CTRI
CRISIS & TRAUMA
RESOURCE INSTITUTE

ADDICTIONS AND MENTAL ILLNESS

Working with Co-occurring Disorders

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ADDICTIONS AND MENTAL ILLNESS – WORKING WITH CO-OCCURRING DISORDERS

Many people who struggle with mental illness also struggle with an addiction. Recovery from both of these issues is complicated because they affect each other and are intertwined. Helpers may often be at a loss for where to start – did the addiction cause the mental illness, did the mental illness cause the addiction, or is there something else leading to both? This workshop provides a framework for working systemically with both issues at the same time. Participants will explore the impact of both addiction and mental illness, be provided with an overview of the theoretical frameworks for working with both issues, and learn how to integrate strategies in a way that supports health and change.

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While many licensing boards, professional colleges and associations accept CTRI workshops for continuing education credits, the following associations and organizations have approved CTRI as an Approved Continuing Education Provider:

Association of Social Work Boards (ASWB)
Association of Cooperative Counselling Therapists of Canada (ACCT)
Canadian Addiction Counsellors Certification Federation (CACCF)
Canadian Assessment, Vocational Evaluation & Work Adjustment Society (CAVEWAS)
Canadian Counselling and Psychotherapy Association (CCPA)
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National Board for Certified Counselors (NBCC)
Ontario Association of Mental Health Professionals (OAMHP)
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The Crisis and Trauma Resource Institute Inc. (Provider Number 1214), is approved as a provider for social work continuing education by the Association of Social Work Boards (ASWB) www.aswb.org, through the Approved Continuing Education (ACE) program. ASWB Approval Period: Aug. 10, 2020 – Aug. 10, 2023. Social workers should contact their regulatory board to determine course approval. Social workers participating in this course will receive 6 continuing education clock hours for a one day workshop, and 12 for a two day workshop.

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DEFINITIONS

Co-occurring Disorders/Dual Diagnosis: Refers to an individual being diagnosed with an addiction and one or more mental health diagnoses at the same time.

Common Examples

- Anxiety Disorders and Marijuana Dependence
- Depression and Alcohol Use Disorder
- Personality Disorders and Stimulants

Mental Illness: Refers to patterns of disruptions of functioning on a person's emotional, cognitive, behavioural or social levels. Symptoms may be mild or severe, may be present all the time or disappear for a while entirely, but cause some level of distress in the person's life.

Addiction: A pattern of continued use of a substance or activity that alters a person's emotional or psychological reality, despite repeated harm as a result of that use.

Substance Addictions: Refers to substances that are taken into the body (ingested, injected or inhaled). Can refer to stimulants, depressants, hypnotics or other classifications of drugs.

Process Addictions: Refers to activities where the process of engaging in them or the result of the activity are addictive. Can refer to gambling, sex, eating, shopping, Internet, online video games, etc.

Self-Medicating: Choices to use a substance or activity other than prescribed, or without a prescription, to mitigate the effects of a mental illness or the effects of the prescribed medication for a mental illness.

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OVERVIEW AND HISTORY OF THE LINK

Until recently, people who presented with both a substance abuse addiction and a mental health diagnosis were caught in a no-win situation. Routinely, people who were connected with the mental health system were referred to addiction treatment in order to manage their substance abuse and detox prior to receiving treatment for their mental health diagnosis, while simultaneously individuals who showed up for addiction services were told that they could receive treatment but needed their mental health diagnoses stabilized first.

From each perspective, the treatment made sense. For people in the mental health field, prescribing medication for a mental health diagnosis is problematic when an individual's system is continually adjusting to other chemicals coming in and out of the body or individuals are unable to comply with a timetable to take their medication. If someone could stabilize their substance use their systems could calm down and the medication would start to have an effect.

From the addiction perspective people would often refer to use of substances or alcohol as *self-medicating* – a way to cope with unbalanced mental health. If someone could have their mental health stabilized it was believed that would help manage the substance abuse problem and people were referred to the mental health system in order to manage their mental health.

For people entering these systems the results were closed doors wherever they went. People either learned to lie to their care providers to avoid the runaround or gave up trying. Not surprisingly, for many it exacerbated both the mental health and the substance abuse issues.

Recently, large efforts are being made to harmonize these systems. Research is showing over and over that concurrent treatment for both mental health and substance abuse is essential for good outcomes. Caregivers in both systems are educating themselves on the other and fewer clients are falling through the cracks.

This workshop is aimed at helping to bridge those two worlds and develop a *both/and* perspective towards the treatment of mental health and addictions.

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How Big Is the Problem?

Statistics

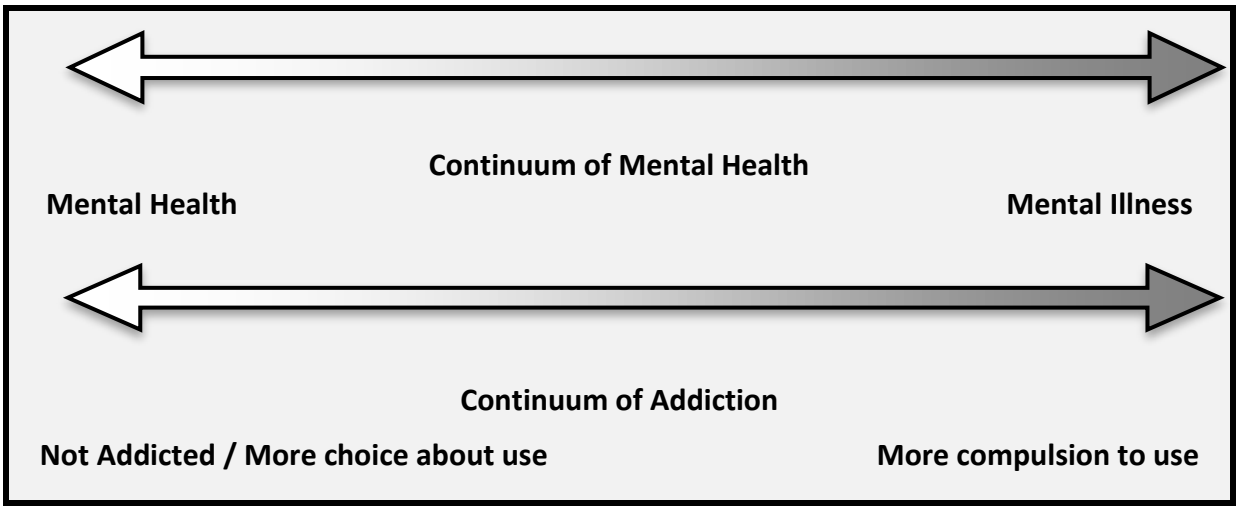
- Approximately 1 in 5 Canadians experiences a mental health or addiction problem. (Smetanin, Briante, Adair, Ahmad & Khan, 2011)
- Youth aged 15-24 are more likely than any other age group to experience mental illness or a substance abuse disorder. (Statistics Canada, 2013)
- People with a mental illness are twice as likely as the general population in Canada to experience a substance abuse problem. 20% of those who have a mental illness also experience a co-occurring substance abuse problem. (Rush, Urbanoski, Bassani, Castel, Wild, Strike, Kimerley & Somers, 2008)
- People who experience a substance abuse problem are three times more likely than the general population in Canada to have a mental illness. Over 15% of those struggling with a substance abuse problem also experience a co-occurring mental illness diagnosis. (Rush et al., 2008)

Stigma
(Canadian Medial Association, 2008)

- While 72% of Canadians would tell friends or coworkers that a family member has cancer (similar rates for other diseases), only half would discuss a family member having a mental illness.
- Socially, less than half (49%) of Canadians would socialize with a friend who had a serious mental illness. Less than 1 out of 8 Canadians (12%) would hire a lawyer if they knew he or she had a serious mental illness.
- Just over 1 in 4 Canadians feel fearful of being around someone who has a serious mental illness.
- Almost half (46%) of Canadians believe that individuals use a mental illness as an excuse for bad behaviour. (Canadian Medical Association, 2008)

CONTINUUMS OF ADDICTION, MENTAL HEALTH & CO-OCCURRING DISORDERS

When considering co-occurring disorders, we often talk in *all or nothing, either/or* language, and the reality is far more complex. We do this with mental health and addiction – either you have a mental illness or you don't, either you are addicted or you are not. In reality, both addiction and mental health exist on continuums and people move up and down the scale as their level of functioning changes.



While we cannot directly control the continuums, what influences them are the balance of risk factors and protective factors in our lives.

What risk factors may influence addictions? Mental health?

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What are protective factors?

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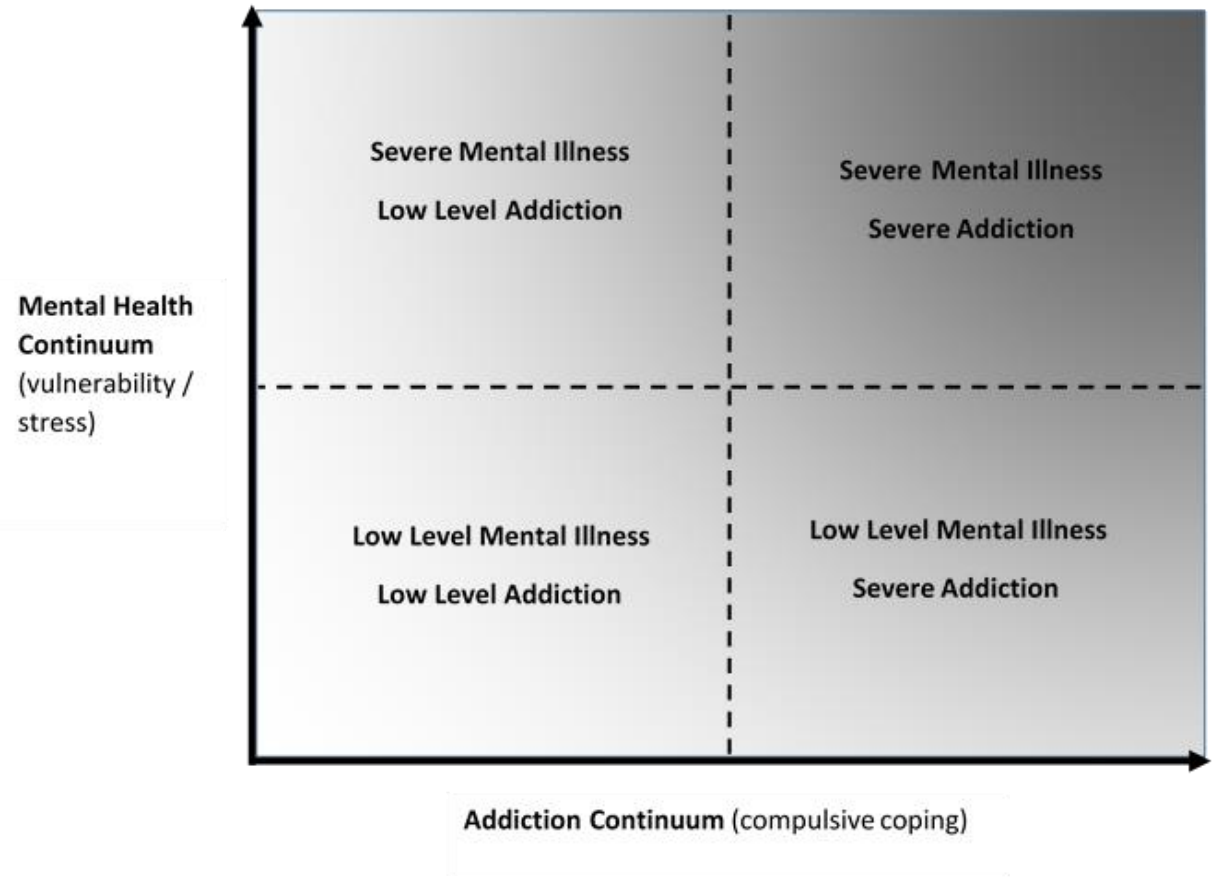
Spectrum of Co-Occurring Disorders

When we combine these continuums, the result is a full spectrum of experiences – all of which get classified as co-occurring disorders.



Those with co-occurring disorders are not a specific population with specific needs, it is a diverse population with diverse needs. Part of the complexity for treatment programs is addressing the unique needs of each individual. This spectrum alone has us considering the unique needs of four groups:

- Severe mental illness with severe addiction.
- Severe mental illness with low level of addiction.
- Low level of mental illness with severe addiction.
- Low level of mental illness with low level of addiction.

The concerns and needs are different between each of these groups, let alone all the differences within each group. Treatment programs that fail to take these differences into account undermine their own programming.

LINKS BETWEEN MENTAL ILLNESS AND ADDICTION

Schizophrenia

Research has shown that individuals diagnosed with schizophrenia have a higher than normal use of alcohol, marijuana, cocaine and opiates, as well as a much higher rate of nicotine addiction than the rest of the population. It has been hypothesized that schizophrenia may also be at times a substance-induced disorder, triggered by substance use and the impacts on the brain. Oftentimes withdrawal from substances exacerbates the symptoms of schizophrenia and some studies have shown that quitting smoking results in a lower level of functioning afterwards.

Psychosis

Typically when psychosis is not related to schizophrenia, it is due to substance use or abuse. Individuals with psychosis (including those with schizophrenia) have described their use of substances as a way to deal with the emotional impact of the hallucinations or delusions, a way to make meaning of bizarre experiences (e.g., "If I was high, what I was seeing or hearing made sense"), and many also describe how using certain substances decreases the number or intensity of psychotic episodes.

Depression and Bipolar Disorder

Many individuals diagnosed with depression or bipolar disorder show a strong link with addictions. Up to 60% of people diagnosed with bipolar disorder have had an addiction. (Cassidy, Ahern & Carroll, 2001). Studies show frequent use of alcohol, especially during struggles with depression and stimulant use (cocaine, etc.), and especially during times of mania.

Anxiety Disorders

Individuals diagnosed with anxiety disorders often describe using alcohol and drugs to mitigate or manage the symptoms. The reality is often that long-term use of alcohol and drugs can exacerbate the problem, but the short-term impact results in feeling like it is being decreased.

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Personality Disorders

While substance use and behavioural addictions are high, no easy pattern exists with personality disorders and addictions. Clinical examples suggest use is frequent and varied depending on the individual involved and their history, and use may occur with any of the typical substances or behavioural addictions (sex, shopping, gambling, etc.).

Dementia

It is believed that dementia may at times be caused by chronic alcohol use. It is difficult to diagnose in the early stages when it is masked by the effects of alcohol use. While alcoholism leading to dementia affects individuals in their later years, substance-induced dementia may also be a result of inhalant use and can affect all age groups.

Fetal Alcohol Spectrum Disorder

FASD is a substance-induced disorder with no choice by the individual to use in the first place. While data is difficult to find, use of substances by individuals diagnosed with FASD is higher than the rest of the population, with alcohol use being the most prevalent. Anecdotal evidence highlights a trend towards individuals with FASD becoming addicted quicker than the general population and experiencing a more difficult time in recovery – in part due to the learning disruptions of the disorder itself.

Attention Deficit Hyperactivity Disorder

An estimated 15-25% of adults who have a substance abuse problem also experience ADHD (Wilens, 2010). Individuals with ADHD report their use of substances as helping them to focus, to concentrate and to manage their anxious and unsettled feelings.

Our Experiences with Co-Occurring Disorders

1. In looking at the co-occurring spectrum (page 8), what groups do you have the most experience with? What have you learned about treatment with this population?

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2. In your experience, with what group on the spectrum is your workplace most suited to work? What would need to change in order to broaden the scope?

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3. What patterns of addiction and mental illness are you most familiar with? Which diagnoses? Which addictions? How do they affect each other?

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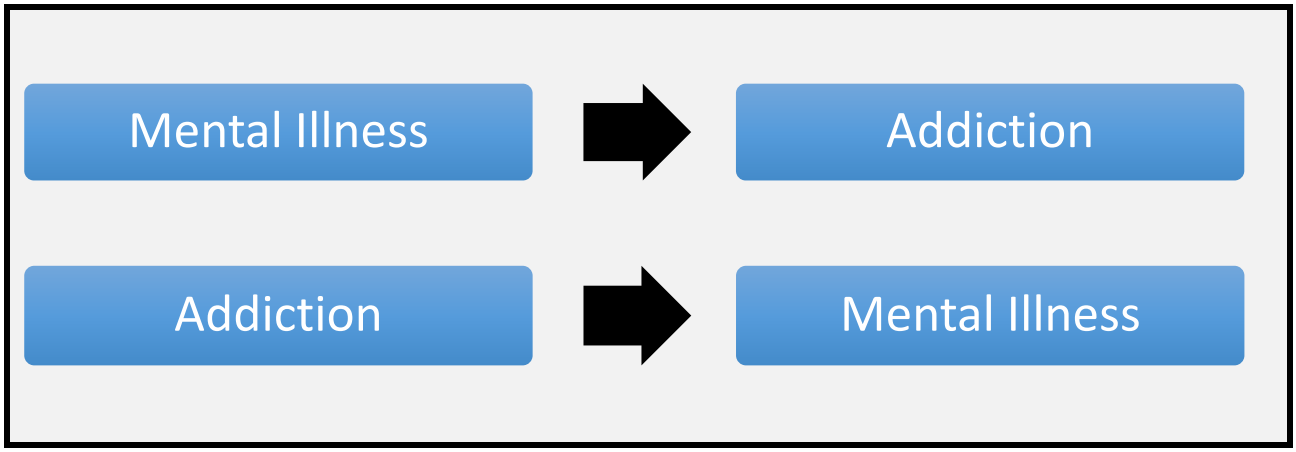
The Relationship Between Mental Illness and Addictions

In exploring the relationship between mental illness and substance abuse, practitioners often make the mistake of seeing the cause in relation to their own expertise – i.e., mental health practitioners often err on the side of assuming the mental illness is the primary issue or cause, and addictions workers often err by focusing too much on the addiction. To get beyond this error of familiarity we need to look at a fuller range of the relationship between addictions and mental illness.



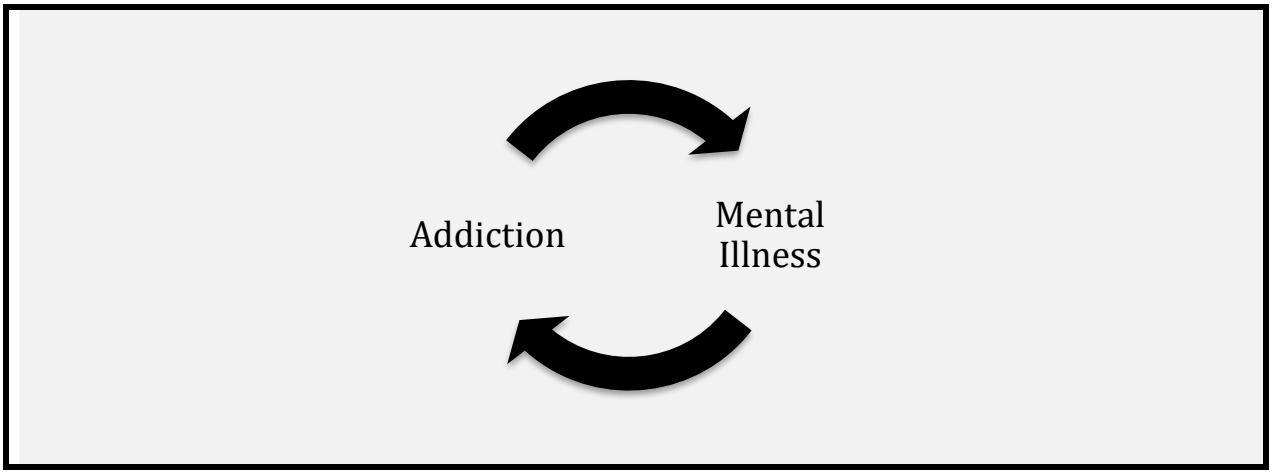
Linear relationships between addictions and mental illness can and do exist. We know that:

- Mental illness can create the conditions where a person seeks a way to escape (i.e., if someone chooses to use during this time, they are much more likely to develop an addiction).
- Mental illness can trigger cravings for substances and addictive activities.
- Mental illness can impede recovery work and trigger more relapses.
- Addictions can mask mental illnesses, making them more difficult to diagnose.
- Substance use can cause or trigger the onset of mental illness.
- Addiction and withdrawal can act like mental illness, leading to misdiagnosis.
- People may choose to use substances to alleviate the symptoms of their mental illness and/or their medication.

If we stop at just understanding the linear causal relationship, we may make the misinformed decision of simply seeing one as a symptom of the other (e.g., the pot use will go away when the anxiety is dealt with, or the depression will clear up as the individual becomes sober).

While either mental illness or addiction may have set the stage or even caused the other, alleviating the first issue doesn't necessarily cure the second (e.g., drug-induced psychosis doesn't go away simply by abstaining from using, and addictions don't necessarily disappear when depression becomes managed).

Regardless which develops first, once someone has both a mental illness and an addiction we are working with two primary diagnoses. Further, the presence of one typically exacerbates the other and makes treatment much more difficult.



For treatment to be effective, we must understand the current circular causality that maintains both the mental illness and the addiction. We must ask ourselves:

- How does the addiction relate with the mental illness and vice versa?
- In what ways is it helpful? In what ways is it harmful?
- What is it about the mental illness that triggers the urge to use?
- What is it about using that triggers or soothes the mental illness?
- What would happen to the client's ability to cope if they stopped using? In the short term or long term? How would this affect their mental illness during this time?
- How may both addiction and mental illness operate to maintain a third experience (e.g., trauma, relationship issues, fear)?

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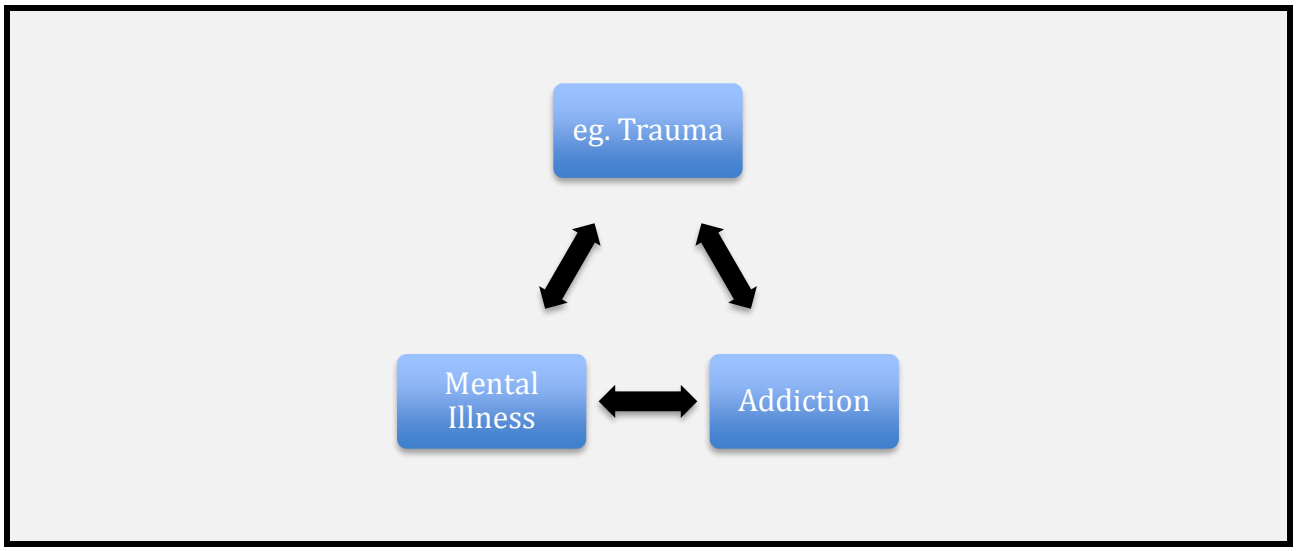
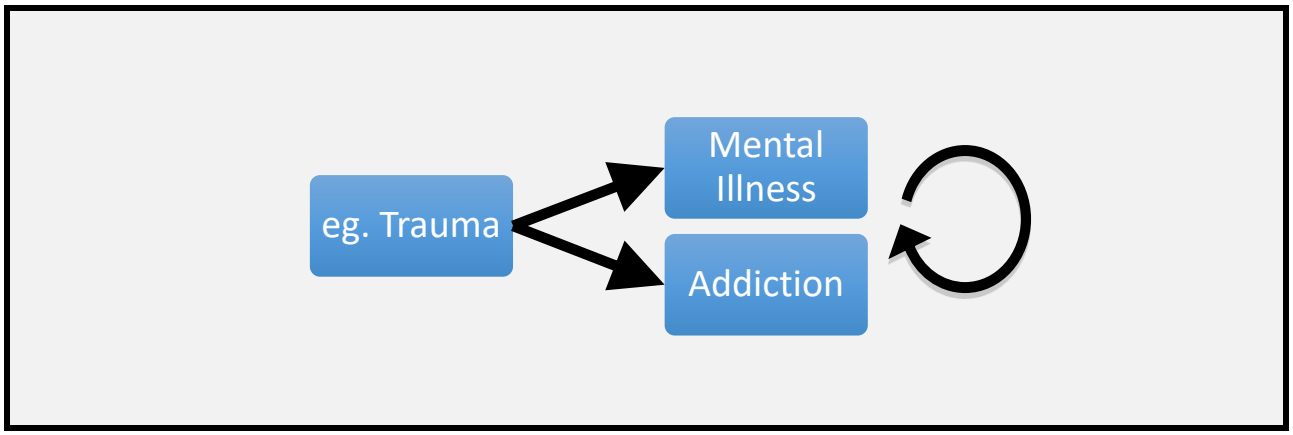
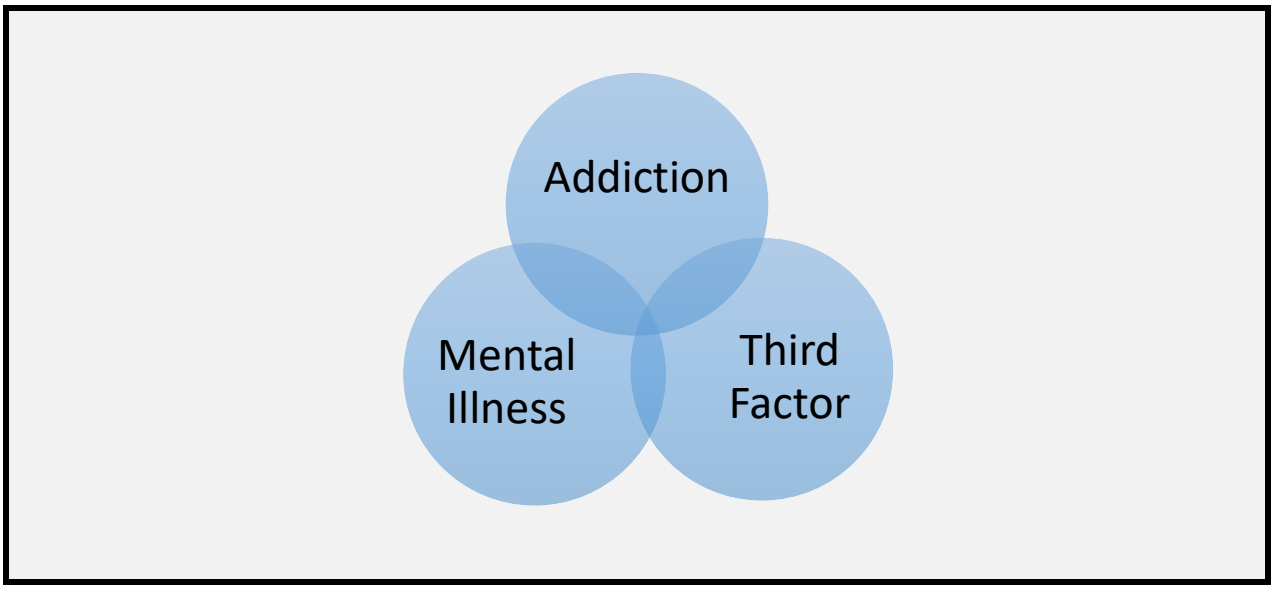
Another difficulty in focusing on the causal relationship between mental illness and addiction is that we assume no other factors are at play. In many cases, both the mental illness and addiction can be results of a third factor (e.g., trauma, early childhood stress, etc.).



If the addiction and mental illness are both results of a third factor or attempts to cope with it, recovery becomes much more complicated. A simplistic understanding would have us prioritize dealing with the third factor, incorrectly assuming that as that is dealt with, the addiction or mental illness will go away. While alleviating the third factor will likely make recovery work easier, once mental illness or addictions have occurred they have a momentum of their own and need to be dealt with.



In many cases, just as the addiction and mental illness can trigger and impede the recovery of the other, they both can function to impede growth or recovery work on the third factor. In these cases, work must be done concurrently on all factors in a way that is mindful of the impact of one on all of the others.



Possible Third Factors for Both Mental Illness and Addictions

- Genetics
- Early childhood stress / loss of attachment
- Response to trauma
- Poverty
- Family dysfunction
- Cultural / generational trauma and loss
- Chronic pain
- Living in prolonged fear
- Brain injury
- Intense loss

COMMON THEMES

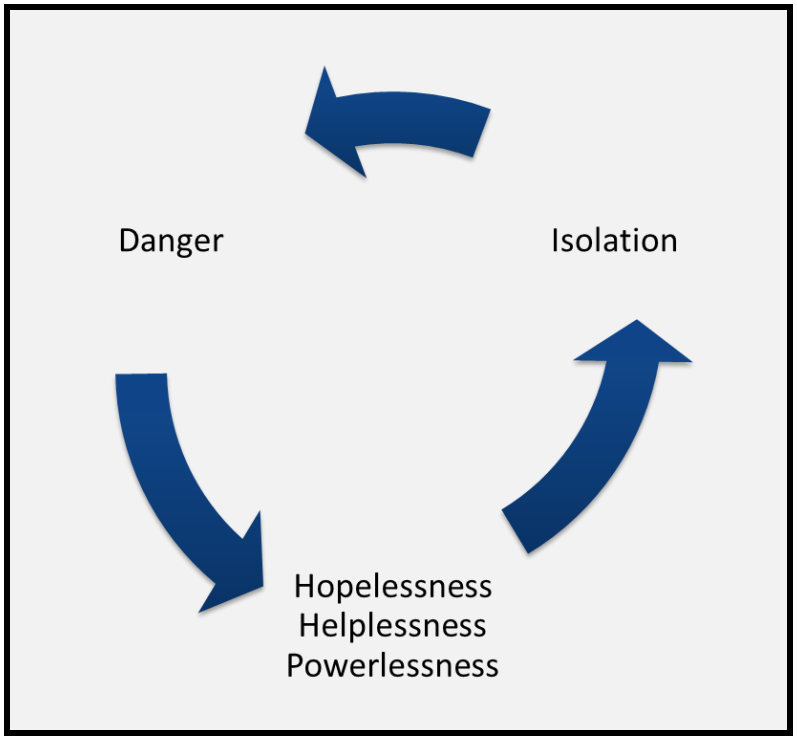
Issues of addictions, mental illness and trauma are complicated therapeutic concerns. At the same time, we can see they share several important and common threads.

Danger: Including safety concerns such as suicidality and self-injury or perceived dangers such as feeling judged, diminished, etc., due to shame, silence and stigma.

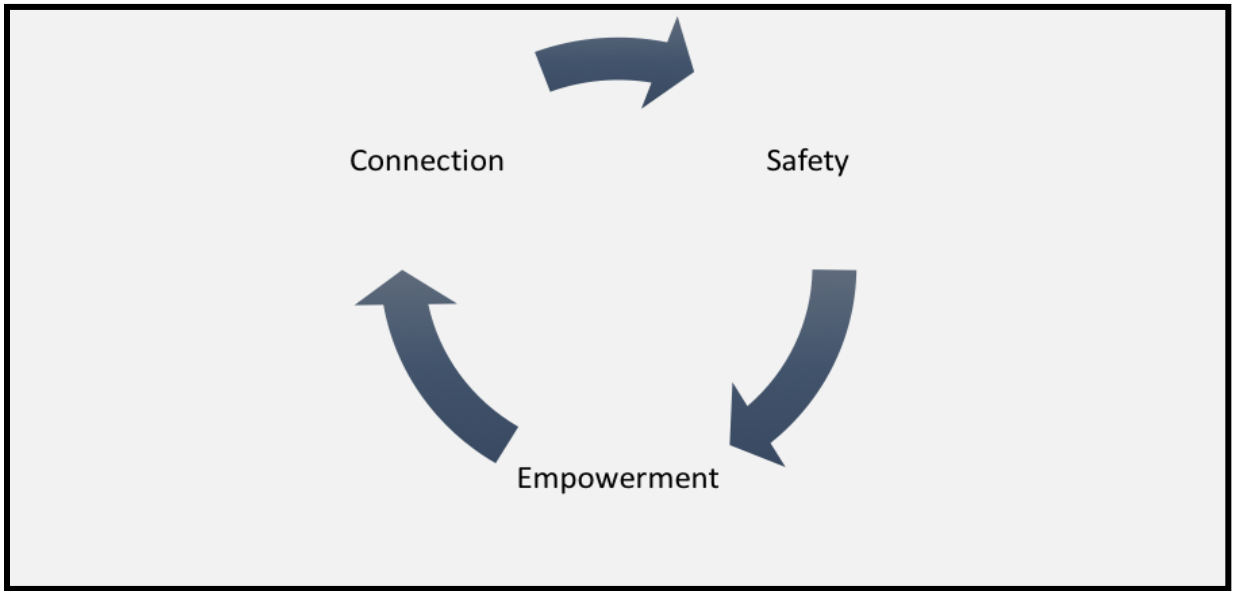
Hopelessness/Helplessness/Powerlessness: Including feelings of being out of control or smaller than the problems that haunt them.

Disconnection: Including feeling alone, misunderstood, shame.

These themes support and reinforce each other.



There are also common threads that form a framework for recovery when working with these issues both independently or when co-occurring.



Safety

- Build the therapeutic relationship
- Work at their own speed
- Continually assess for issues of suicidality (see Appendix, pp. 45-46) and self-harm
- Harm reduction framework

Empowerment

- Including creating hope, choice, knowledge
- Focus on strengths
- Explore coping and emotional regulation
- Provide information re: the problems
- Make connections between problems
- Use stages of change model

Connections

- To oneself, their goals, to resources
- Attention to the therapeutic relationship

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BELIEFS AND ASSUMPTIONS

1. To what degree is choice involved in people developing addictions or mental illness?

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2. Do you differentiate between an addiction and someone self-medicating? Where is the line? How would you tell?

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3. Why would a person hide addictions or mental health concerns from a caregiver? What is the *best* way for a caregiver to deal with this?

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UNDERSTANDING ADDICTIONS

The causes and factors that maintain addictions are complex. No one theory can explain addictions. Rather, a variety of issues stemming from the biological, psychological, social and spiritual ought to be considered. This has implications for intervention.

Biological Roots of Addiction

Addictions (process or substance) primarily work by either disconnecting the pain centres in the brain or stimulating the dopamine sites in the brain. These centres are what light up when we see a loved one, play, have fun, make love or do anything that brings us pleasure. Research has shown that rats (and humans) will forgo other essentials in life in order to keep this centre stimulated, sometimes to the point of starvation. Our bodies try to exist in a state of balance; as things happen to unbalance us, our systems respond in an attempt to restore the balance (homeostasis).

Tolerance
As our system becomes used to a substance acting in the brain it reacts by producing more or less of our own neurochemicals to account for the routine effects of the substance. Our system compensates for the substance use and more of it is required to create the same effects.

Withdrawal
A physical or psychological reaction to the lack of a substance in the body. If we stop using after developing tolerance, the lack of the substance changes the physiology of the body. Typically, withdrawal symptoms are the opposite of the symptoms of the substance entering the body. For example, withdrawal from a depressant (e.g., nicotine, alcohol) can increase a person's heart rate, muscle tension (shakes), etc., while withdrawing from a stimulant (e.g., caffeine, cocaine) can show a decrease in energy levels, lack of pleasure in life (anhedonia), etc.

Psychological Roots of Addictions

Our thoughts, moods, behaviours and experiences all make us unique. These factors also may influence the development of addictions. Issues of mental health concerns, trauma and coping patterns all may make a person at risk for addictions.

Coping
When people use substances or activities to "self-medicate," we begin talking about their choice to use as coping. If addictions play a part in managing distress, care needs to be taken prior to removing them in a person's life. There is a strong correlation with issues of addiction and mental illness. Also, the earlier a person begins use of addictions as coping and the more addiction is engaged, the more ingrained this pattern becomes.

Social Roots of Addiction

While addictions have devastating impacts on our social lives (distance, holding of secrets, prioritizing addictions over relationships, etc.), our social experiences also can trigger or maintain our use of addictions to escape.

Social Impacts Underlying Addiction

- Family dysfunction
- Trauma and abuse
- Lack of safety, security
- Modelling by caregivers, peers
- Peer influences
- Hopelessness about lifestyle
- Relationship stress
- Attachment styles
- Poverty
- Oppression / Discrimination
- Lack of access to opportunity
- Lack of treatment options
- Lack of resources

Role of Attachment

Our style of attachment is our default strategy for how to seek comfort when distressed and for how we regulate ourselves. It governs the degree to which we can self-soothe or accept comfort from others. Our style of attachment is influenced by our early interactions with parents and caregivers, creating a blueprint for further relationships and coping patterns.

Attachment Relationship with Addictions

If attachment is about how we seek comfort when distressed, our relationship to substances or process addictions becomes very important.

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Anxiety about Connections with Others

	Secure Human Attachment Figure	Addictive Substance or Process
Reliable (I can count on them when I need them)	Yes	Yes
Accessible (If I look for them, I can find them)	Yes	Yes
Sensitive (They are aware of my needs)	Yes	(don't expect)
Responsive (They help me manage distress)	Yes	Yes
Safe (They help me feel safe)	Yes	Yes (especially for some, as they don't require trust in human relationships)

*Adapted from Fraley, R.C., Waller, N.G., & Brennan, K.G. (2000). An item response theory analysis of self-report measures of adult attachment. *Journal of Personality and Social Psychology, 78*, 350-365.

Spiritual Roots of Addiction

People's stories of addiction are often linked with their sense of connection to their spirituality, sense of purpose and how they make meaning about the world around them. People often talk about the emptiness they feel inside or the void that they are trying to fill. For some individuals, spirituality and religion have been a place of fear and punishment, adding to the isolation they feel in the world, while for others they are a source of strength and hope.

Many self-help movements (e.g., Alcoholics Anonymous and others) see a relationship with a higher power and the belief in the strength of that higher power to help overcome the addiction as one of the cornerstones to healing. Others stress the higher power less, but talk about finding meaning and purpose in life and acceptance for the self.

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BARRIERS TO ASSESSMENT AND TREATMENT

Lack of Awareness on the Part of the Caregiver

- Lack of awareness of either mental health or addictions.

Lack of Time or Failure to Allocate Enough Time or Resources to Do a Proper Assessment

- Proper assessments take time to complete and may happen over many sessions instead of one neat 15 to 45 minute intake spot. Collateral information may be required from past caregivers, partners, family, workplaces, etc.

The Caregiver's Agenda

- When working with vulnerable clients, especially with many serious needs, it can be difficult to separate client's agenda from our own. Caregivers often focus on: housing, increased self-care, coping and connections. These are perfectly valid; however, when such goals are prioritized over the client's, there is a risk of overwhelming the client and damaging the therapeutic relationship**.**

Shame or Fear on the Part of the Person Coming for Help

- Both mental illness and addictions bring stigma and often come with some struggle with shame or fear. People may be hesitant to divulge information that they are struggling to accept even to themselves, let alone to say it out loud to someone else.
- Someone who is hesitant to share may have good reason to be cautious. We can't make someone trust us. They may have had negative helping experiences before.
- People will often tell their stories many times to the same caregiver, gradually taking more and more risks as they go, another reason assessments need to be ongoing.
- People may fear disclosing addictions in case they will be made to give them up. Although also causing problems, addictions are also often used as a coping strategy. People will rarely give up a way of coping until a better one is available and routine.

Denial on the Part of the Person Coming for Help

- As people come to terms with either addictions or mental health diagnoses, they often go through a period of struggle and denial where they refuse to believe they have a problem. They often will use all manner of defence mechanisms and cognitive distortions (minimizing, rationalizing, blaming, etc.) to avoid acknowledging having either an addiction or mental health issue.

GETTING TO KNOW THE PERSON OUTSIDE OF THE PROBLEM

Problems such as mental illness and addictions have a tendency to overshadow a person's identity. We often see this in language used to describe the person:

- She or he is depressed, "schizo", etc.
- She or he is an addict, drunk, etc.

Such problems may influence identity but they are not who that person is. Identity is complex and fluid rather than simple and static. How we are and who we are is shaped by many, many factors and influences.

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Getting to know the person outside of the problem is an important aspect of assessment (and intervention) as it assists in joining and provides valuable information in terms of resources, values and preferred direction in their life.

It can be helpful to explore:

- What is it you do for fun (explore interests, hobbies, etc.)
- Who are important people in your life (friends, family, pets, etc.)
- How would _____ (close friend, family member, etc.) describe what they value in you?
- What would you like me to know about you?
- What is going well for you?
- What would you like to see different in your life?

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ASSESSING FOR CO-OCCURRING DISORDERS

Regardless of whether you work in the addictions or mental health field, you are working with individuals with co-occurring disorders. Anecdotal evidence suggests that many workers in both fields fail to adequately incorporate screening questions from the other field – i.e., addictions workers are not asking about mental health history and vice versa.

The first step in assessing is asking some specific questions to inquire about either addictions or mental health in your regular intake procedures.

Mental Health Screening

- Diagnosing needs to be done by a qualified professional.
- Consider referring to a mental health professional if a person's thoughts or feelings seem out of context to their experiences.
- Informal questions exploring mental health:
    - Has there been a diagnosis of a mental illness? (Explore who diagnosed this, when, and their thoughts about the diagnosis.)
    - What do you do for fun?
    - Has your mood gotten in the way of things?
    - Are others concerned for you and your mental health?
    - Have you or others noted any changes in your thoughts, mood or behavior?
    - Is there a history of mental illness in your family?
    - Have you ever heard or seen things that others don't?

Addiction Screening

Whether you use a structured tool (see below) or informally ask the questions, screening for addictions is often focused on patterns of use, evidence of habituation, evidence of harm and impacts on relationships (including their relationship with their self). When exploring addictions, it is important to explore both substance and behavioural/process addictions (e.g., gambling, gaming, sex, etc.).

Simple Addiction Screening Tool

(Two or more "yes" responses indicate a potential problem)

(Coping) 1. Have you ever used drugs, alcohol or an activity to escape uncomfortable feelings?

(Shame) 2. Have you ever tried to hide your use of drugs, alcohol or your chosen activity?

(Harm) 3. Has your use of drugs, alcohol or a chosen activity hurt your family, friends, work or feelings about yourself?

(Tolerance) 4. Do you find yourself needing to use higher amounts or riskier activities in order to feel an effect?

(Dependence) 5. Do you experience any negative feelings or effects if you do not use for a period of time?

(Powerlessness/ Cravings) 6. Have you ever tried to cut back on your use and given in to cravings?

More In-Depth Assessment Tools

A number of professional tools are available that assess for co-occurring disorders.

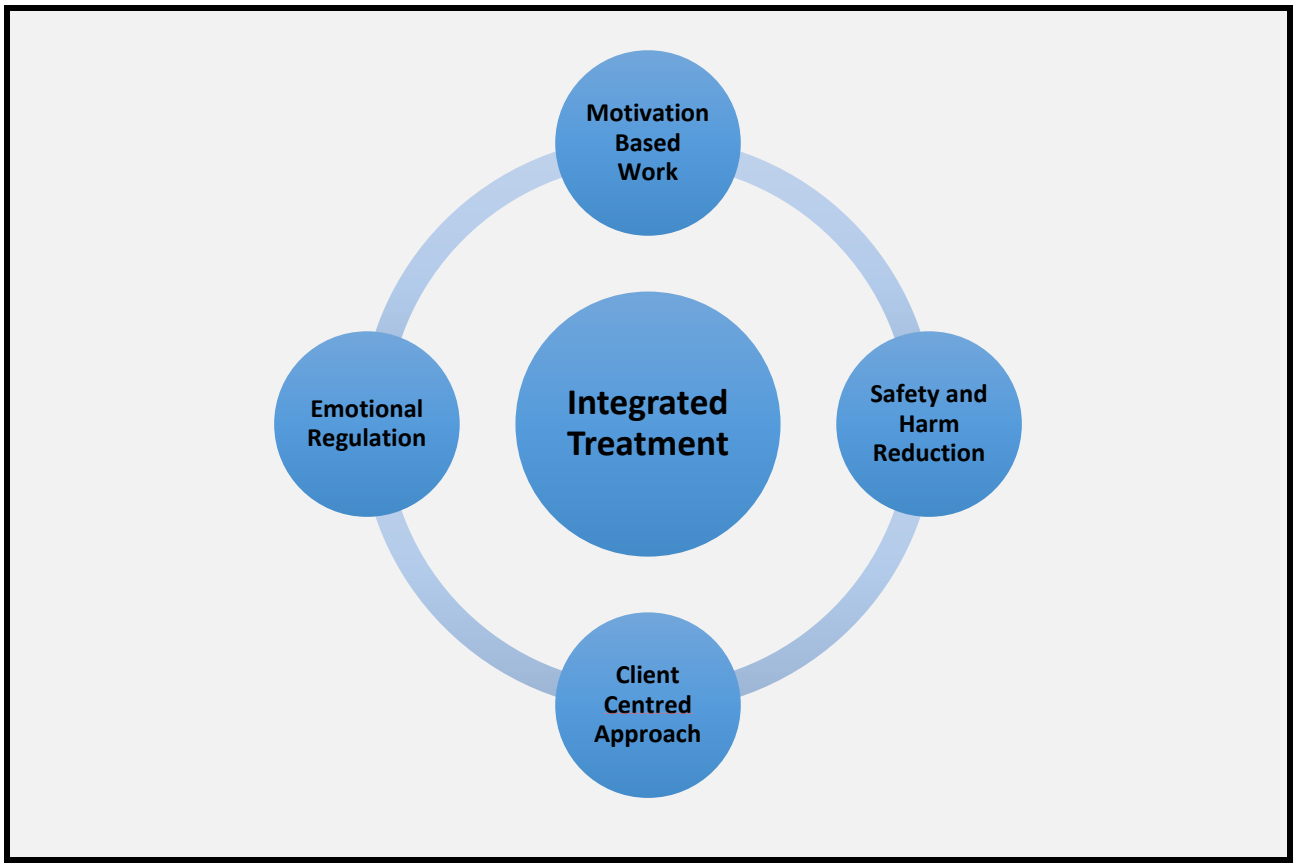
Practical Adolescent Dual Diagnostic Interview (PADDI)
Tool for screening for both major mental illnesses and substance abuse disorders in youth. Appropriate for a wide variety of community and clinical settings.

Comprehensive Addictions and Psychological Evaluation (CAAPE)
Adult screening tool for both addictions and mental illness. Covers a wide range of Axis 1 and 2 mental health diagnoses and substance use and dependence.

Note: Listing of these tools is offered as one possible option but should not be considered an endorsement of them.

Intervention Strategies with Co-Occurring Disorders

Helping is an art rather than a science. Each person we work with will have their own unique strengths as well as challenges. As we consider the intervention(s), the following strategies provide a useful framework for effective support of those experiencing co-occurring disorders. Each strategy builds upon and supports the others.



MOTIVATION BASED WORK

Helpers need to be flexible and seek to match interventions to fit with the motivation and energy level of the person in terms of their relationship with addictions and their mental health. Understanding this can help avoid power struggles and ensure the helper isn't working harder than the person they are helping. Change is a process, and it is normal for energy, motivation and leverage for change to vary along the way.

Stages of Change (*from Prochaska, Diclemente and Norcross, 1994*)

Pre-contemplation
This is when a person is not considering change for themselves in this area.
Strategy: Validate that the choice is theirs and focus on encouragement of self-exploration rather than pushing to consider change. It may be helpful to share concern or observation of any risk involved with a behaviour or attitude.

Contemplation
This is when a person is torn or unsure about change, "sitting on the fence".
Strategy: Explore and validate concerns around change. Exploring pros and cons for both changing and not changing can be helpful to clarify a decision. Help the client imagine a future with and without change.

Preparation
The client is wanting to change but may be unsure what steps to take.
Strategy: Here it is possible to use problem-solving strategies to brainstorm possible actions and clarify hopes and goals. It is important to connect the client to his or her resources and supports. Encourage small manageable steps.

Action
The client has taken steps and is adjusting to change. Often one change then requires other changes. Sometimes there are losses involved with change.
Strategy: Continued support and re-evaluation of goals and successes is important. New supports and strengths may be developed.

Maintenance
A normal part of change is to spiral back to old patterns and learn to re-focus.
Strategy: It is important to normalize and predict this. Continue to encourage new coping strategies and facilitate development of new goals.

Ending: "New Normal"
Sometimes a person will reach a point where the change no longer requires effort – it has become their "new normal". Other situations will require ongoing maintenance off and on throughout a lifetime.

SAFETY AND HARM REDUCTION

Attention to issues of safety is paramount in any intervention. This is especially true with work around issues of mental health and addictions. Continued awareness and assessment around issues of suicide ideation is critical.

A central goal of integrated treatment is to work towards enhancing safety. However, what a person considers "safe" can be individually defined. For example, a person who experiences homelessness may not personally consider their current housing circumstances unsafe. Rather than working towards absolute safety, harm reduction strategies are more helpful.

Harm Reduction Strategies

Harm Reduction Strategies Seek to

- Assess the current levels of risk and harm
- Understand the underlying needs being met by the addiction
- Work systematically at a realistic rate to increase safety and reduce harm and risk
- Work systematically to meet the underlying needs in safer, more permanent ways
- Have goals that are realistic and achievable

Examples of Harm Reduction Strategies May Include

- Safe injection sites
- Needle exchange programs
- Opioid replacement therapy
- "Wet shelters"

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CLIENT CENTRED APPROACH

There is no cookie cutter approach to working with those experiencing co-occurring disorders. We need to understand, respect and work with each individual's unique needs. They are the experts of their reality. When working collaboratively, issues of inclusion, pacing and the therapeutic relationship ought to be foremost in our work.

Inclusion

Focus on creating a sense within the individual that you are alongside them in their goals, rather than pulling them towards *your* goals. Caregivers need to be sensitive that the focus is on meeting the individual's perception of their needs, rather than the perception of meeting the service provider's or treatment program's needs.

Pacing

This is key so as not to re-traumatize the individual or overwhelm them and trigger distress. Too slow of a pace and there is not enough stimulation or change to create momentum. Too fast and it is overwhelming and can trigger hopelessness, powerlessness and distress.

The Therapeutic Relationship

A strong working relationship is the foundation of effective helping, especially when working with those experiencing co-occurring disorders. This involves developing a positive rapport and a sense of genuine connection, plus a collaborative means of engagement. As helpers we need to be constantly aware of the relationship; focusing on review, repair and continued development is key. When there is client resistance or a sense of *stuckness*, these may be indicators of a shift in the therapeutic relationship.

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EMOTIONAL REGULATION

The ability to identify, understand and respond appropriately to our emotions is a key life skill. However, many people struggle with this. This is especially true with those experiencing co-occurring disorders.

Identifying Emotions

Some people have a vast emotional vocabulary and ability to list and differentiate a wide variety of emotions. Others have difficulty identifying emotions beyond happy, sad and angry. There are many ways to help people identify their and others' emotions:

- Use of face charts
- Storytelling
- Music
- Helper sharing of their own emotions and experiences
- Other

Understanding Emotions

A common yet misguided understanding of emotions separates them into the positive (e.g., happy, glad, surprise, etc.) and negative (e.g., anger, sadness, etc.). Emotions are neither good nor bad, they just are. Rather than separating them into the good and bad, it is more helpful to understand emotions as messengers. A key task in understanding emotions is learning whether they are appropriate or inappropriate given the situation. Emotions can be viewed as a compass pointing us to rewards and threats in our environment. It is up to us to interpret this message and assess its validity (some emotions can be "tricksters" and choose our behaviour).

As helpers, an important aspect of assisting clients to understand their emotions is slowing down the process to better understand their experience:

- What emotion(s) are you experiencing?
- What are your emotions trying to telling you?
- Does the emotion(s) and its intensity fit the situation?
- Are there other explanations for this?
- In the past how has (the emotion(s) influenced your behaviour?
- How do you want to respond in this situation?

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Regulating Emotions

Emotion regulation skills help one tolerate or move through difficult emotions in a way that does not cause problems for the person or others. In addition, the use of these skills can help with:

- Reducing impulsive behaviour(s)
- Promoting choice
- Making decisions
- Calming the body and mind

In order to be effective, all skills should be done with mindfulness, paying attention and being aware in the present moment without judgement. There are many paths to emotional regulation which may include:

Relaxation Techniques

- Practice deep breathing
- Listen to music
- Engage the senses – e.g., listen to music, focus on art, etc.
- Spend time in nature
- Meditate, pray, smudge, go to a place of worship

Physical Exercise and Movement

- Go for a walk, run, swim
- Yoga
- Do housework or gardening

Creative Expression

- Write in a journal
- Engage in art, music
- Dance

Communicate and Connect with Others

- Family member or friend
- Utilize professional supports (counsellor, crisis lines)
- Provide assistance to someone in need or volunteer in the community

Use Diversion Techniques

- Occupy oneself in a task – e.g., a puzzle, Sudoku, chores
- Change environment

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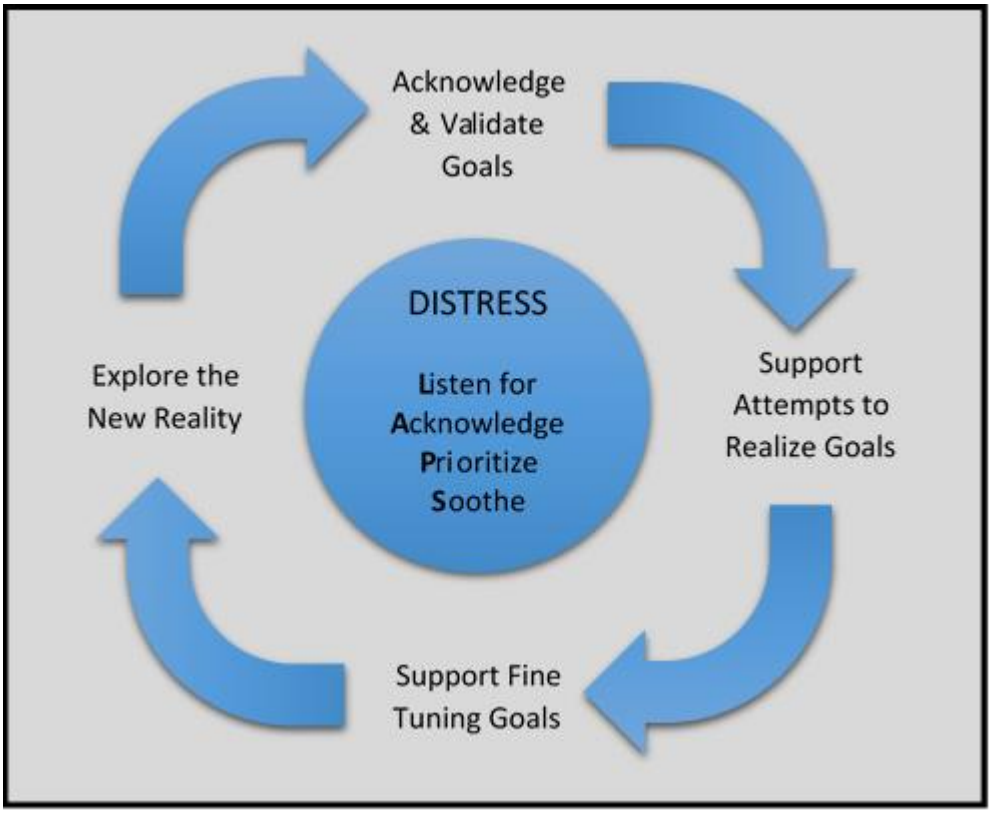
COLLABORATIVE INTERVENTION STRATEGY

A Collaborative Intervention Strategy (CIS) involves pacing change at the speed of the individual. It requires us to focus on the long-term progress rather than immediate results. By doing so, changes are often found to be deeper and longer lasting.



In the CIS, intervention is happening on two different levels. On the **surface level**, focus is given to the individual's goals for their life in either addictions or mental health, and the cycle of setting, realizing, adjusting and building on goals begins.

On the **deeper level**, we are continually paying attention to the level of distress present in the individual. Relationship building occurs as distress is Listened to, Acknowledged, Prioritized and Soothed (LAPS). If caregivers miss this or pace themselves incorrectly here, the relationship and goal process is undermined. If this level is done well, activation is managed, trust and intimacy are deepened, and the external process is accelerated.

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GOAL SETTING

The focus of goal setting is to validate the individual's stated goals. It is important that we do not have hidden agendas or goals for them, pushing them deeper and faster than they are ready to go, but rather we actually support them in identifying and working towards their own goals. If initial goals are not about either addictions or mental health, that is fine. It is more important to work on the deeper level and be congruent than to have the individual set false goals. Generally, most goals are about feeling better or safer on some level, which is directly relevant to both addictions and mental health.

Goal setting can be a very vulnerable process for many individuals. Especially if they haven't had success in prior attempts, it can take a fair amount of courage to set and declare a goal for themselves. Many times individuals will set very shallow goals in the beginning. These need to be treated with the same weight and importance as you would the later, deeper goals. Keeping ourselves in sync with their priorities is working at the deeper level.

Support Attempts to Realize Goals

Often times when we strive towards a goal, our first attempts have mixed success. These steps taken need to be supported and strengthened. Often the most important part is beginning and starting to build momentum towards change. Distress experienced as individuals begin to put their goals into action is very important and real.

Support Fine-Tuning of Goals

All goals need adjustments. Our initial hopes are often slightly off the mark of what is actually realistic, and that is okay. As we get experience in moving towards our goals, we get better at realizing what is realistic, and where our largest priorities are.

After we have moved towards realizing our goals, we begin to shift our reality. Even taking a step when we haven't before changes our internal reality. This new reality needs to be explored, and from there we set new goals and the process begins again.

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Goals of Integrated Treatment – The Helper's Agenda

Although we are prioritizing the client's goals, we need to acknowledge that we too have goals and agendas for the client within the process. These include:

- Working towards acceptance of addiction and mental health diagnosis.
- Mental health symptom reduction.
- Reduction of harm.
- Promotion of longer term coping strategies.
- Relapse management.
- Strategies for coping with cravings.
- Links to positive supports in family, friends, community.

Effective Treatment Includes

- Coordinated approach between service providers.
- Mental health team to monitor diagnosis and medication, working in conjunction with addictions professionals.
- Therapy with someone familiar with co-occurring diagnoses.
- Role for informal supports (family, friends).
- Possible connection with self-help organizations, peer support.

CASE STUDIES

Case Study #1

Sam, a 28-year-old male, comes to your office looking for help staying away from crack. He has a history of childhood sexual abuse by his father. He has suffered many bouts of panic attacks throughout his life and talks about his insecurity in being close to others. He has a history of violence with several past partners, often coinciding with increased fear and anxiety after contact with his own father.

At age 17 Sam's mother, who is in and out of his life, brought him to a psychiatrist for two sessions. That psychiatrist considered a diagnosis of borderline personality disorder, but then diagnosed Sam with generalized anxiety and panic disorder.

Sam has had difficulty sleeping, particularly if other people are present – sometimes sleeping as little as three to four hours per night for weeks at a time. This has gone on for many years. He doesn't agree with his diagnosis, and gets frustrated with people thinking that he is "screwed up". He has been put on anti-anxiety medications several times, but tends to go on and off of them. He has also been prescribed sleeping medication, but doesn't like how groggy he feels in the morning. He uses pot on a semi-daily basis, and he finds it helps the most leading up to and after contact with his father, to cool him down and help him get to sleep at night.

He talks about his use of crack as "getting out of his head and feeling his problems melt away". He doesn't like the amount of money he spends on the crack and how it ends up swallowing large chunks of time in his life – he has lost two jobs because he went on a binge and failed to show for work.

Questions to Consider

- What are their goals for themselves?
- What are your goals for them?
- What stage of change are they at for their addictions?
- What stage of change are they at for their mental health?
- How would you handle the different stages?

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Case Study #2

Betty is a 44-year-old woman who has come for help to manage her depression. She grew up in fairly stable home with both parents, but there were times of instability when her mother would leave to "unwind" spontaneously for somewhere between two days and two weeks, and the family wouldn't hear from her during this time. She remembers her father having a difficult time during these episodes and remembers him drinking periodically, but never considered it a problem in the family.

Her own depression came to the front towards the end of her own marriage five years ago. She had been married for 10 years and has two children (son and daughter, currently aged 9 and 11). The relationship had been rocky since the birth of their son (Betty had significant post-partum depression that coincided with a stressful time at her partner's work, which meant long hours of being away from the family and Betty being on her own with the two children). Betty recovered from the post-partum, but the relationship didn't get back on track. Her husband began drinking more late in the evening towards the end of the relationship, and she began joining him. Two years before the end of her relationship, she began drinking daily (approximately four to five drinks a day).

At that point the relationship had become abusive, with her partner criticizing her daily, and included angry outbursts where she often saw him throw furniture around and punch walls. He had started pushing her around during the last two outbursts. Betty found she was crying all the time and felt hopeless and helpless. She had begun thinking about suicide, but was afraid what that would do to her children.

She reached out for help and with support ended the relationship. She relied on her father and best friend for support and has cut her own drinking back to one to two drinks per day (occasionally a couple more, but not more than one to two times per month). But she is still struggling with feelings of depression, not wanting to wake up or get going in the morning, and has occasional thoughts of suicide. Her doctor has told her that for her medication to work she needs to quit drinking, but she isn't sure that she wants to do that, as she feels she is managing it just fine – one to two drinks is a "normal" level in her mind.

Questions to Consider

- What are their goals for themselves?
- What are your goals for them?
- What stage of change are they at for their addictions?
- What stage of change are they at for their mental health?
- How would you handle the different stages?

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Case Study # 3

Isabel, a 17-year-old woman, comes for help to manage both her anxiety and her pot use. She had a close call with the police last week, narrowly escaping possession charges, while a friend was arrested for trafficking.

Isabel was diagnosed with PTSD after a sexual assault at age 14; she began experimenting with pot shortly afterwards and liked the "fog" that came with it. Her largest issue in life right now revolves around a new same-sex relationship with her partner Sarah. While she believes her parents love her completely, they are also quite traditional in their beliefs and she is scared about how to deal with their reaction. Since the sexual assault, her parents have supported her, but also have somewhat pulled back from her and never discuss what happened. She is scared that if she brings up more troublesome issues for them, they will withdraw even further.

On the other hand, with Sarah she feels safe, loved and accepted and can talk openly about anything and everything. The main struggles in their relationship are dealing with the secrecy of their relationship (who to tell what to when?) and Isabel's use of pot (which triggers Sarah's own issues from her family of origin).

Isabel would like to stop using, but whenever she has tried, she finds the overwhelming feelings and flashbacks from the PTSD get worse and she doesn't know how to handle it.

Questions to Consider

- What are their goals for themselves?
- What are your goals for them?
- What stage of change are they at for their addictions?
- What stage of change are they at for their mental health?
- How would you handle the different stages?

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Case Study #4

Theo (age 29) has been a client of yours for some time and is working on dealing with his symptoms of schizophrenia and use of hallucinogens and marijuana.

His first diagnosis of schizophrenia happened after his older sister brought him in to emergency when she found him climbing to the top branches of a downtown tree, “to be closer to God”.

Theo is an up-and-coming artist in the city who often will go off of his medications and use various hallucinogens to begin huge paintings in his loft. He finds that the medications dull his creativity, and he likes the freedom that comes with playing with reality – something he believes most people need to shake up periodically. He has made it the mission of his art to help others in that journey and to chronicle his own relationship between his inner and outer realities. He has begun painting without using, but doesn’t feel that same freedom and feels too self-conscious about the process.

After he comes down from his “art trips”, he often uses marijuana to even out his emotions and he eventually starts his medication again. He agrees with his doctor that he probably has schizophrenia, but disagrees that the best life is the completely managed one.

Questions to Consider

- What are their goals for themselves?
- What are your goals for them?
- What stage of change are they at for their addictions?
- What stage of change are they at for their mental health?
- How would you handle the different stages?

APPENDIX

Mental Status Examination (MSE)

A mental status examination (MSE) is an assessment of a person's level of cognitive ability, appearance, emotional mood, and speech and thought patterns at the specific time of evaluation. The most commonly used test is the Mini-Mental Status Examination (MMSE), developed by Folstein in 1975. This exam can be purchased from Psychological Assessment Resources (PAR), http://www4.parinc.com/.

While exams utilize numerous rating and recording systems, most exams are interested in:

Appearance

- Inappropriate dress to the season/occasion/gender
- Poor hygiene
- Clothing is dishevelled, dirty

Behaviour

- Eye contact
- Facial expressions
- Coordination

Affect

- Labile (sudden shift in emotions)
- Blunted, flat (lacking emotions)
- Inappropriate emotional response to situations and content

Mood

- Displays hopelessness and feeling depressed
- Displays euphoria
- Displays hostility

Thought Process

- Tangential (running on, lacking a point)
- Blocking (losing track of where they are in the thought process)
- Disconnected thoughts

Mental Status Examination (MSE) – Continued

Thought Content

- Auditory or visual hallucinations
- Delusions
- Suicidal thoughts or plans
- Assaultive plans
- Obsessive or persistent thoughts

Cognition

- Impaired to orientation of person, place, time
- Poor recent or remote memory
- Ability to perform simple tasks – e.g., counting backwards

Speech

- Increase or decrease in volume
- Slurring, stuttering
- Length of answers to questions

Judgment and Insight

- Limited understanding of situation or problem
- Blames external factors for situations
- Displays inability to manage daily living activities
- Inability to make reasonable life decisions

Other Things to Consider in Assessments

- Duration of the problem
- Personal history
- Living environment
- Sleeping and eating habits
- Increased tearfulness
- Use of substances
- Medical history – both physical and mental
- Mental health history of family
- Relationships
- Suicidal thoughts

Impact on the Family

Both addictions and mental health issues can have significant impacts on families.

- Families can face stigma, be ashamed and not sure whom to tell what to.
- Family members may face their own struggles with either addictions or mental health issues.
- There can be fear or lack of understanding of the member who faces the struggles.
- Both addictions and mental health problems come with losses for family members.
- Family members may blame themselves or worry about their role in supporting healing or supporting the problem.
- Family members may have their boundaries crossed or violated and may struggle with how to set their boundaries with their loved one.
- Families can have significant fear or anxiety for their loved one, or anger at their loved one for causing the fear and anxiety.
- Families can struggle with hope and hopelessness.
- There likely will be times of powerlessness.
- Family members may go through their own grief processes as they come to understand and accept the mental health and addiction struggles of their loved one.
- Families can struggle with how to intervene appropriately, and when and if to intervene against the will of their family member.
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Self-Care: Feelings and Needs Log

The root of self-care is identifying our feelings and needs. When we know what our feelings are telling us and take care of them, we become unstuck and our feelings begin to shift and move. The more we do this, the more faith we have in ourselves to be able to meet our needs, and the less distressed we become in the future. We also are more able to choose the best way to take care of ourselves instead of seeking instant relief (often leading to escape and addictions).

The following two exercises are best done at a quiet time of the day, reflecting back on the more stressed times. As you get better at doing them in the calm times, you will find yourself doing them automatically in the stressed ones.

This first one starts with our emotion, connects it to our body state, and identifies our underlying need.

1. When I feel _____, what I notice about my body is _____ and I need _____.
2. When I feel _____, what I notice about my body is _____ and I need _____.
3. When I feel _____, what I notice about my body is _____ and I need _____.
4. When I feel _____, what I notice about my body is _____ and I need _____.

The second one starts with the body state and works through the closest emotions, action impulse and underlying need.

What I Notice in My Body Is…	The Closest Emotion Is…	My Impulse Is to…	What I Actually Need Is…

Ways To Deal With Triggers

- Identify triggers for use (people, places, feelings, thoughts) and plan for ways to manage or avoid.
- Focus on the positive.
- Self-talk (present-focused, positive, first person – “Right now, I am making this work”, as opposed to “You screw up – you’ll never be able to quit.”)
- Set small, meaningful goals around use (time-limited, manageable, realistic).
- Set medium- and longer-term goals for life and find ways to begin a small piece of them in the present.
- Remember that triggers and cravings are time-limited. They will go away.
- Identify and connect with supports you can use when triggered or craving.
- Be honest with yourself and realistic about what you can and can’t do.
- Respect your own boundaries and limits.
- Believe in yourself.
- Remember you have choices between short-term and long-term coping.
- Remember that cravings don’t chose behaviour, you do.
- Keep busy.
- Remember that discomfort now means that you are changing.
- Remind yourself about why you are choosing to make changes in your life.
- Focus on what you can do.
- Get good sleep (you need more than you think you do) and eat well daily.
- Seek out new ways to deal with old stress.
- When you slip back from your goals, acknowledge it, seek support and praise yourself for getting back on track.
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When to Reach Out…

The first sign that I'm getting into trouble with my life is…

Feelings that I need to be careful of…

Thoughts that are dangerous for me…

Situations that I need to be careful of…

Ways to calm myself down are…

Things I can say to myself to calm down are…

People who are good for me to reach out to are…

Services that I can reach 24 hours a day are…

Parts of my life where I feel strong are…

Suicide Warning Signs

Warning signs are often the subtle things (and sometimes not so subtle) we observe or hear. Many of these warning signs are not overly alarming individually, but collectively they become very concerning.

1. Loss of interest in things they used to care about
2. Irritability and edginess increases
3. Giving things away
4. Visiting or calling people and saying "Goodbye"
5. Methodically making amends, settling quarrels
6. Withdrawal and isolation from friends and family
7. Sudden decline in functioning at school or work
8. Suddenly happier, right after a long deep depression
9. Change in appearance – hygiene, etc.
10. Increased risk-taking behaviour (e.g., use of drugs, reckless driving)
11. Talking about feeling hopeless, helpless or worthless
12. Hoarding of pills, hiding of weapons
13. Talking about suicide or what it would be like to die (preoccupied with death)
14. Self-injury
15. Threatening suicide
16. Indirect statements
    - "What's the use of going on."
    - "My parents would be happier if I'd never been born."
    - "I just can't take it anymore."
17. Direct statements
    - "Sometimes I just feel like killing myself."
    - "If I killed myself, then people would be sorry."
    - "You won't have to worry about me much longer."

**Unfortunately, sometimes there are no warning signs.*

Assessing the Severity of Suicide Risk

Throughout the previous steps you might have gained a good idea about the severity of risk for suicide. The following questions may already have been answered. If not, make sure you know the answers:

- Do they have a plan? If yes, what is the plan and do they have access to this plan?
- Have they felt suicidal in the past, or is this the first time?
- Have they ever attempted suicide before? When?
- Are they using drugs or alcohol – do they have access?
- Will they be home alone?
- Do they take medications for mental health concerns – have they been taking them?

If you're not clear about the level of risk, you might ask:

- *"On a scale of 1-10 how serious are you about killing yourself?"*
- *"On a scale of 1-10 how hopeful are you that this situation will improve?"*

LEVEL OF RISK	**LOW**	**MODERATE**	**HIGH**
Suicidal ideation frequency (how often?)	Occasional	Intermittent	Continuous
Intensity (how strong?)	Mild	Strong	Overwhelming
Lethality of method	Not high	Possibly lethal	Very lethal
Availability of means	Doesn't have access	Can get access	Has immediate access
Specificity of plan	Not considered	Considered details (how, what, where, when)	Details worked out

If the level of risk is very high and help is needed immediately, take the individual directly to an emergency room. If you are worried that the individual may jump out of a moving car or put your life in danger by possibly grabbing your steering wheel while in motion, then phone the local police for assistance.

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CTRI WORKSHOPS AND SERVICES

Training

Our training is available in **public** (open workshops that anyone can attend), **on-site** (on-location, right where you are), **live stream, on-demand** and **webinar** formats (access training right from your computer, from any location). Below is a sample of the 50 different workshops we offer. For a complete list of the training we offer, please visit our website.

Trauma and Crisis Response Workshops
Crisis Response Planning
Critical Incident Group Debriefing
Trauma – Strategies for Resolving the Impact of Post-Traumatic Stress
Trauma Informed Care – Building a Culture of Strength
Vicarious Trauma – Strategies for Resilience
Walking Through Grief – Helping Others Deal with Loss

Counselling Skills Workshops
Anxiety – Practical Intervention Strategies
Brief Focused Counselling Skills – Strategies from Leading Frameworks
Cognitive Behavioural Therapy – Tools for Thinking Differently
Depression – Practical Intervention Strategies
Dialectical Behaviour Therapy – Balancing Acceptance and Change
The Ethics of Helping – Boundaries and Relationships
Mindfulness Counselling Strategies – Activating Compassion and Regulation

Children & Youth Issues Workshops
Addictions and Youth – Substances, Technology, Porn
Challenging Behaviours in Youth – Strategies for Intervention
Mental Health Concerns in Children and Youth
Play Therapy – Tools for Helping Children and Youth
Self-Injury Behaviour in Youth – Issues & Strategies

Addictions & Mental Health Workshops
Addictions and Mental Illness – Working with Co-occurring Disorders
Borderline Personality Disorder – Understanding and Supporting
Harm Reduction – A Framework for Change, Choice and Control

Violence and Restorative Justice Workshops
De-escalating Potentially Violent Situations™
Restorative Justice – Guiding Principles for Communities and Organizations
Violence Threat Assessment – Planning and Response

Disability Support
Autism – Strategies for Self-Regulation, Learning and Challenging Behaviours
Fetal Alcohol Spectrum Disorder – Strategies for Supporting

Member Plan

CTRI offers a membership plan that provides the member with unlimited access to our on-demand webinars for $12.99 a month. Member benefits include:

- Unlimited access to all pre-recorded webinars whenever and however often you want. New content added throughout the year.
- Notification of special discounts and promotions on products and training only available to members

Consulting Services

CTRI's consulting services are designed to help individuals, caregivers, communities and organizations prevent and cope with unfortunate and distressing events. To explore how to implement these services, please contact us to discuss your needs in more detail.

- Clinical Consultation
- Crisis Response Team and Plan Development
- Critical Incident Group Debriefing
- Disability Support – FASD and Autism Consultation
- Mediation – Conflict Resolution
- Suicide Prevention Plan Development
- Violence Risk Assessment and Planning

Assessment Tools

CTRI Assessment Tools help leaders and organizations have thoughtful and proactive discussions related to a variety of topics and issues. Each Assessment Tool Package includes one Facilitator's Guide and 25 copies of the Assessment Tool questionnaire.

- Wellness Assessment Tool
- Workplace Violence Assessment Tool
- Emergency Preparedness Assessment Tool

Books

Through our ACHIEVE Publishing division, we have three book titles available for purchase:

- *Counselling Insights – Practical Strategies for Helping Others with Anxiety Grief and More,* edited by Vicki Enns and written in collaboration with eight of CTRI's trainers.
- *The Culture Question – How to Create a Workplace Where People Like to Work* by Randy Grieser, Eric Stutzman, Wendy Loewen and Michael Labun
- *The Ordinary Leader – 10 Key Insights for Building and Leading a Thriving Organization,* by Randy Grieser

Notes

Addictions and Mental Illness Evaluation Form

Please evaluate the workshop according to the following scale. ***CLEARLY MARK AN × IN THE BOX:*** ☒

1 = Unsatisfactory; 2 = Below Average; 3 = Average; 4 = Good; 5 = Excellent

	1	2	3	4	5
1. Stated learning objectives of course were met	☐	☐	☐	☐	☐
2. Organization and clarity of course delivery	☐	☐	☐	☐	☐
3. Information presented was current and relevant	☐	☐	☐	☐	☐
4. Case studies and small group discussions were valuable	☐	☐	☐	☐	☐
5. Training materials (manual, av etc.) were helpful	☐	☐	☐	☐	☐
6. Workshop met your expectations	☐	☐	☐	☐	☐
7. Overall rating of workshop	☐	☐	☐	☐	☐
8. Facilitator held my interest and attention	☐	☐	☐	☐	☐
9. Facilitator's professional knowledge	☐	☐	☐	☐	☐
10. Overall rating of facilitator	☐	☐	☐	☐	☐
11. Administrative (registration, location, etc.) details adequate	☐	☐	☐	☐	☐
12. Requests for accommodations (if applicable) were addressed	☐	☐	☐	☐	☐

13. I would recommend this workshop to a friend or colleague ☐ Y ☐ N

14. What were the strengths of this workshop?

15. How could this workshop be improved?

16. Additional comments:

***To be notified of upcoming workshops, free webinars, and blog posts, please provide your e-mail:**

OPTIONAL:

Do you give permission for CTRI to use your comments in promotional material?..... ☐ Y ☐ N

Please fill in the box and write your name, position and organization where you work.

Name*

Position

Organization

*Required if seeking ASWB continuing education credit

Do not write on this page – evaluation on other side