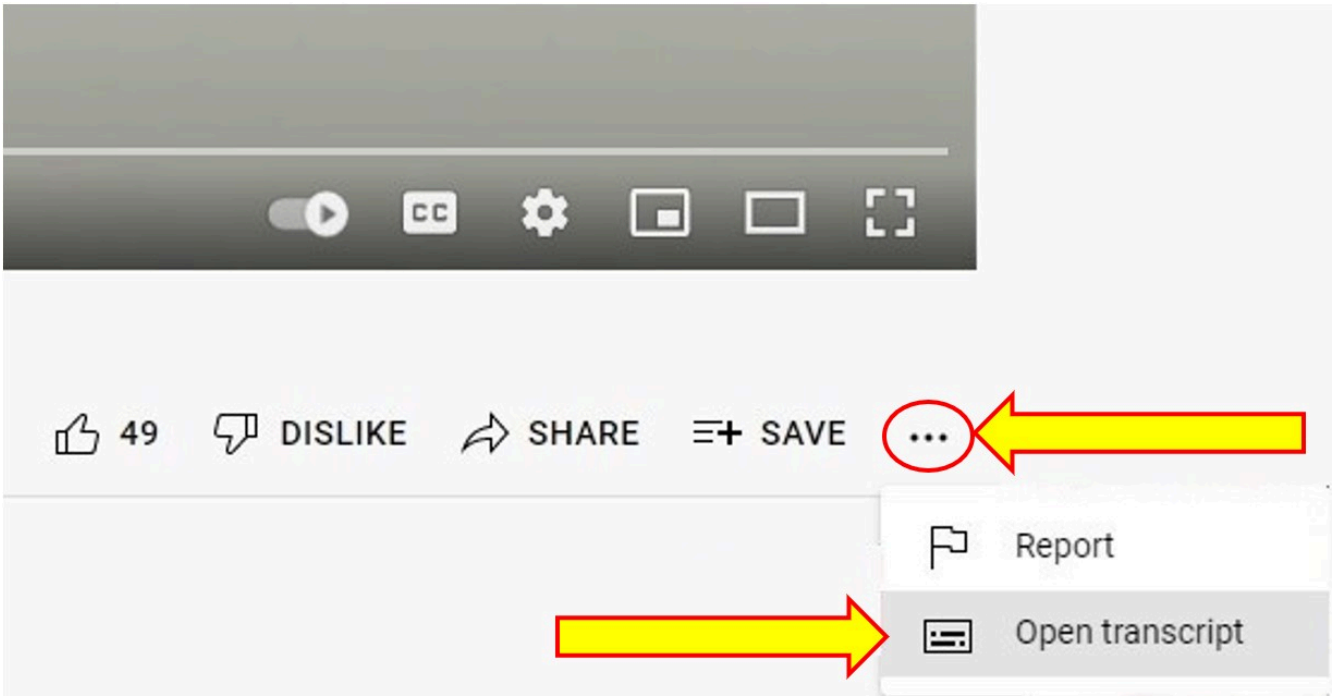

SOURCE: YOUTUBE, HTTPS://YOUTU.BE/QP9X1NNCWNY

2. Indigenization

Material in this section is adapted from:

Indigenization is a collaborative process of naturalizing Indigenous intent, interactions, and processes and making them evident to transform spaces, places, and hearts. In the context of community development practice, this involves including Indigenous perspectives and approaches to the benefit of all community members (Cull et al., 2018)

Indigenization seeks a fundamental shift in the ways that communities:

- Include Indigenous perspectives, values, and cultural understandings in daily practices
- Position Indigenous ways of knowing at the heart of community development work
- Integrate cultural protocols and practices in the operations of our organizations

Indigenization values sustainable and respectful relationships with First Nation, Métis, and Inuit communities, Elders, and organizations. When Indigenization is practiced at the community level, Indigenous Peoples see themselves represented, respected, and valued and all community members benefit. We all gain

a richer understanding of the world and of our specific location in the world through an awareness of Indigenous knowledges and perspectives. Indigenization also contributes to a more just world, creating a shared understanding that opens the way toward reconciliation between Indigenous and non-Indigenous people. It also counters the impacts of colonization by upending a system of thinking that has typically discounted Indigenous knowledge and history.

Indigenization, like decolonization, is an ongoing process, one that will shape and evolve over time.

Starting With Ourselves: Good Intentions Are Not Enough

Good intentions are not enough for community development work. Our work must be grounded in anti-oppressive, anti-racist, and decolonizing practices and relations; otherwise, **we risk repeating harmful mistakes of the past.**

It is our responsibility to question the ways in which we show up in communities, the space we take up, the power and privilege we have been afforded, and how we (knowingly or unknowingly) perpetuate systemic oppressions and settler-colonialism while engaged in community work.

Reflection Questions:

If you are a settler on this Land, it is your responsibility to reflect on how you have benefitted (and continue to benefit from) the **ongoing devastation and genocide of Indigenous Peoples** as a result of colonialism. How have you been complicit in upholding these colonial systems of oppression? Who are you accountable to?

A Shift In Perspective and Power

Indigenous Worldviews on working with communities are valuable for *all* community and social service workers. Decolonizing our practice requires an ongoing commitment to learning and *un*learning; to critical thinking; and to inviting uncomfortable questions that interrogate and challenge accepted knowledge and ways of thinking.

Decolonizing community practice requires an intentional shift in perspective and power from working *for* a community to working *with* a community.

"If you come here to help me, you're wasting your time. If you come because your liberation is bound up with mine, then let us work together." – Lilla Watson

As outlined in the ***Seven Sacred Teachings***, the value of **humility** is critical in reminding us that we are merely one small piece of the bigger puzzle. **Nobody is an expert on other people's lives.** Adopting a stance of "*not-knowing", humility, openness, and curiosity,* together with a willingness to be held accountable by the communities we serve, are key ingredients for this work.

Change does not happen overnight. Social change takes intentional, ongoing, consistent actions from individuals, groups, and communities. We must look to – and listen to – Indigenous Peoples throughout the process.

Taking Action

We would like to acknowledge that this resource would not have been possible without the work of Indigenous scholars, who have been researching and writing in this field for decades.

When learning about settler colonialism and working in communities:

- Do not act out of guilt, but rather out of a genuine interest in challenging the larger oppressive power structures.
- Understand that [you] are secondary to the Indigenous Peoples that [you] are working with and that [you] seek to serve. [You] and [your] needs must take a back seat;
  – Lynn Gehl, "My Ally Bill of Responsibilities."
- Accept that you will make mistakes and upset people as you learn.
- Take responsibility for your own learning. *Where do you live? Whose Land are you on? Are you on* ***unceded Land****? Are you on* ***Treaty Land****?* Learn what your responsibilities are and how you can act in solidarity with Indigenous Peoples in your community.

Some preliminary steps for settlers in decolonizing community development practice can be found here at the Community Development Learning Initiative.

To get started with your (un)learning journey, check out this database of anti-racism and decolonization resources.

For More Information:

Seven Sacred Teachings

Video: Indigenous Education & Services: Seven Grandfather Teachings By: George Brown College. Learn about the Seven Grandfather Teachings, also known as the Seven Sacred Teachings, from Indigenous Counsellor and Professor Bob Whiteduck Crawford

Transcript

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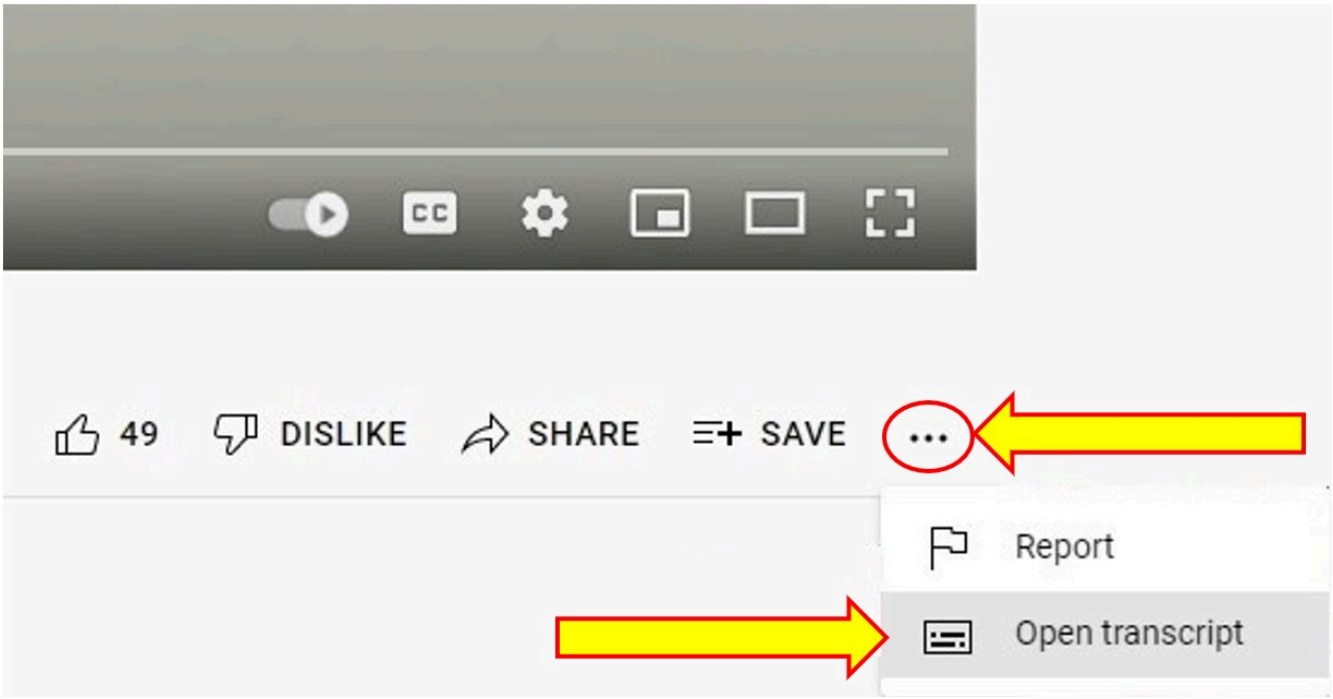

Indigenous Case Management Model: Adapting Housing First for Youth for Indigenous Youth (HF4Y)

Making the Shift Youth Homelessness Demonstration Lab (MtS DEMS) is a collaborative project working to develop and test approaches to support the prevention of and facilitate sustainable exits from homelessness. It

is a joint endeavour co-led by A Way Home Canada (AWHC) and the Canadian Observatory on Homelessness (COH) with support from MaRS Centre for Impact Investing. (Indigenous Case Management Model: Adapting Housing First for Youth for Indigenous Youth (HF4Y), 2021).

In this video, Sheryl Green from HRIC showcases how to use the Indigenous case management model developed by Endaayaang.

Indigenous Case Management Model

Video: Indigenous Case Management Model: Adapting Housing First for Youth (HF4Y) for Indigenous Youth by Homeless Hub. Learn how to use the Indigenous case management model developed by the Endaayaang Housing First for Youth Project (HF4Y) in Hamilton, ON to help adapt HF4Y for Indigenous youth.

Transcript

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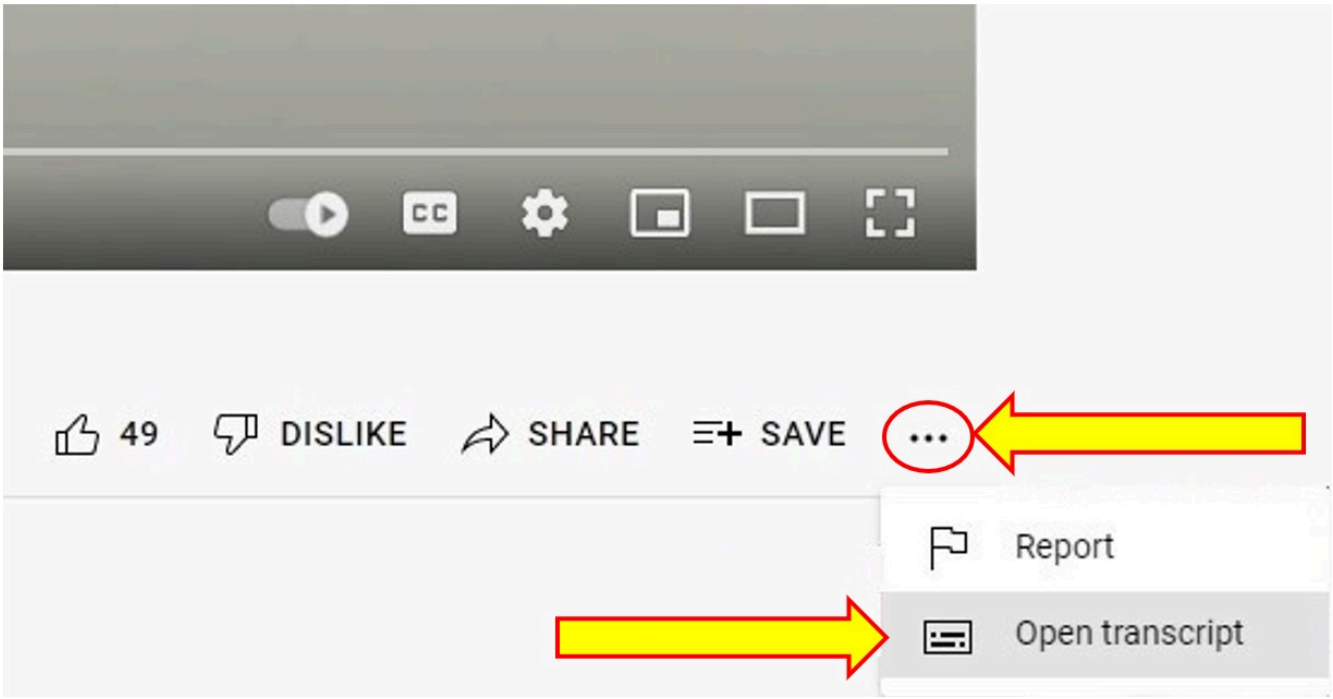

To Explore Further:

- NCCT – Native Canadian Centre of Toronto – Case Management for Adults
- Indigenous Case Management Model: Adapting Housing First for Youth for Indigenous Youth (HF4Y)
- Making the Shift Youth Homelessness Demonstration Lab
- Hamilton Regional Indian Centre
- Traditional Health and Wellness

Elders

What is an Elder? The term Elder "refers to someone who has attained a high degree of understanding of First Nation, Métis, or Inuit history, traditional teachings, ceremonies, and healing practices" (University of Toronto, 2019, para. 1) and is not defined by their age. Elders do not belong to just one family, they are part of the community, and respect should be given to Elders from all, both Indigenous and non-Indigenous peoples. Elders have a revered place among Indigenous communities in Canada. "Elders were the carriers of knowledge of both physical and spiritual reality and that they have been educated through the oral tradition" (Marsh et al., 2015, para. 7). The role of Elders in Indigenous communities cannot be stressed enough. They are the keepers of knowledge and are honoured and respected. Please watch the video below to deepen your understanding of Elders.

The Elders: Getting to know some of the most honoured members of First Nation communities. By: CBC News. Elders from Mi'kmaw, Wolastoqi and Peskotomuhkati communities shared their stories for this five-part weekly series

Transcript

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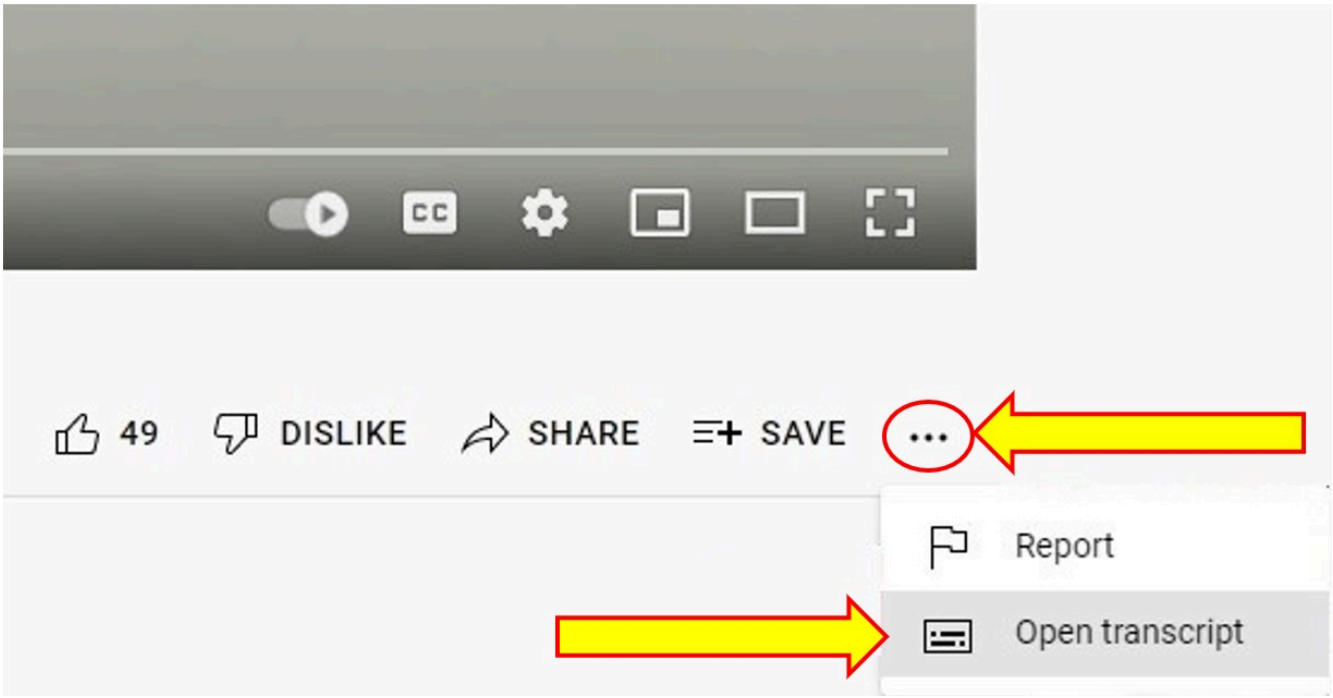

Land Based Treatment

Nature is a powerful force and how we engage with nature depends on many factors, where we live, access to wilderness, finances, ability, safety and more. One of the social determinants of health is environment; consequently, where we live plays a role in our health. The earth takes care of us, it is where we build our homes, grow/hunt/fish our food, drink our water, and we live, work, and play on the land.

Drumming

Excerpt from "Interview with Morning Star River Singers" November 7, 2004, Toronto, ON

The drum is circular; Mother Earth is circular and that's what that drum represents. It represents Mother Earth. When the singers sound the drum that is the heartbeat of Mother Earth and we give thanks for everything that she gives us. She has been taking care of us from the beginning of time, taking care of us with food, water, medicine, everything. She has never turned her back on us. So when the singers are sounding that drum and the dancers are coming around that drum, they are dancing in time with that drum to show that connection to her. While they are dancing they are thinking about those things that Mother Earth provides for us, but as well they are thinking about all their friends and family that have helped them along the way in their life. Every one of us has been through trying times and we needed our relatives for support. We need our friends for support and they've been there for us no matter how down we have been; they have been there for us. So we need to acknowledge and remember all those people because that drum there represents life, represents all of the seasons, represents all of those things – like the medicine wheel teachings on that drum.

Activities:

1. Choose one of the following films about Indigenous drumming.
    1. https://www.nfb.ca/film/first_stories_his_guidance_okiskinotahewewin/
    2. https://www.nfb.ca/film/poundmakers_lodge_healing_place/
2. Brian Knockwood of Sipekne'katik First Nation – Uses this for Substance Abuse .

To Explore Further:

- Historical and Contemporary Realities: Movement Towards Reconciliation
- The Seven Grandfather Teachings – Government of Canada

Attribution:

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4.6 CORRECTIONAL CASE MANAGEMENT

The Correctional Process

The Correctional Service of Canada (CSC) oversees an offender's correctional process through several stages:

The Process includes:

- An Assessment
- Security Classification
- The Correctional Plan
- Case Management
- Preparation for Release
- Community Corrections
- Warrant expiry (end of the sentence)

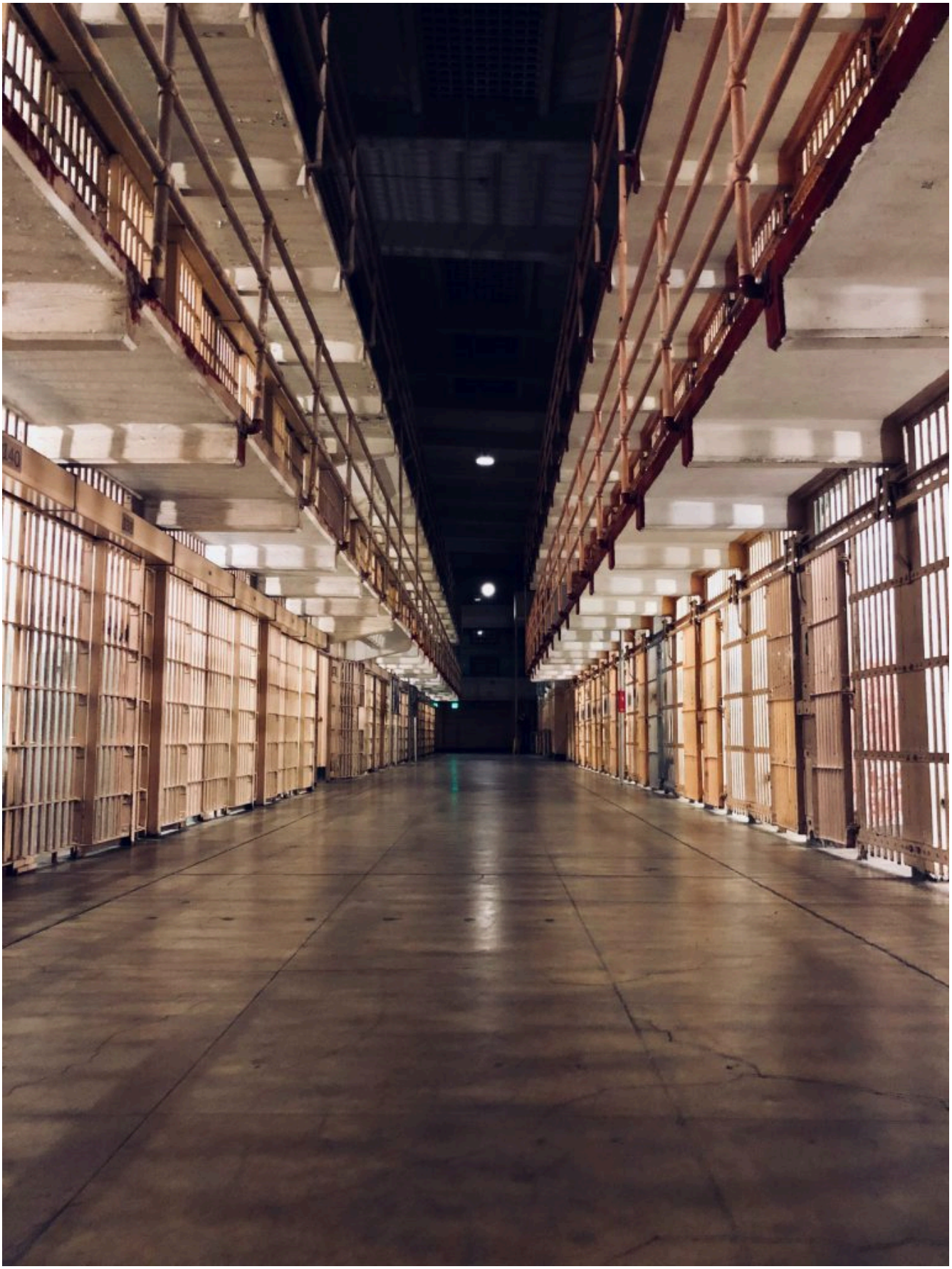

Figure 4.6.1 Photo by Carles Rabada on Unsplash

Case Management

Case management is an ongoing process. It has many components to it and includes assessing, and supervising offenders throughout their sentence.

Each inmate is assigned a Case Management Team which includes:

- a Correctional Officer
- a Parole Officer
- a Manager of Assessment and Intervention
- an Aboriginal Liaison Officer (if applicable)
- an Elder (if applicable)

The team members work together to support the inmate's rehabilitation efforts. They develop and evaluate the inmate's behaviour, work performance and progress they are making in their correctional plan.

For More Information:

- Quick Facts – Case Management – Correctional Service Canada
- Management Action Plan – Correctional Service Canada
- Community Releases – Correctional Service Canada
- Community Involvement – Correctional Services Canada
- Elizabeth Fry – Canada
- John Howard Services of Canada

1

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4.7 WITHDRAWAL MANAGEMENT, OVERDOSE PREVENTION & HARM REDUCTION

Withdrawal Management Programs

Figure 4.7.1 – Pixabay Medication

In this chapter we examine the challenge & barriers around the diversity in the variety of Withdrawal Management Programs that include RAAM clinics, OAT (Opioid Agonist Treatment) / MMT (Methadone Maintenance Treatment) including Suboxone, MAP (Managed Alcohol Prevention) and Peer Supports.

Rapid Access to Addictions Medicine (RAAM) Clinics

The RAAM Clinic is an easy to access walk-in/drop-in clinic that people can visit to get help for substance use without an appointment or formal referral. RAAM Clinics are attached to hospitals and have a multi-disciplinary team. RAAM Clinics are situated in most provinces across Canada. Services are provided on a first come, first served basis, with some prioritization by clinic staff based on urgency. Contact the closest clinic to find out what their hours and days are.

What is a RAAM clinic and who is it for?

RAAM clinics are for:

- people looking to get help with high risk substance use and addictions
- interested in trying medical assistance to reduce or stop their substance use
- experience frequent intoxication or overdose symptoms, as well as unpleasant withdrawal symptoms when attempting to reduce or stop their substance use
- people who have substance-related health issues, such as hepatitis, pancreatitis, or infections, among others.

RAAM clinics are not for people who:

- need urgent medical attention for urgent physical problems or mental health symptoms such as psychosis (paranoia, delusions, hallucinations) or agitation
- active risk of harm to self or others
- requiring police/security involvement.

The people working at these clinics know how difficult it is to ask for help. You don't need an appointment to go to the clinic – just show up during clinic hours with your Health card.

It is that medical treatment for problematic substance use is safe and effective.

What happens when you go to a RAAM clinic?

Figure 4.7.2 – Photo by KOBU Agency on Unsplash

The clinic team will ask you about your history of substance use:

- when and how you started using
- how much and how frequently you use
- how it may impact your life and responsibilities

> Substance use conditions are treatable.

The RAAM clinic team then recommends what treatment will likely work best for you. There are four options:

1. **Advice** – Many people who have to go to the hospital for a substance-related problem are injured as a result of using too much. In these cases, the RAAM clinic team will provide you with advice on how to make choices that will minimize the risks of substance use, such as tips on how to pace your use and situations to avoid.
2. **Counselling** – The RAAM clinic team may refer you to counselling as part of your treatment. Counselling programs can include education on substances and healthy lifestyle choice, group and individual therapy sessions, help with developing coping skills, cognitive behavioural therapy, and peer support groups. The team will work with you to determine what form of counselling would be most helpful for you.
3. **Medications** – Addiction to some substances, such as alcohol or opioids, can be treated with a medication that will help to lessen cravings, as well as the withdrawal symptoms that may accompany your early days of sobriety. Medication usually makes other types of treatment much more effective and reduces the risk of relapse. These medications are safe, effective, and non-addictive. The team will discuss your options with you.
4. **Support** – If you're feeling anxious or hesitant about going to the RAAM clinic, consider bringing a supportive person with you. Changing your substance use can be very difficult, and having someone with you while you speak to the team may make you feel less overwhelmed and less alone.

Figure 4.7.3 – Photo by Joshua Hoehne on Unsplash

IMPORTANT – If you are seeking treatment for opioid addiction, abstinence (including withdrawal management/detoxification) is NOT recommended. Opioid Agonist Treatment (OAT) (the use of long-acting medications to treat withdrawal and prevent relapse) is recommended as a safe and effective way to treat your opioid addiction.

When you begin your recovery from opioid addiction, abstinence can place you at higher risk of overdose, medical harms and death. You are welcome to attend a RAAM clinic or contact other OAT providers to discuss your options.

YOU SHOULD KNOW

Individuals do not have to be substance-free for any length of time to access RAAM services. However, they must be able to have an informed conversation about treatment, understanding the risks and benefits of treatment options. If a person is too intoxicated to have an informed conversation, they may be asked to return at a later date or referred to another community service.

If an individual with **opioid use disorder** is to receive **Opioid Agonist Treatment (OAT)** with buprenorphine/naloxone (Suboxone), the time from last opioid use will factor into the decision on how to

safely start the medication.**There is no specific timeframe of required abstinence from opioids before attending RAAM**

> Harm reduction supplies, including Naloxone (a medication to counter an opioid overdose) are available at all RAAM clinics.

OPIOID AGONIST THERAPY (OAT)

Figure 4.7.4 – Photo by Towfiqu barbhuiya on Unsplash

How does Opioid Agonist Therapy (OAT) Work?

(OAT) is an effective treatment for addiction to opioid drugs such as heroin, oxycodone, hydromorphone (Dilaudid), fentanyl and Percocet. The therapy involves taking the opioid agonists methadone (Methadose) or buprenorphine (Suboxone). These medications work to prevent withdrawal and reduce cravings for opioid

drugs. People who are addicted to opioid drugs can take OAT to help stabilize their lives and to reduce the harms related to their drug use

When a person is addicted to shorter-acting opioids, a long-acting opioid (methadone and buprenorphine) are used. The long-acting means that the drug works for a longer period of time by acting more slowly in the body. This prevents withdrawal for 24 to 36 hours without causing a person to get high. OAT reduces or eliminate cravings for opioid drugs. When combined with support, such as individual or group counselling, there are best outcomes.

Usage of opiates in Canada is being called a public health crisis by both advocates of substance use treatment programs (Canadian Centre on Substance Use and Addiction, 2021) and the Government of Canada (2021b). The Government has recognized this crisis has only worsened during the Covid-19 pandemic. Many urban and rural communities across Canada have reported a record number of opioid-related deaths, emergency calls and hospitalizations (Government of Canada, 2021b). While medications like medical grade heroin and hydromorphone can treat opiate use disorders, there are other medications that have also positively impacted the lives of people who use opiates.

More Information:

- CAMH: Opioid Agonist Therapy

MMT (Methadone Maintenance Treatment)

Figure 4.7.5 – Photo by Towfiqu barbhuiya on Unsplash

Methadone is a medication primarily used to treat chronic pain and as a treatment for opioid use disorder. It is a controlled substance that is regulated under the Controlled Drugs and Substances Act (CDSA), and the Narcotic Control Regulations (NCR).

In the past, practitioners were required to obtain an exemption from Health Canada before they could prescribe, sell, provide or administer methadone.

Methadone is a long-acting opiate, which is substituted for short acting opiates like fentanyl, Percocet, oxycodone, and heroin (Centre for Addiction and Mental Health, 2021b). This type of OAT manages the withdrawal symptoms a person experiences as withdrawal from opiates can be physically painful. It can also be emotionally distressing, particularly if the substance is being used as a coping tool. Evidence from research around the globe has demonstrated that methadone is an effective treatment; it can help people with an opioid addiction in more ways than one (Centre for Addiction and Mental Health, 2021).

Suboxone (Buprenorphine/Naloxone)

Figure 4.7.6 – Photo by Danio Alvesd on Unsplash

Buprenorphine/naloxone, sold under the brand name Suboxone among others, is a fixed-dose combination medication that includes buprenorphine and naloxone. It is used to treat opioid use disorder, and reduces the mortality of opioid use disorder by 50%. It relieves cravings to use and withdrawal symptoms.

Is Suboxone legal in Canada?

Health Canada has **authorized 2 dosage forms** of SUBOXONE (buprenorphine and naloxone), a sublingual tablet and soluble film, that are not bioequivalent at all doses and routes of administration.

> Methadone, along with buprenorphine and suboxone, other opioid agonists, have changed lives. Opioid agonist does not work for every person; it may be offered as an option.

Regulations Amending the Narcotic Control Regulations and the New Classes of Practitioners Regulations (Diacetylmorphine (Heroin) and Methadone): SOR/2018-37.

Important Information:

Suboxone

- Ontario expands use of Suboxone as part of new provincial opioid strategy
- Important Safety Information on SUBOXONE (buprenorphine and naloxone) and the Risk of Overdose or Underdose when Switching Between Dosage Forms or Routes of Administration

MAP (Managed Alcohol Prevention)

Figure 4.7.7 – Photo by LOGAN WEAVER on Unsplash

The MAP Program originally was considered withdrawal management but is now considered a Harm Reduction model. Originally when MAP were created it was to be harm reduction. It was quite controversial and created polarized views on the reasoning for such a program. The goal was to support an individual where they were at on the substance use continuum. It was important to assist with the withdrawals of Alcohol as one of the most widely used substances in Canada; alcohol use is on a spectrum.

MAPs have become an important part of harm reduction in Canada. Click here for a list of MAP sites in Canada (Canadian Institute for Substance Use Research, 2021).

This documentary by CBC highlights some of the individuals who utilize MAPs as well as the healthcare and shelter staff who support these individuals. Please click here to watch The Pour (CBC, 2016).

Withdrawal Management (Detoxification)

All substances have an impact on the body and the brain. Some substances like alcohol have such a strong impact that they can cause death. Alcohol withdrawal requires medical intervention when a person wants to slow down or stop. This service is often referred to as detoxification (detox); however, today we use the term withdrawal management. This can be inpatient or outpatient.

Activities:

1. Other words associated with substance use disorders have stigma. When you hear detoxification or detox, what do you think of?
2. Compare the terms detoxification and withdrawal management. Why do you think this has changed?
3. Is withdrawal management clear? Do you think language matters in this case? Why or why not?
4. Click on this link to an alcohol screening guideline in British Columbia. Notice the language.
5. Would you change the term "problem drinking"? Why or why not?

You may think of a broader health perspective than substance use when you hear the word detoxification; in this context, detoxification or the preferred term, withdrawal management, is a medically assisted/managed program. Medications and devices can be used to manage withdrawal symptoms, prevent relapse, and treat

co-occurring conditions. Withdrawal management is not in itself "treatment," but only the first step in the treatment process.

In-Patient Withdrawal Management

Figure 4.7.8 – Photo by Kinga Cichewicz on Unsplash

If a person has access to a provincial health card, in-patient withdrawal management may be referred by a health care provider, or it may also be self-referred. If people have the financial means, they may pay privately or access funds through an insurance provider for private in-patient withdrawal management at a private facility. Regardless of public or private, all individuals are screened to see if they meet the criteria for in-patient withdrawal management. It is important to note that screening is **not** diagnosing, screening is a tool to determine which service an individual may benefit from, based on their substance use. Screening may highlight some of the areas of intersectionality of substance use. In-patient withdrawal management is provided by all provincial health care services. It is important to note that health providers utilize different screening tools to determine suitability for all treatment services, not least of which is in-patient withdrawal management.

Food For Thought:

- Are in-patient withdrawal management available for every substance?
- Where are the in-patient withdrawal management centres in all provinces and territories?
- Is out of province for in-patient withdrawal management possible?
- Why do you think someone would leave their province to go to treatment?
- What are the challenges with accessing in-patient withdrawal management?
- Is in-patient withdrawal management available to everyone? If not, who might be excluded?
- What happens after in-patient withdrawal management?
- When you think about intersectionality of substance use, does in-patient withdrawal management address all the concerns? Are there barriers people could face in a hospital setting?
- Does in-patient withdrawal management impact all genders equally? What concerns might women bring with them to in-patient withdrawal management?
- Does in-patient withdrawal management support people of all races and cultures?
- When you think about the social determinants of health, does in-patient withdrawal management address all the concerns?
- How would you find out if there a wait list for any in-patient withdrawal management in any province or territory?

In-patient withdrawal management is an important component of treatment, particularly for substances that are life threatening to withdraw from, like alcohol. Substances like opioids are painful to withdraw from, in which case some individuals may be prescribed opiate replacement therapy, including methadone or buprenorphine, which we will discuss below.

In-patient treatment is also offered by many privately owned facilities in many provinces and territories. Imagine spending days and nights in a beautiful facility with private doctors, registered nurses, and counsellors, all for the cost of approximately $600/day+. Some insurance companies cover the costs of private treatment; however, for those without private health insurance, treatment facilities like these may be out of reach.

Activities:

1. Compare and contrast a program at a private facility with a provincially funded program.
2. Are privately owned facilities allowed in Canada?
3. Who licenses these facilities?
4. What does the presence of private clinics indicate about healthcare?

Outpatient Withdrawal Management

Along with in-patient withdrawal management, people living in any province will need a health card may have access to out-patient withdrawal management. This program "combines functions of an outpatient (day program) withdrawal management (detox) and structured treatment, providing the support of a team-based approach" .

Food For Thought:

- Why do you think someone might choose out-patient withdrawal management instead of in-patient? Think about intersectionality and the social determinants of health.
- What is the difference between the two?

Outpatient Treatment

For people who have completed a withdrawal management program, this is often not the end of their journey; it may be just the beginning. In many provinces and territories, options exist for people who are choosing

to engage with a health care provider about their substance use. Each Health Authority provides a variety of outpatient treatment programs in various locations, from two-week full day programs to weekly appointments. Each province and territory have many different options.

Medication Assisted Treatment (HAT – Heroin Assisted Treatment)

When we talk about using medication to treat substance use disorders, some people suggest it is not different, that in fact we are swapping one substance for another. This is a myth. For some individuals, using a different medication or a similar medication may reduce some of the harms of the substance. The Providence Health Clinic in Vancouver recognized that the continued use of heroin can be fatal if not treated (McLellan et al., 2000) and began working with a small number of individuals who had an opiate use disorder. They developed SALOME, a prescribed heroin project or heroin assisted treatment (HAT). SALOME developed out of the NAOMI project, North America's first HAT program, an initiative between the US and Canada in the 1990's (Garty et al., 2009). These projects were breaking new ground as well as challenging ideologies about substance use. Both NAOMI and SALOME were challenged by previous federal Governments; however, the Providence Health Clinic challenged those decisions and became the only clinic in North America to "provide medical grade heroin and hydromorphone within a supervised clinical setting to chronic substance use patients" (Providence Health Clinic, 2021, para. 1).

(Providence Health Vancouver, 2016).

This approach to treating substance use allowed individuals, in partnership with their healthcare provider, to manage their substance use like a chronic illness. For some, this was a novel approach to treating substance use; for others, it was a clear example of how programs based on a public health approach can change/save lives.

Food For Thought:

- Take a moment and think about how you feel about treating heroin use with medical-grade heroin.
- What does the evidence say about the safety and effectiveness of medication assisted treatment?
- What do you want to know more about?

- What are some of the challenges with programs like these?

Activities:

1. Review the following Centre for Addiction and Mental Health pamphlet on opiate agonist treatment.
2. How long can someone use methadone or bupenorphine?
3. Are there side effects of these medications?
4. What are the positive aspects of OAT? Negative aspects?
5. Create a poster for OAT. Include three main facts that you believe would help reduce the stigma of OAT.

Drug Court Programs (DCP)

Figure 4.7.9 Photo by Tingey Injury Law Firm on Unsplash

Many people who use substances are incarcerated. According to the 2017 report on drug offences in Canada, over 95,000 people were charged with various drug offences, many of which were related to cannabis (Boyd, 2017). One way in which Nova Scotia has decided to tackle the issue of incarceration for substance related criminal activity is the creation of a Court Monitored Drug Treatment Program or Drug Court Program (DCP). "In 2015, the Mental Health Court Program partnered with the Nova Scotia Health Authority's Opioid Treatment Program to introduce the Court Monitored Drug Treatment Program" (The Courts of Nova Scotia, n.d. para. 1). The DCP offers "alternative criminal sentences for people charged with crimes directly related to their opioid addiction" (para. 1).

Drug Courts began in the United States, who were dealing with an unprecedented epidemic of substance use and incarceration as part of the war on drugs. To deal with the issues facing the criminal justice system, DCP's were born, which began to recognize the role of intersectionality in substance use and provided "expedited case processing, outpatient treatment, and support services (e.g., job placement and housing)" (Lurigio, 2008, p. 13). Canada adopted its first drug court program in Toronto in 1998 (Government of Canada, 2021a). The programs have evolved, but the focus is still the reduction of the number of individuals

incarcerated for substance related crimes and addressing the substance use disorder as the main issue, rather than the crime itself. DCP's focus on access to treatment for offenders who meet criteria and provide an alternative to incarceration by offering an opportunity to complete a substance use treatment program (Government of Canada, 2021a). The data on DCP's is quite promising. Regardless of the recidivism rates of the individuals who participated in a DCP, "the majority of them had achieved some quality-of-life improvements (e.g., no longer homeless, received several months of addiction treatment and were connected to social supports within the community)" (Government of Canada, 2021a, para. 18).

PEER SUPPORT

Figure 4.7.10 – WordArt Created by Denise Halsey

Who is on your team? What is a friend? It is important to know who is on your team as a peer, friend, professional and knowing what their role actually is. It can be someone you can count on or trust to talk about problems or a bad day. Peer support builds on the concept of friendship, but a peer supporter is different than a friend. "Peer support can be defined as the process of giving and receiving nonprofessional, nonclinical assistance from individuals with similar conditions or circumstances to achieve long-term recovery from psychiatric, alcohol, and/or other drug-related problems" (Tracy & Wallace, 2016, p. 165).

Peer support is a multi-faceted system within the field of substance use with varying opinions and efficacy. Peer support plays a role at all stages of substance use. It can happen with individuals starting their substance use and can move through all the way to recovery; there is significant value in peer support among individuals who use substances (Tracy et al., 2016, Boisvert et al., 2008, Kelly et al., 2017).

Informal peer support may take place in a situation where someone who uses substances is increasing their

use and injecting for the first time. They may be guided by someone who knows how to inject properly and safely, offering clean supplies and ensuring the person tests their substance and does not use too much, putting them at risk of overdose. This is called informal peer support, peer helping or natural helping. Peer helpers try to dissuade people from starting to inject, act as first responders for overdoses, test drug potency, administer first aid, share prescription drugs such as antibiotics, offer temporary housing, counsel on emotional/psychological issues, and support those who are striving to reduce their drug consumption. (Dechman, 2015, p. 497)

In Vancouver, the Vancouver Area Network of Drug Users (VANDU) emerged in 1997, the first drug users union in Canada. This group secured a permanent site in 1997 and began offering support, education, and advocacy for group members. They advocated for safe injection supplies and saw the creation of Insite, Canada's first safe injection site in 2003. They have provided informal peer support to individuals for over 24 years and continue to do so today (Vancouver Area Network of Drug Users, 2016).

Peer Support available:

- AA – Alcoholics Anonymous
- Active Aging Canada
- Aids Groups
- Al-anon – people caring about family/friends who are alcoholic
- Ala-teen -is a peer support group for *teens* who are struggling with the effects of someone else's problem drinking
- ACA – Adult Children of Alcoholics
- any 12 step programs (can look up local meetings)
- Celebrate Recovery
- CMHA (Canadian Mental Health Association)
- CA (can look up local meetings)
- CoDA – Co-Dependents Anonymous
- Indigenous Groups
- GA – Gamblers Anonymous
- NA – Narcotics Anonymous
- Racialized peoples and communities
- Refuge Recovery – Buddhist Path to Recovering from Addiction
- 2SLGBTQIA+ peoples and communities
- Youth
- Seniors

Benefits of peer support groups in the treatment of addiction

Principles of Effective Treatment

The following key principles should form the basis of any effective treatment program:

- Substance use disorders are complex.
- No single treatment is right for everyone.
- People need to have quick access to treatment.
- Effective treatment addresses all of the individuals needs, not just their substance use.
- Staying in treatment long enough is critical.
- Counselling and other behavioural therapies are the most commonly used forms of treatment.
- Medications can be an important part of treatment, especially when combined with behavioural therapies.
- Treatment plans must be reviewed often and modified to fit the individuals changing needs.
- Treatment should address other possible mental health disorders.
- Treatment should address the social determinants of health.
- Medically assisted withdrawal is only the first stage of treatment.
- Substance use during treatment must be monitored continuously, to prevent overdose.
- Treatment programs should encourage individuals to test for HIV, hepatitis B and C, tuberculosis, and other blood borne illnesses as well as sexually transmitted infections if they engage in risky behaviours. This way individuals will have a more complete picture of their health.
- Treatment programs should teach individuals about steps they can take to reduce their risk of these illnesses (harm reduction).

(Schwab, 2021)

For More Information on Withdrawal Management

- Provincial Guidelines for Biopsychosocial Plus Withdrawal Management Services in BC
- Medical Withdrawal Unit – CAMH
- Withdrawal Management Services in Canada: The National Treatment Indicators Report (2015-2016 Data) – CCSA
- Modernizing Withdrawal Management Services – The Canadian Journal of Addiction: June 2021 – Volume 12 – Issue 2 – p 33-38

References:

- Figure 4.7.10 – Halsey, D. (2022, March 29). Peer Support [WordArt].
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4.8 SCREEN & ASSESSMENT / ASSESSMENT TOOLS

When we look at Addictions Case Management Assessment Screening Tools it is not simple. There are many different kinds of Screening Tools that are used depending on the Agency, Hospital, Services, Mental Health, Residential, Outpatient, Addiction and who is doing the screening.

Figure 4.8.1 – Photo by Pandu Aryantoro on Unsplash

If someone has been hospitalized then there are protocols for the discharge process working with Case Managers/Doctors/professionals for the discharge of each individual, and will links them to appropriate addiction and addiction-related services and supports upon discharge in their community. Together, the client and the staff will work to create and implement a plan of care for enhancing stability and meeting the client's most urgent addiction-related needs.

The Coordinated Care will also differ depending on which Province, Territory or city that the individual lives in or has access to.

Healthcare and allied health professionals — including family physicians, nurses, addiction specialists, psychologists and social workers — use alcohol screening, brief intervention and referral to treatment (SBIRT)

to help individuals manage their alcohol consumption. There are other screening tools and resources depending on the the Substance is used.

Screening and brief intervention tools

Alcohol and other drug screening tools are sometimes used to identify people with early drug problems, and to facilitate referral to treatment services. When these tools are available it allows people to reflect on their pattern of alcohol or other drug consumption and are provided with clear information about how to moderate their risk, a significant number will make positive changes without the need for more intensive, extensive and expensive healthcare services. Individuals can use self-administered screening tools to assess their own alcohol or other drug use. For people working in various settings screening can be used as an opportunity to have a conversation with students, patients, clients or community members.

Canadian Screening Tools

Screening Tools – eMentalHealth.ca

CCSMH – Canadian Coalition for Seniors' Mental Health

Canadian Coalition for Seniors' Mental Health also work with Substance Use with the Senior population. They have an online resource for Prevention, Screening, Assessment and Treatment for Alcohol, Benzodiazepine Use Disorder, Cannabis Use Disorder and Opioid Use Disorder as these tend to be what presents the most for Seniors.

Figure 4.8.2 – Photo by Artyom Kabajev on Unsplash

For more information on Canadian Coalition for Seniors' Mental Health

Canadian Public Mental Health Association

Canadian Public Mental Health Association offer Cannabis Screening tool for cannabis dependence and problematic use that may be of use for providers in their practice.

Screening tools include:

- CUDIT-R – The Cannabis Use Disorder Identification Test – Revised [Opens in a new window]
- ASSIST – The ASSIST Project: Alcohol, Smoking and Substance Involvement Screening Test [Opens in a new window]
- Severity of Dependence Scale – The Severity of Dependence Scale (SDS) [Opens in a new window]

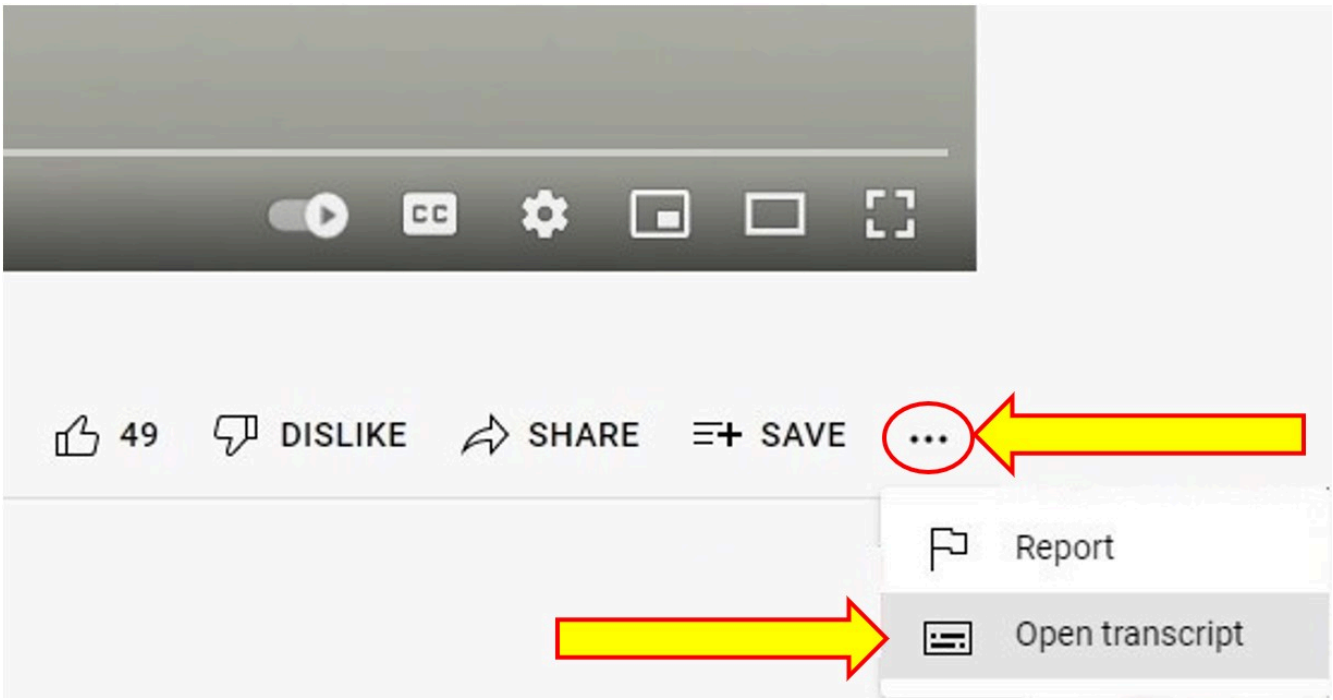
- e-CHUG & e-TOKE – eCHECKUP TO GO [Opens in a new window]

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=119#oembed-1

Transcript

To Access the Video Transcript:

1. Click on **"YouTube"** on the bottom-right of the video. This will take you directly to the YouTube video.
2. Click on the **More Actions** icon (represented by three horizontal dots)
3. Click on **"Open Transcript"**



For More Information:

- Alberta Health Services
- Health Care Ontario
- Canadian Centre on Substance Use and Addiction
- University of Victoria – Canadian Institute for Substance Use Research

- Canadian Public Health Association – Cannabis Screening
- Connex – Ontario

CAMH – Screening Tools

Figure 4.8.3 – Photo by James A. Molnar on Unsplash

CAMH has many different Screening tools, that are applied to different communities. Depending on the challenges or communities there are different screening tools that would be used. There are different Substance Use Disorders and depending on the Culture / C (Centre for Addiction and Mental Health, 2022)

The Fundamentals of Case Management – Government of Canada

Case management is a goal-oriented approach that aims to help employees remain at work and facilitate a safe and timely return to work. It is best accomplished with a multidisciplinary team. (Secretariat, n.d.)

Case Management Services for Veterans – Government of Canada

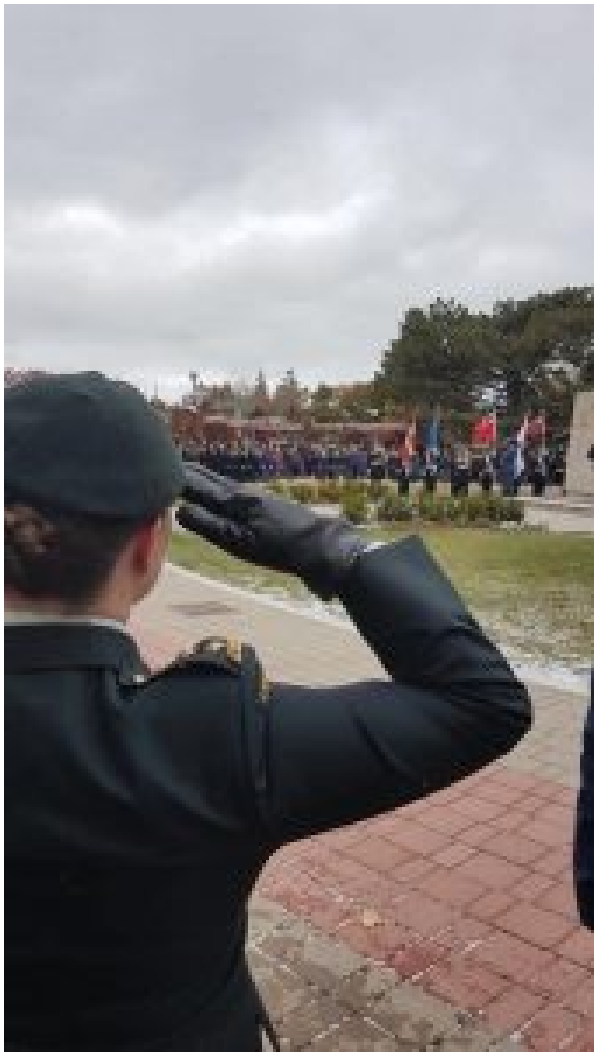


Figure 4.8.4 – Remembrance Day – Captain Donna Franks by Denise Halsey

Government of Canada has created Case Management Tools to be used specifically for Veterans (VAC). They have evaluated and created a new screening tool to assist those who have experienced trauma.

During the period of the evaluation, VAC's Case Management Support Services Directorate and VAC's Research Division developed and piloted a new screening tool which would replace the Regina Risk Indicator Tool ((Section 4.1(a)) as well as the Regina Risk Indicator Tool – Reestablishment (Section 4.1(b)). The evaluation team participated in the assessment of this new tool and conducted a comparison analysis between the current risk tools and the new screening tool. Analysis available at the time of writing of this report is

reflected in section 4.1(c) – Risk Comparison Analysis. (4.0 Case Management Tools – 2019-evaluation-case-management-services – Veterans Affairs Canada, n.d.)

Correctional Service Canada (CSC)

The CSC has a graduated case management approach with joint case discussions. The process begins at the work site and then, if employees have not returned to work after a 6-month absence, the case is reviewed regionally. Nationally, the Committee members meet on average 6 times per year, reviewing cases of correctional officers who are away for more than 1 year; they review about 100 cases annually. Its National Joint Return-to-Work Advisory Committee, which includes union partners, meets twice per year to discuss general return-to-work issues, trends, and associated issues. The CSC also has joint case discussions with union representatives.

For More Information (Explore)

- Commonly Used Substance Use Disorder Screening Instruments – MassHealth
- Fundamentals of Addiction: Screening – CAMH
- Case Management – Government of Canada
- Corrections Canada – Government of Canada
- The Provincial System Support Program – CAMH

References

Images:

- Figures 4.8.1, 4.8.2 & 4.8.3 – Unsplash License
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4.9 SOCIAL HISTORIES

Figure 4.9.1 – Social Histories – Word Art by Denise Halsey

Social workers help people of various communities cope with different problems and issues, often working with specific clients / communities. To do this we need to understand the importance of obtaining a client's history, its purpose, and use effective strategies for obtaining it.

When we are aware there is going to be an interview (whether it is on the telephone or in person) we need to understand that there is a process of preparing for the first interview. If the person has accessed services before at our agency, we begin with that information. Where you will meet, what sort of things do you need to have available for that interview is also important.

There are 3 tasks that you need to accomplish in the first interview:

1. Listen and convey an accurate understanding of clients' perceptions about themselves and their problems

2. Formulate a professional understanding of what it is the individual is experiencing and what they will need and while being assisted by your agency.
3. Establish rapport with clients so they feel comfortable with you and your agency.

As social workers we work and assist people in various communities cope with many different challenges. To do this we need to know their journey, experiences, knowledge, history, trauma, family and many other moving pieces that are part of each individual. We cannot know someone by simple seeing them. It is important to have a conversation with them and explore why they are in front of us (what brought them to our agency) but also what their social history is through their eyes, and how we can assist them.

Figure 4.9.2 Photo by LinkedIn Sales Solutions on Unsplash

When we refer to a social or client history there is specific information that is to be gathered so that we can assist our clients/individuals. The information that is gathered gives us a picture of the client that is accessing our agency. The most important information includes:

1. Description and history of the presenting problem (the reason the client is accessing our agency)
2. Background information about the person's life, which will also include the information around the presenting problem

3. Worker's impressions and recommendations from the intake appointment

All agencies have their own layouts and format for this but a typical outline for a social history will include the above 3 pieces of information .

The Biopsychosocial Plus model assists in many of these areas. The information gathered would be: biological (health related issues), psychological (mental health disorders), physiological (health issues in the organs / body), sociological (communities, relationships, culture), spiritual (individual faith/ belief), education, employment, addictions, or legal issues etc.

It is important for social workers to take the time to get to know the client, gather all of this information of a client's history, both positive and challenging, as it can assist us in providing viable options to assist the client. This information is vitally important to be able to develop and create treatment plans based on all of their clients' unique needs, strengths and goals.

Through the discussion we get to understand the client better and be more effective, whether we are assisting them in our agency, or assisting them in finding the best fit for them through a referral.

Each agency has different Social Histories that they will use.

4.10 MMT (METHADONE MAINTENANCE TREATMENT CASE MANAGEMENT)

Figure 4.10.1 – Pixabay Medication

In this chapter we look through a Case Management lens and examine a variety of Withdrawal Management

Programs that include RAAM clinics, OAT (Opioid Agonist Treatment) and MMT (Methadone Maintenance Treatment) including Suboxone. Each area will have different components of Case Management.

MMT (Methadone Maintenance Treatment)

Figure 4.10.2 – Photo by Towfiqu barbhuiya on Unsplash

Methadone is a medication primarily used to treat chronic pain and as a treatment for opioid use disorder. It is a controlled substance that is regulated under the Controlled Drugs and Substances Act (CDSA), and the Narcotic Control Regulations (NCR).

In the past, practitioners were required to obtain an exemption from Health Canada before they could prescribe, sell, provide or administer methadone.

Methadone is a long-acting opiate, which is substituted for short acting opiates like fentanyl, Percocet, oxycodone, and heroin (Centre for Addiction and Mental Health, 2021b). This type of OAT manages the withdrawal symptoms a person experiences as withdrawal from opiates can be physically painful. It can also be emotionally distressing, particularly if the substance is being used as a coping tool. Evidence from research

around the globe has demonstrated that methadone is an effective treatment; it can help people with an opioid addiction in more ways than one (Centre for Addiction and Mental Health, 2021).

2 minutes – Neuroscience on Methadone

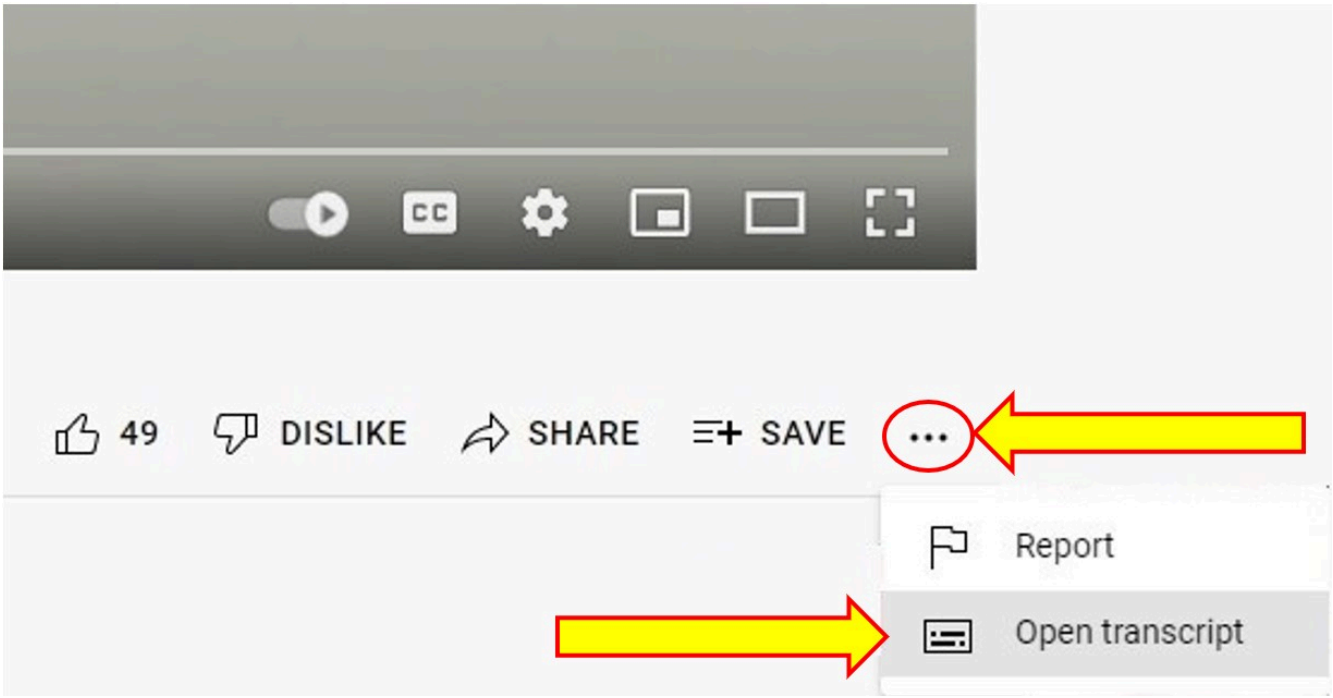
One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=546#oembed-1

2-Minute Neuroscience: Methadone. By: Neuroscientifically Challenged. Methadone is commonly used to treat opioid use disorder even though its pharmacological action is very similar to that of other opioids like morphine. In this video, I discuss the qualities that make methadone an effective treatment for opioid addiction, along with how it acts to reduce the risks associated with opioid abuse.

Transcript

To Access the Video Transcript:

1. Click on **"YouTube"** on the bottom-right of the video. This will take you directly to the YouTube video.
2. Click on the **More Actions** icon (represented by three horizontal dots)
3. Click on **"Open Transcript"**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Suboxone (Buprenorphine/Naloxone)

Figure 4.10.3 – Photo by Danio Alvesd on Unsplash

Buprenorphine/naloxone, sold under the brand name Suboxone among others, is a fixed-dose combination medication that includes buprenorphine and naloxone. It is used to treat opioid use disorder, and reduces the mortality of opioid use disorder by 50%. It relieves cravings to use and withdrawal symptoms.

Is Suboxone legal in Canada?

Health Canada has **authorized 2 dosage forms** of SUBOXONE (buprenorphine and naloxone), a sublingual tablet and soluble film, that are not bioequivalent at all doses and routes of administration.

> Methadone, along with buprenorphine and suboxone, other opioid agonists, have changed lives. Opioid agonist does not work for every person; it may be offered as an option.

Regulations Amending the Narcotic Control Regulations and the New Classes of Practitioners Regulations (Diacetylmorphine (Heroin) and Methadone): SOR/2018-37.

Important Information:

Suboxone

- Ontario expands use of Suboxone as part of new provincial opioid strategy
- Important Safety Information on SUBOXONE (buprenorphine and naloxone) and the Risk of Overdose or Underdose when Switching Between Dosage Forms or Routes of Administration

MMT (Methadone Maintenance Treatment) Case Management in Ontario

The Ontario Ministry of Health and Long-Term Care has recognized the importance of case management in MMT (Methadone Maintenance Treatment Case Management). Because of the multi-faceted issues involved in MMT, effective case management is critical for client success. It is necessary to have many skills to be able to work effectively in MMT as a case manager. The case manager provides the link between the many resources, services and roles involved in the MMT program.

When we look at the different components/areas that are important as a MMT Case Manager, we need to take into consideration:

- Role of Case Management in MMT
- Who's on the MMT
- Assessment and Client Matching (Intensity of Case Management Services)
- Core Knowledge, Competencies and Training
- Confidentiality
- the Client consultation
- Co-ordination of continuity of care and support
- Crisis/drop-in

- Case conferences
- Advocacy
- Counselling
- Treatment planning
- Effective communication skills

For More Information on Methadone Maintenance Treatment – Case Management (CAMH)

- Methadone Maintenance Treatment – Best Practices Case Management – CAMH
- CAMH: Downtown Toronto Clinics

Food for Thought

Creating and implementing standardized and accredited training in the role and functions of case manager is difficult in Canada. Substance use counsellors and case managers are not always accredited and have various levels of education. Methadone is a regulated and controlled medication, but there are many laws, regulations and standings in Ontario for prescribing, distributing and supporting.

The better informed and trained a case manager is about these policies and laws, the more support, advocacy and assistance they can provide effectively to a client. Since case managers are client advocates, they need to translate and clarify programs, systems, services, resources, and other information for their clients.

Clients' Handbook – CAMH

Education for everyone, even clients, is mandatory for a standard of care. Clients' Handbook: Making the Choice, Making it Work – CAMH

This handbook is to provide clients with answers to the questions they have about participating in an MMT program. Reading this handbook will help you better understand a client's perspective on MMT.

For More Information

- Overview of Methadone Maintenance Program (CAMH)
- Fundamentals of MMT (CAMH)
- Methadone Maintenance Treatment – A Community Planning Guide

Methadone Maintenance Treatment (MMT) is a very broad term that covers a variety of components and supports. At its core, it usually involves the prescription of methadone to long-term opioid users. Methadone is a synthetic opioid which was created to assist in the withdrawal and long-term recovery from opioid addiction. It has been found to be very effective when used for tapering and stabilizing clients and for chronic pain management.

In Canada, MMT programs generally include (in addition to methadone):

- Medical care
- Counselling and support
- Treatment for other substance use
- Mental health services

- Community-based services and supports (e.g. housing, transportation, employment, school, life skills)

Roles involved in MMT

MMT also involves many professionals including medical doctors, nurses, social workers, psychiatrists, pharmacists and case managers who are specifically trained to work with this population. Learning about each professional's roles and expectations will assist the client as well as the case manager.

Challenges in MMT Programs

There are many challenges and gaps in MMT programs, including:

- Distribution of services, such as not having access to medication during holidays
- Fewer programs for rural and suburban communities
- Access to methadone while in hospital (for other medical issues)
- Access to newer drug treatments (for example, Ontario health system pays for methadone, but not suboxone, which is a newer drug for treating opioid addiction)
- Lack of education for professionals
- Stigma within health, social work and general communities

How much do you know about methadone? Take the Methadone Awareness Test.

Learning Activity

As a case manager for MMT, choose three of the above listed skills, experiences, or competencies that you feel you have and rate your skill level.

Skills/ Competencies	0 (none)	1 (little)	2 (average)	3 (above average)	4 (excellent)
Skill 1					
Skill 2					
Skill 3					

What do you need to do, learn, or practice to move each of these three skills to a higher skill level?

Rapid Access to Addictions Medicine (RAAM) Clinics

The RAAM Clinic is an easy to access walk-in/drop-in clinic that people can visit to get help for substance use without an appointment or formal referral. RAAM Clinics are attached to hospitals and have a multi-disciplinary team. RAAM Clinics are situated in most provinces across Canada. Services are provided on a first come, first served basis, with some prioritization by clinic staff based on urgency. Contact the closest clinic to find out what their hours and days are.

What is a RAAM clinic and who is it for?

RAAM clinics are for:

- people looking to get help with high risk substance use and addictions
- interested in trying medical assistance to reduce or stop their substance use
- experience frequent intoxication or overdose symptoms, as well as unpleasant withdrawal symptoms when attempting to reduce or stop their substance use
- people who have substance-related health issues, such as hepatitis, pancreatitis, or infections, among others.

RAAM clinics are not for people who:

- need urgent medical attention for urgent physical problems or mental health symptoms such as psychosis (paranoia, delusions, hallucinations) or agitation
- active risk of harm to self or others
- requiring police/security involvement.

The people working at these clinics know how difficult it is to ask for help. You don't need an appointment to go to the clinic – just show up during clinic hours with your Health card.

It is that medical treatment for problematic substance use is safe and effective.

What happens when you go to a RAAM clinic?

Figure 4.10.4 – Photo by KOBU Agency on Unsplash

The clinic team will ask you about your history of substance use:

- when and how you started using
- how much and how frequently you use
- how it may impact your life and responsibilities

Substance use conditions are treatable.

The RAAM clinic team then recommends what treatment will likely work best for you. There are four options:

1. **Advice –** Many people who have to go to the hospital for a substance-related problem are injured as a result of using too much. In these cases, the RAAM clinic team will provide you with advice on how to make choices that will minimize the risks of substance use, such as tips on how to pace your use and situations to avoid.
2. **Counselling –** The RAAM clinic team may refer you to counselling as part of your treatment. Counselling programs can include education on substances and healthy lifestyle choice, group and individual therapy sessions, help with developing coping skills, cognitive behavioural therapy, and peer support groups. The team will work with you to determine what form of counselling would be most helpful for you.
3. **Medications –** Addiction to some substances, such as alcohol or opioids, can be treated with a medication that will help to lessen cravings, as well as the withdrawal symptoms that may accompany your early days of sobriety. Medication usually makes other types of treatment much more effective and reduces the risk of relapse. These medications are safe, effective, and non-addictive. The team will discuss your options with you.
4. **Support –** If you're feeling anxious or hesitant about going to the RAAM clinic, consider bringing a supportive person with you. Changing your substance use can be very difficult, and having someone with you while you speak to the team may make you feel less overwhelmed and less alone.

Figure 4.10.5 – Photo by Joshua Hoehne on Unsplash

IMPORTANT – If you are seeking treatment for opioid addiction, abstinence (including withdrawal management/detoxification) is NOT recommended. Opioid Agonist Treatment (OAT) (the use of long-acting medications to treat withdrawal and prevent relapse) is recommended as a safe and effective way to treat your opioid addiction.

When you begin your recovery from opioid addiction, abstinence can place you at higher risk of overdose, medical harms and death. You are welcome to attend a RAAM clinic or contact other OAT providers to discuss your options.

YOU SHOULD KNOW

Individuals do not have to be substance-free for any length of time to access RAAM services. However, they must be able to have an informed conversation about treatment, understanding the risks and benefits of treatment options. If a person is too intoxicated to have an informed conversation, they may be asked to return at a later date or referred to another community service.

If an individual with **opioid use disorder** is to receive **Opioid Agonist Treatment (OAT)** with buprenorphine/naloxone (Suboxone), the time from last opioid use will factor into the decision on how to

safely start the medication.**There is no specific timeframe of required abstinence from opioids before attending RAAM**

> Harm reduction supplies, including Naloxone (a medication to counter an opioid overdose) are available at all RAAM clinics.

OPIOID AGONIST THERAPY (OAT)

Figure 4.10.6 – Photo by Towfiqu barbhuiya on Unsplash

How does Opioid Agonist Therapy (OAT) Work?

(OAT) is an effective treatment for addiction to opioid drugs such as heroin, oxycodone, hydromorphone (Dilaudid), fentanyl and Percocet. The therapy involves taking the opioid agonists methadone (Methadose) or buprenorphine (Suboxone). These medications work to prevent withdrawal and reduce cravings for opioid

drugs. People who are addicted to opioid drugs can take OAT to help stabilize their lives and to reduce the harms related to their drug use

When a person is addicted to shorter-acting opioids, a long-acting opioid (methadone and buprenorphine) are used. The long-acting means that the drug works for a longer period of time by acting more slowly in the body. This prevents withdrawal for 24 to 36 hours without causing a person to get high. OAT reduces or eliminate cravings for opioid drugs. When combined with support, such as individual or group counselling, there are best outcomes.

Usage of opiates in Canada is being called a public health crisis by both advocates of substance use treatment programs (Canadian Centre on Substance Use and Addiction, 2021) and the Government of Canada (2021b). The Government has recognized this crisis has only worsened during the Covid-19 pandemic. Many urban and rural communities across Canada have reported a record number of opioid-related deaths, emergency calls and hospitalizations (Government of Canada, 2021b). While medications like medical grade heroin and hydromorphone can treat opiate use disorders, there are other medications that have also positively impacted the lives of people who use opiates.

More Information:

- CAMH: Opioid Agonist Therapy

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4.11 DEVELOPING A SERVICE PLAN & MONITORING

When we are looking a Developing a Service Plan and then monitoring how the client is doing there are many different systems to doing this. Depending on the agency we work in as well as the population your agency serves these plans may have different names. They could be: service plans, treatment plans, goal pans, care plans or Healthy Living Plans.

A service plan contains broad, general goals for the case management unit to follow in regard to that specific client. Referral will then happen to those in the agency or outside the agency that would help the person reach those goals.

Developing a Service Plan at the Case Management Unit

Figure 4.11.1 – Photo by Gabrielle Henderson on Unsplash

When developing the Service Plan it is important to take into consideration all information that is shared and documented. It is considered an important piece to include the Client and their family as todays service plans take into consideration the family unit, as well as the environment that the Client is returning to.

There is an expectation that all agencies engage both the client and their family (with permission from the client) when this inclusion is appropriate. This allows for a stronger success rate when the family unit is supported.

It is important to document all information that is gathered when doing an Assessment Interview. The Assessment Form will show many different types of information that can be asked and information gathered. It is also important to correctly document and record all necessary information as it assists in giving a clear picture of the client, the issues, the challenges and critical information that we need to be aware of when creating a service plan.

Implement Documentation and Recording of Important information

An important piece to remember is that if it isn't documented it is like it never happened. Verbal conversation isn't enough, it must be documented that the conversation took place.

Figure 4.11. 2 – Photo by TienDat Nguyen on Unsplash

In some agencies it must be documented for funding purposes. When working in supportive housing, a set # of hours had to be documented as face to face time with our clients. Therefore documentation was critical. This is not an option, documentation is critical for legal purposes as well as making sure that appropriate care is being given to our clients.

Monitoring client, agencies and service is also another component of what documentation and recording is being done appropriately.

Prepare a Treatment Plan

A lot of agencies have clinical meetings or a meeting of staff where discussions are around clients and their treatment plans and needs. It is important to have a provisional plan for your client when you attend this meeting.

Treatment plans are a written document that includes:

- identifies the client's most important goals for treatment
- describes measurable, time sensitive steps toward achieving those goals
- time-limited and reflects a mutually agreed upon, written agreement, between the clinician and the client
- a bridge between assessment and treatment
- is individualized

Why are Treatment Plans Important?

- gives a roadmap of the recovery process
- provides structure – very important (client's will have experienced some chaos)
- outcome driven – focus on treatment
- individualized treatment plan will be reviewed, approved and signed by counsellor and client
- treatment plans will include progress notes, addressed whats been accomplished, showing goals and objectives and progress (and occasionally challenges)

Figure 4.11.3 – Photo by Christina @ wocintechchat.com on Unsplash

Identifying Challenges / Problems

- important to show challenges that the client has had to create solutions
- note most significant issues presenting (ADHD, substance use etc)
- challenges that are most challenging
- treatment plans will address a selected # of challenges, the direction and focus
- diagnosis / challenges

Creating a Goal

- brief statement of something you'd like to change
- tied to the assessment
- broad goals in order to replace dysfunctional behaviours with healthier ones (longer term)
- at least 1 goal to relate to the substance abuse
    - attend meetings
    - meeting with a counsellor

Creating objectives

- action client will do to meet the goals (skill development)
- objectives (visible) in measurable behavioural language – clear
- stated clearly
- objectives are skill developed by client
- target date attached for completion

Using SMART Goals

- **SPECIFIC**
- **MEASURABLE**
- **ATTAINABLE**
- **RELEVANT**
- **TIME LIMITED**

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=549#oembed-1

Learnstorm Growth Mindset: How to write a SMART goal by Khan Academy.

Treatment Plan Updates / Progress Views

These are important and should be completed ongoing. It is important to record it so that it shows progress and keeps client motivated

SAMPLE TREATMENT PLAN

Problem: Substance Use – chaos in life

Goal #1 – stopping active use and long term health and wellness

Objective #1 – write a detailed history of what you have experienced and challenges

Objective Established 6/9/22. Targeted Completion 2/28/15 Completed On:

Interventions:

Duration: 3 months

Examples of Treatment Plans:

- Alberta Health Services Treatment Plan
- What Does a Substance Abuse Treatment Plan Look Like? – WebMD

MONITORING

Monitoring is one of the main case management tasks when working with a client/family. Not only do you monitor the client/family but also the agencies that you made referrals to for several reasons. One of the requirements is documentation for your agency to get reimbursement for their time, as well as ongoing contact with the client/family offers reassurance and support.

It also offers an opportunity to trouble shoot before a situation becomes too large and perhaps a hospitalization or critical situation can be avoided.

As one of the pieces we do is developing goals and objectives are personal to the client/family that is supported so if its domestic violence or health issues then it is relevant to make sure that we are making sure that the goals are being met.

Figure 4.11.4 – Photo by Glenn Carstens-Peters on Unsplash

The function of Monitoring and adapting a treatment plan for client/ family

Monitoring is two-fold. It confirms that the client is actually active in the process and are accessing the services and plans that were made for them. It also gives an opportunity to see if the service that was referred and is supposedly being used is actually the best fit for the client.

If there's a disconnect or crisis that is going on, again it is easier to know at an earlier stage than when it has escalated into a larger problem. There is also an accountability piece for the agency as well as for the funder. If money is being spent it is important to make sure it is being spent wisely and therefore accountability is vitally important.

Advocate on behalf of a client/family on micro level, meso and macro level

Advocating on behalf of a client/family is critically important, especially on the micro level (client's), meso level

(context surrounding the person) and macro (larger society's characteristics) specially to see how it is working for them.

If the client/family is unwilling or unable to participate or the agency is unwilling or unable to give the services to the client/family is it important to look into it and possibly change the agency to another one that could deliver the service.

If you can work with the agency that provides the service you require that is great, but if not and you need to look at another agency then that might be what is needed.

Figure 4.11.5 – Photo by TienDat Nguyen on Unsplash

We have looked at some of the pieces that will arise when monitoring services and following the client, we will be able to understand the many different situations we may encounter and it is important to equip ourselves and know what to do in different situations arise. The clients that we will work with have come to our agency for assistance and we can better support them if we understand best practices in all areas and continue to build on our relationships with other agencies.

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4.12 CLOSURE, TERMINATING THE CASE

In monitoring services and following the client – closure and termination of a case is a normal component when working in the Human Services system.

There are many reasons a case can be terminated.

- The individual and the case manager agree the individual is ready to move on
- The individual dies or moves away
- The funding source will no longer finance service or a program
- The individual no longer wants the services
- You cannot find the individual

Not all clients will leave case management. A child/adult with special needs may need services for life or other special needs assistance that will need help. Depending on the agency this will mandate how Monitoring Services and Terminating the Case will play out.

Figure 4.12.1 – Photo by Chris Liverani on Unsplash

The Emotional Process when Ending the Client/Worker relationship

Leaving anything can be challenging and when leaving services that have been collaborative it is not unheard of to feel sad about leaving people that have supported you and have had a positive work environment. For many people this may be the first time they've been able to be part of this process.

Occasionally people will regress in order to not have to leave services. It is important to recognize what is going on for the client and the underlying emotions that they are having. This might have been one of the only supportive relationships that they experienced and therefore do not want to let it go. It is important though for termination to happen in a healthy way.

> Having worked in this field for many years, it continues to amaze me how surprised clients are surprised to be emotional on the last day working with a Case Management or an Addictions Counsellor. There are many different reasons for this. I've had clients ask their parents / family if they could have a word with me and let them know he'll be out in a couple of minutes and as soon as they close the door the client has tears and is shocked at how hard it is to say goodbye. Some of them are coming back as Outpatients but are still emotional. Part of this is they haven't said good-bye before, for some they love who they've become and don't want to leave in case they lose their way.
>
> **The feelings are real** – Denise Halsey

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=551#oembed-1

Termination in Counseling & Psychotherapy. By: Russ Curtis, Ph.D., Professor of Counseling

Transcript

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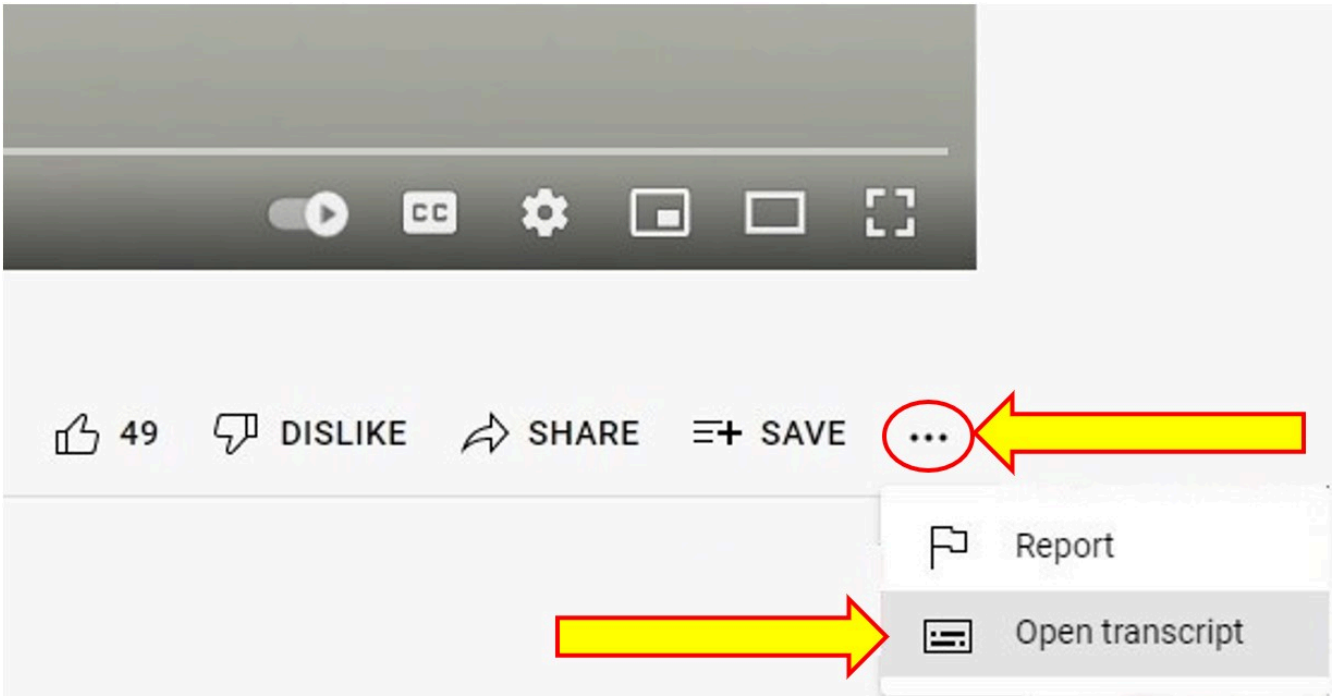

Tasks required by a Case Manager when terminating a client

When it is time to terminate services with a client, it can be challenging but there is an important reason for it to happen. In the final interview it is important to summarize all that has been accomplished and reasons for the termination.

A discussion, sense of reassurance is important, allowing questions and answers. Going over all the gains and accomplishments that the client has obtained. It is also important to go over where the client is going when they leave this services. They may be joining self-help groups or other services that they've progressed to.

Termination – the action of bringing something or coming to an end

Closure – an act or process of closing something, especially an institution, thoroughfare, or frontier, or of being closed.

As professionals who do case management termination is one of the tough parts. It is important to equip ourselves and our client that this will be happening. The clients that we will work with have come to our agency

for assistance and part of this will be when we support them through a healthy termination and progress to the next step. It's important to have this part of the process.

Picture represents the # of people we will work with in our time as Case Managers or Counsellors

Figure 4.12.2 – Photo by Eugenio Mazzone on Unsplash

Examples of Closure:

Type your examples here.

- Saying Goodbye and Getting closure
- Termination in Therapy: The Art of Gently Letting Clients Go – Psychology Today

References

- Waldman, S. (2020, October 26). *Saying Goodbye: The Importance of Termination in Therapy*. Bridges Therapist Directory for Asian Americans in NYC. https://bridgesmentalhealth.com/2020/10/26/saying-goodbye-the-importance-of-termination-in-therapy/
- Sutton, J., PhD. (2022, August 21). *Termination in Therapy: The Art of Gently Letting Clients Go*. PositivePsychology.com. https://positivepsychology.com/termination-in-therapy/
- Russ Curtis, Ph.D., Professor of Counseling. (2021, November 5). *Termination in Counseling & Psychotherapy*. YouTube. https://www.youtube.com/watch?v=N3uhrJDTEFw

4.13 KEY TERMS STUDY GUIDE

Figure 4.13.1 – Wordart by Denise Halsey

The material in this chapter are the core of being an effective **Case Manage**r. Once you understand the important knowledge base, skills and guidelines for case management you will have a solid foundation for understanding how to be an effective case manager. You may be familiar with these terms, but If you are not familiar with the terms below, I recommend you download this study sheet, add more spaces to write in definitions and relevant information (or make flashcards) as you read the chapter and watch videos.

1. A - r i r i n R s s n r e l r e n n e e s r r i l c e e l a m 9 e C u H l a a y l n O e v a c t a m e 4 a C n o e r a g 6 C C 7 u C e o / a r d t l p n u r u i n 1 0 f E o t p s e c e i 3 c C m g l t s , m t t a o m o c n I r 8 a C u C e c l a m t d e c g i p s P 2 t A - i a a e 5 i C u T i i h s n e r t a n c t u r o t e t l i y S t o i

c w o d o a s s u d c n g 7 r I a v 0 k M n s t e o n c c r A n s u s o r a
a o g e , 2 d 3 F H c e e o e l n l i i o g e i n p s e e e 9 t S p t r a g
l r i l M o a a t 5 p I u n d d s e l 1 n O P o t 5 u R s P e 8 s S k p e y w e
F k c – e L m r i e n s o v 8 i I w l i v r 3 n P l 6 e S l n e e i 2 m W a m
1 r E a M s e i m o n 6 d I u i v n i s t e 2 e P e a s e a i s n l r s i l e
a c l i o v l R n d i n s e i t 9 n M o r v a e t o r n n s i l t T t M n
m o M c & e i 4 e I e g d W w d e g M r d e t r i u 7 v S g m o 1 s S h h a t
e l o r M l e d n n e i o s u r S T i o n 4 i P o r i c & e 0 r S y e d n

4.14 SELF CARE

Creating a community of practice is one way Social workers can engage in self care. Communities of practice are groups of individuals who gather together to share information, resources and best practice.

Watch the video below on Community of Practice and it's importance.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/centennialfundamentalsofaddictiontraumainformedmotivationalinterviewingcasemanagement/?p=684#oembed-1

About Communities of Practice. By: Cochrane Training. A brief talk about Communities of Practice, by Stephanie Lagosky from Cochrane's Knowledge Translation Department

Transcript

To Access the Video Transcript:

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2. Click on the **More Actions** icon (represented by three horizontal dots)
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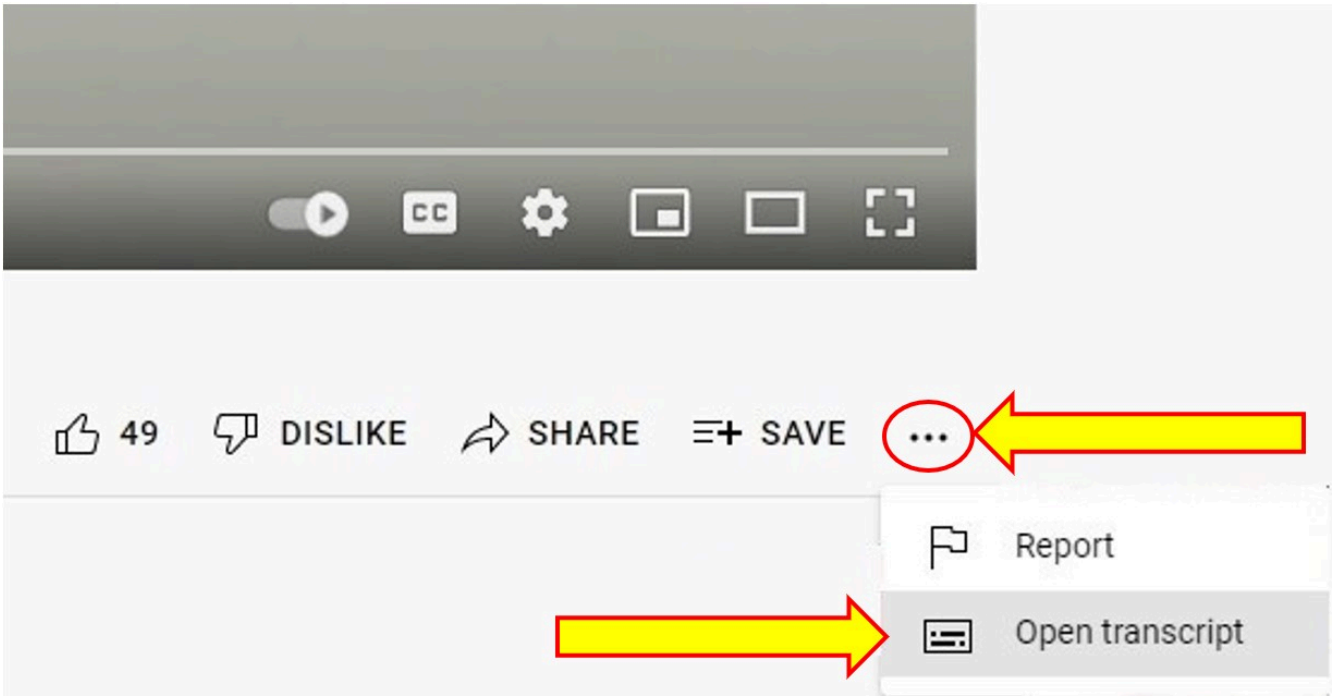

How can you create a community of practice with your peers?

References

- Cochrane Training. (2021). *About Community of Practice* [Video]. YouTube. https://www.youtube.com/watch?v=af5HxZKZk4c

ADDITIONAL RESOURCES

Additional Resources:

Homeless Hub

Step-by Step: A Comprehensive Approach to Case Management

Case Management Referral and Coordination / Addictions and Substance Abuse

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Case Management Referral and Coordination | Addiction and Substance Abuse Counselors. By: Doc Snipes. Dr. Dawn-Elise Snipes is a Licensed Professional Counselor and Qualified Clinical Supervisor. She received her PhD in Mental Health Counseling from the University of Florida in 2002. In addition to being a practicing clinician, she has provided training to counselors, social workers, nurses and case managers internationally since 2006 through AllCEUs.com

Transcript

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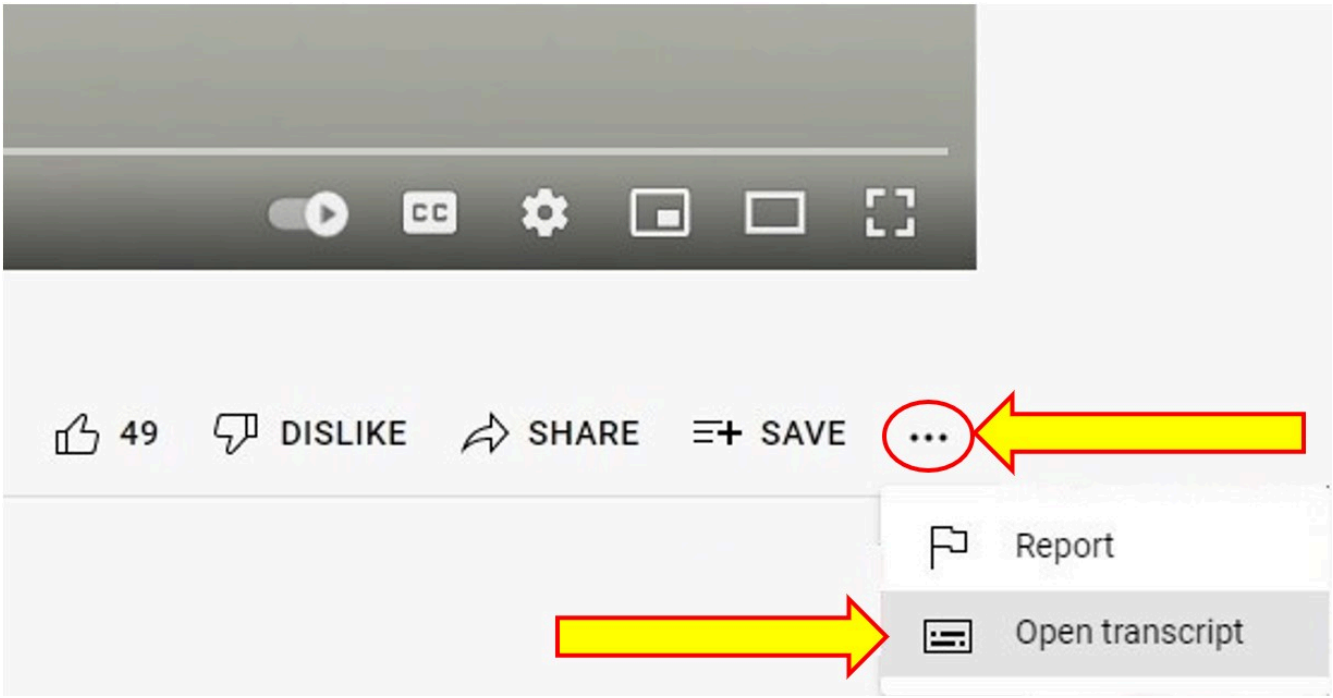

Increasing Case Management Effectiveness

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Increasing Case Management Effectiveness | Comprehensive Case Management Certification by Doc Snipes. Dr. Dawn-Elise Snipes is a Licensed Professional Counselor and Qualified Clinical Supervisor. She received her PhD in Mental Health Counseling from the University of Florida in 2002. In addition to being a practicing clinician, she has provided training to counselors, social workers, nurses and case managers internationally since 2006 through AllCEUs.com

Transcript

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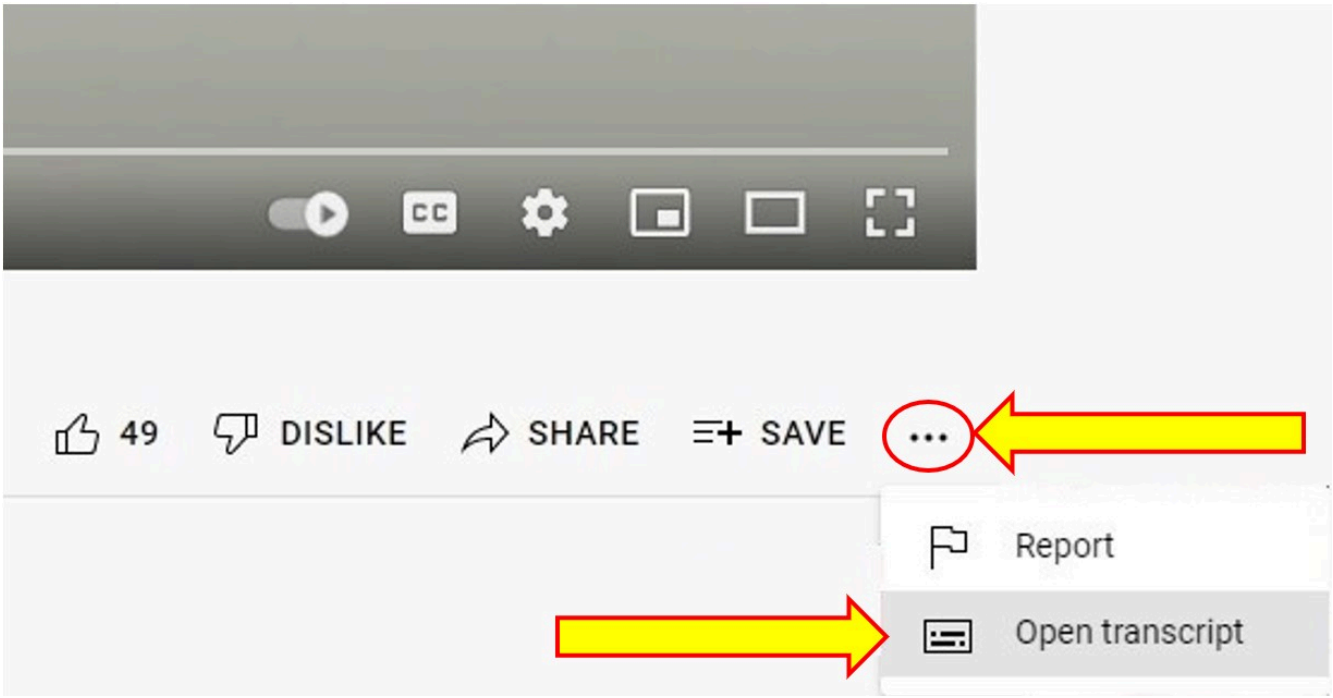

References:

- Doc Snipes. (2012b, March 10). *Case Management Referral and Coordination | Addiction and Substance Abuse Counselors* [Video]. YouTube. https://www.youtube.com/

watch?v=qv5pElBz10Q

- Doc Snipes. (2019b, July 10). *Increasing Case Management Effectiveness | Comprehensive Case Management Certification* [Video]. YouTube. https://www.youtube.com/watch?v=Td1uKiRIhrQ

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Weblinks	If weblinks must open in a new window, a textual reference is included in the link information	N/A
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Embedded Multimedia	Captions of all speech content and relevant non-speech content are included in the multimedia resource that includes audio synchronized with a video presentation	N/A
Embedded Multimedia	Audio descriptions of contextual visuals (graphs, charts, etc.) are included in the multimedia resource	N/A
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Formulas	Formulas are images with alternative text descriptions, if MathML is not an option	N/A
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Drugs, Health, Addictions & Behaviour – 1st Canadian Edition

VERSIONING HISTORY

This page provides a record of changes made to Fundamentals of Addition – Trauma Informed and Solution Focused Counselling. Each set of edits is acknowledged with a 0.01 increase in the version number. The exported files for this toolkit reflect the most recent version.

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Version	Date	Details
1.0	March 23, 2022	Fundamentals of Addiction – Trauma Informed and Solution Focused Counselling