Addictions Services and Transitional Outreach: A Field Practicum Report

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By

Ryan Labatt

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ABSTRACT

This report is a reflective consideration of my MSW graduate student practicum at the Regina Qu’Appelle Health Region’s Addiction Services, an agency which provides several programs and services to address client needs in the Regina and surrounding area. My practicum objectives were for me to improve my knowledge in the area of addiction services and to specifically develop a program model to transition addiction clients who required housing into homes in the community. The result of my practicum was the creation of the Transitional Outreach Program (TOP) Model which I believe addressed the scope, objectives and learning activities identified in my MSW Practicum Proposal. This paper utilizes the Direct Practice Framework outlined for MSW Integrative Practicum Reports with headings that include: Ideology, Theory, Values, Ethics, Relationships, Strategies, Skills and Visions. It is through this identified structure that existing Addiction Services Programs and the TOP Model are explored. This report bridges both the theoretical and practice implications present in my practicum experience. Relevant literature is considered in relation to existing Addiction Services Programming and for the TOP Model.
ACKNOWLEDGMENTS

I wish to thank Brian Danyliw, Manager of the Regina Qu’Appelle Health Region’s Addiction Services, for providing me with a rich practicum experience. I also wish to thank the staff at the agency for sharing their professional expertise and for making me feel welcome. There is a great collective sense of humour in the agency that makes for a very enjoyable work environment. I believe all of you provide an excellent service to the clients you serve.

Thank you to Dr. Douglas Durst for his direction during my Masters of Social Work Program. His positive support provided me with increased confidence in completing the various program requirements. His teaching taught me a great deal about writing and social work research. Finally, I thank Doug for his guidance as my Academic Supervisor.

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Thank you to my family, Tina Carter, my amazing wife whose love and support is unbeatable and also to my wonderful kids Arden and Rory. Your support over the past year made it possible to complete this program.
Introduction

A three-month (450 hour) practicum was completed between May 3, 2010 and July 23, 2010 at the Regina Qu’Appelle Health Region’s Addiction Services new Addiction Treatment Centre. Dr. Douglas Durst of the Faculty of Social Work, University of Regina was very supportive in providing advice about the process involved in securing my practicum placement. Housing has been a major topic of focus for me in this graduate program over the past year. Being offered the opportunity to develop a program model that focused on housing and addiction could not have been a better fit for me. I chose to pursue my Master degree in Social Work (MSW) because of the degree’s versatility in opening doors within the human service field. Given my strong interest in program and community development choosing the practicum route in the program made good sense.

This report explores existing programs and services within Addiction Services for the purpose of providing a foundation and context for the Transitional Outreach Program (TOP) that I developed during my practicum. My intention is to weave existing practice within addiction services with recommended new directions that are outlined in the TOP Model. The TOP shares the same Client-Centred foundation as all others programs within the agency (Rogers, 1951). With this base in place the TOP utilizes other strategies to bring Addiction Services into the community in an outreach capacity. The TOP Model and existing agency programs and services are considered within the framework for this report.

In the ideology chapter there is a discussion about the client population served by Addiction Services. This section considers determinants of problems and beliefs about the client/worker relationship. The next section of the report considers theory dealing with families, individuals, groups, community and other important considerations that provide insight into the
agencies practice. Values are then considered in relation to addiction clients, addiction staff, the agency itself and society at large. It is interesting to consider how congruent and opposing values between these various groups affect the overall functioning of the agency. Another section explores ethics within the agency, and the ethics that guide various professions including that of the Social Work Field. The next section on relationships provides insight into the various dynamics within the agency and between the agency and the client as well as the community and society. The next two chapters explore the strategies and skills used within Addiction Services Programming. Finally this report considers my own personal visions for my future as a Social Worker and for the profession at large.

*Transitional Outreach Program*

Although the Transitional Outreach Program (TOP) is discussed in relation to each of the sections in this report, I believe a brief overview of the model enhances the proceeding discussion. I had initially thought I would be completing my practicum with the Government of Canada’s Department of Human Resources and Skills Development (Human Resources and 2010) in the area of housing; however, late in the 2010 winter semester this possibility was no longer viable. I phoned Brian Danyliw, Manager of Addiction Services, asking if he had any work that he or his staff could not get to that could become a practicum. Brian advised that dollars were available for an addiction outreach program; however, a lack of time had not yet allowed them to develop it. I was excited about the opportunity to develop a program model at a time when the agency was undergoing significant changes. At the start of my practicum Addictions Services Adult Therapy Staff and former Regina Detox Centre Staff amalgamated into the new Regina Qu’Appelle Health Region Addiction Treatment Centre. I believe the timing was great for an outreach program to become part of the agency’s programs and services.
Brian advised that the main criteria for an addictions outreach program centred on individuals with addiction challenges who were also in need of housing or risk of losing their housing. I came to the practicum with this in mind and set out to develop an addiction outreach model. In the first weeks of the practicum I met with staff and researched the philosophy that the agency’s programs and services are founded on: The Transtheoretical Model (TTM) (Prochaska, Diclemente, & Norcross, 1992) and Motivational Interviewing (MI) (Miller, & Rollnick, 2002). It became clear that this Client-Centred philosophy (Rogers, 1951) would fit well in an outreach program. Given the strong addiction foundation already in place, my efforts focused on housing issues and on building a new foundation for shifting work with addictions clients into the community. I focused on developing standards related to integrated case planning, addressing complex gaps in service, cognitive disability, cultural identity, housing, safety and training. These standards were designed to provide a vehicle for TOP staff to be successful in their outreach work.

The main challenge I saw was in ensuring that the TOP model adequately bridged traditional Addiction Services expertise with a new direction. I believe the standards I have outlined in the model address factors that are critical for the program to be an asset to the community at large. I have detailed specific processes for this new direction to reduce what, I believe, may be a tendency for TOP staff to retreat to the comfort of the traditional ways they previously worked with clients. If this retreat were to happen I believe the TOP model would be seen by the community as largely ineffective with benefit only to internal functions of Addiction Services. On the flip side buy-in by TOP staff to be highly integrated in the community, I believe, provides a great opportunity for them to be leaders in capacity building within Addiction Services.
Services and the Community. Figure 1.1 below highlights the TOP standards in the model I developed which will be addressed throughout this Integrative Practicum Report.

- Figure 1.1  Transitional Outreach Program Standards: At a Glance
Direct Practice Framework

This paper follows a framework from the Faculty of Social Work at the University of Regina that is to be used in the creation of Integrative Practicum Reports. This report includes eight specific components: ideology, theory, values, ethics, relationships, strategies, skills and visions. This report considers appropriate social work literature as it relates to my practicum experience at the Regina Qu’Appelle Health Region’s Addiction Services. This framework was a good guide throughout my practicum in helping me organize information.

Ideology

This Integrative Practicum Report’s primary focus is on a recommended program model I developed titled the Transitional Outreach Program (TOP). This model, although congruent with existing Addiction Services ideology and philosophy, recommends a significant shift in how services are typically delivered in the agency. Instead of the existing practice where Addiction Services programs are typically offered in the office, the TOP model recommends that most work be done with the client in the community. To provide a better context for the TOP model, existing ideology and philosophy of the agency will first be explored to provide context.

Image of Client

The image of the client population serviced by addiction services is reflective of the diversity evident in society-at-large. Within its numerous programs the agency works with every socio-economic position, culture, age group and gender. As detailed in the introduction, Addictions Services works with clients within several distinct program areas including Youth, Adult Therapies/Day Program, Brief/Social Detox, Gambling, Drug Treatment Court, Harm Reduction Methadone, Four Directions Health Centre, Dual Diagnosis, Domestic Violence Treatment and programming at the Regina Provincial Correctional Centre. During this practicum experience, I
met with representatives from each of these programs to learn and determine varying perspectives on having an outreach program connected to Addiction Services.

After meeting with each program area, it became clear that clients who would benefit from an addictions outreach program would most likely come from Adult Therapies/Day Program, Brief/Social Detox and the Regina Provincial Correctional Centre. I was advised that the majority of clients seeking services for problem gambling do not generally have challenges related to housing. The majority of client referrals from within Addiction Services would relate to clients who have more severe chemical dependency challenges. Despite staff suggestion that gambling-based referrals will not be prevalent in the TOP, my personal social work practice experience suggests otherwise. When talking with the manager of the gambling program, I was advised that most gambling clients are higher income earners who have homes and are not at risk of losing them. This suggests to me that a percentage of individuals with gambling problems who are low income earners and who frequent video lottery terminals are not coming in to see staff at Addictions Services. In my opinion, the TOP could provide outreach services to find these people and bring addiction programming to them. These individuals often do not have housing and also struggle with chemical dependency issues. The recommended eligibility requirements outlined in the TOP model state that clients must have an addiction issue and challenges related to lack of housing or inability to maintain housing.

To provide a sense of the volume of cases and specifics around them the following data is provided. The Province of Saskatchewan’s 2007-2008 Annual Report for Saskatchewan Liquor and Gaming Authority indicates that the Province adheres to a cap of 4,000 video lottery terminals with 3,975 in operation as of March 31, 2008 (Province of Saskatchewan, 2008). Another statistic indicates that 1 in 5 gamblers in Canada show signs for being at risk of having
negative behaviours associated with gambling (Azmier, 2005). The Regina Qu’Appelle Health Region’s Addiction Services is reported to have had 5,049 clients involved with its various programs between 2008 and 2009 with 66% (3,334) male clients and 34% (1,715) female clients (Community Program Profile, 2008 – 09). Of the total clients involved, 18% were youth under age 19 and 82% were adults over 19 (Community Program Profile, 2008-09). In this same time frame there were 1,182 women age 15-40 in the Region Addiction Services Programming with 66 identifying as pregnant (Community Program Profile, 2008-09). It is argued that the TOP could provide outreach to see if there are more pregnant women who are simply not coming forward to access addiction services. It is reported that 441 clients attended inpatient addictions programs (Community Program Profile, 2008-09). In relation to detox services, 1,012 adults attended and 189 youth attended detox program in the RQHR (Community Program Profile, 2008-09). There were reportedly 531 admissions to hospital as a result of alcohol or drug abuse (360 alcohol related and 171 drug related) (Community Program Profile, 2008-09).

Beliefs about Client Worker Status

At its core, the Regina Qu’Appelle Health Region’s Addiction Services works from a client-centred perspective utilizing The Transtheoretical Model (TTM) (Prochaska et al., 1992) and Motivational Interviewing (MI) (Miller et al., 2002). In Carl Rogers’ (1951) book *Client-Centered Therapy*, he writes about “the attitude held by the counsellor towards the worth and significance of the individual” (p. 20). In reference to clients, Rogers asks, “Do we respect his capacity and his right to self-direction, or do we basically believe that his life would be best guided by us?” (Rogers, 1951, p. 20). It is clear that TTM and MI do not employ a philosophy of experts directing clients, but rather one that seeks equality in relationships between client and
worker. Throughout the practicum, it was my experience that Addiction Services Staff viewed their clients as having an inherent worth, dignity and ability to realize their life goals.

Determinants of Problems

In many ways Addiction Services employs a philosophy more than an ideology in relation to TTM and MI. In my practicum experience, specific ideologies began to emerge when looking at the continuum of programs and services offered by the agency. The Addiction Services Policy and Procedures Manual states, “The mission of Addiction Services is to reduce alcohol and other drug problems and to work in partnership to provide a continuum of holistic services to reduce the impact of addiction on individuals, families and communities (Addiction Services Policy, 2005, policy 203, p. 1). On one end of the continuum exists abstinence based ideology that is rooted in Bill Wilson’s creation of Alcoholics Anonymous (AA) (Lobdell, 2004) while on the other lies Harm Reduction ideology which holds a pragmatic view of addiction (Beirness, Jeddeman, Nortandrea, & Perron, 2008). To provide an example of the diversity of programming offered at Addiction Services, an Adult Outpatient Program is compared with The Harm Reduction Methadone Program. These programs operate on different spots on the addictions continuum and have unique beliefs about determinants of problems.

I attended an Adult Outpatient Program meeting which was based on the work of Terrance Gorski in his Passages Through Recovery: An Action Plan for Preventing Relapse (Gorski, 1989) and The Staying Sober Workbook: A Serious Solution for the Problem of Relapse (Gorski, 1992). Gorski adheres to the idea that addiction is a disease and that abstinence is the only real solution. In this view the client’s problem is believed to be that he has a disease. The Harm Reduction Methadone Clinic run by Addiction Services does not concern itself with abstinence thinking, but rather in seeking to immediately reduce the impact of addiction by
administering methadone in a controlled manner. The goal in using methadone is to eliminate client reliance on illegal street drugs. An example of an immediate benefit could be that a client is no longer drawn into prostitution to pay for drugs. The problem identified in this program is to find ways to reduce risks by safely replacing one drug for another.

The belief about determinants of client problems varies depending on the program or service being delivered. Regardless of the varying ideological positions of each Addiction Services Program, it is argued that the continuum fits well with the overall client-centered approach. It is my understanding that the expectation of Addiction Services Staff is for them to be willing and able to move across the continuum as clients require. In the example of the Harm Reduction Methadone Program, clinic staff may direct a client who wishes to explore the abstinence-based group.

*The Transitional Outreach Program*

The TOP was developed with both TTM (Prochaska et al., 1992) and MI (Miller et al., 2002) as its foundation. As such the model is also client-centered (Rogers, 1951). Building from this existing platform the TOP outlines recommendations for how to utilize Cross-Sector Partnerships (Selsky and Parker, 2005), Integrated Planning, Community Development, Disability Advocacy and Creative Housing Initiatives to meet the needs of client’s with addiction and housing challenges. It is argued that the TOP Model is essentially an addition of several community oriented strategies that provide an enhanced addiction service that is primarily delivered out of office. The TOP is intended as a vehicle to fuse addiction expertise with an additional set of competencies in which staff can demonstrate leadership in community capacity building. These various competencies are highlighted in Figure 1.1.
Theory

In my practicum experience, Addiction Services programming focused almost entirely on the individual. However, the TOP does not rule out involvement of the family with the consent of the client. To begin this chapter the theory behind existing Addiction Services programs will be outlined followed by a discussion of new directions within the TOP model.

The Transtheoretical Model

As indicated in the prior section, Addiction Services uses The Transtheoretical Model (TTM) as a major tenant in its programming (Prochaska et al., 1992). This model has primarily been utilized within the context of addictive behaviors (Prochaska et al., 1992) and three major tenants of the model are the Stages of Change, the Processes of Change, and the Levels of Change (Miller, & Heather, 1998). As the model has evolved since the late 1970s, the concept of Motivational Interviewing (MI) has become an intrinsic tool in helping people struggling with addictive behaviors to move through the various stages of TTM (Miller et al., 2002). The Stages of Change relates to the precontemplation stage, the contemplation stage, the preparation stage, the action stage and the maintenance stage (Miller et al., 1998). In the precontemplation stage “individuals are either ignorant of the nature and extent of a problem needing to be changed or unwilling to change the problematic behavior” (Miller et al., 1998, p. 4). The contemplation stage “involves thinking seriously about change and includes a decision-making evaluation of the pros and cons of both the problem behavior and the change” (Miller et al., 1998, p.4). The preparation stage “represents resolution of the decision-making task and a commitment to a change plan to be implemented in the near term” (Miller et al., 1998, p. 4). In the action stage “the change plan is implemented, active coping is initiated, and the actual behavior change is made” (Miller et al., 1998, p. 4). For individuals able to maintain the action stage for three to six
months, the maintenance stage begins, meaning “behavior change must become integrated into lifestyle” (Miller et al., 1998, p. 4).

The Processes of Change are the things that help individuals move through The Stages of Change indicated above (Miller et al., 1998). Ten processes have been identified including consciousness raising, self-reevaluation, environmental reevaluation, dramatic relief, social liberation, self liberation, counterconditioning, stimulus control, reinforcement management and helping relationships (Miller et al., 1998). TTM states that use of these processes at varying stages “are responsible for movement through the Stages of Change” (Miller et al., 1998, p. 4).

The Levels of Change takes into consideration that individuals with addictive behaviors tend to have numerous problems affecting their functioning (Miller et al., 1998). The following quote further addresses this concept: “The concept of levels of change incorporates the realization that individuals are in different stages of change with respect to problem areas” (Miller et al., 1998, p. 4). There are five levels of change in TTM which include symptom/situational, maladaptive cognitions, interpersonal conflicts, family/systems problems and interpersonal conflicts (Prochaska, & Diclemente, 1984).

Motivational Interviewing

As indicated in the previous chapter, Miller and Rollnick (2002) credit client-centered psychotherapy as developed by Carl R. Rogers and his students as a major influence behind the creation of MI. They also credit TTM from James Prochaska and Carlo Diclemente, Human Values from Milton Rokeach and Self-perception Theory from Daryl Bem as other considerable influences of MI (Miller et al., 2002). MI is used to motivate individuals with addictive behaviors to move through the stages of change as outlined in TTM (Miller et al., 2002).
Collaboration, Evocation and Autonomy are described as important aspects of MI (Miller et al., 2002). Collaboration is described in terms of the importance that there is a “partner-like relationship” as opposed to one in which a counselor takes on a position of power or authority over the client (Miller et al., 2002, p. 34). This is the idea of supporting the client and verifying one’s own agenda as a counselor (Miller et al., 2002). Evocation refers to the importance of a counselor not “imparting things (such as wisdom, insight, reality) but rather of eliciting, of finding these things within and drawing them out of a person” (Miller et al., 2002, p. 34). Autonomy refers to the client being “free to take counsel or not” and that “responsibility for change is left with the client” (Miller et al., 2002, p. 34). The following quote from Miller and Rollnick (2002) provides an important context for the remaining discussion of MI:

A meta-issue to be dealt with here is the question of where motivational interviewing is applicable and where it is not. As the name implies, its intended focus is on motivational struggles, issues of change for which a person is not clearly ready and willing, or ambivalent. Motivational interviewing itself is a skillful clinical method, a style of counseling and psychotherapy. It is not a set of techniques that one can learn in order to deal with annoying motivational problems. (p. 35)

Four primary principles of MI are Express Empathy, Develop Discrepancy, Roll with Resistance and Support Self-Efficacy (Miller et al., 2002). Express Empathy is also described as “acceptance” of the clients “feelings and perspectives without judging, criticizing, or blaming” (Miller et al., 2002, p. 37). Develop discrepancy refers to how best to “present an unpleasant reality so that the person can confront it and be changed by it” (Miller et al., 2002, p. 38). Roll with Resistance means that “Resistance that a person offers can be turned or reframed slightly to
create a new momentum toward change” (Miller et al., 2002, p. 40). Support Self-Efficacy is described as “A general goal of motivational interviewing is to enhance the client’s confidence in his or her capability to cope with obstacles and to succeed in change” (Miller et al., 2002, p. 41).

**Harm Reduction**

The Canadian Centre on Substance Abuse (CCSA) defines the principles of Harm Reduction as Pragmatism, Humane Values, Focus on Harms, Balancing Costs/Benefits and Priority of Immediate Goals (Beirness et al., 2008). Pragmatism refers to the belief that “some level of drug use in society is to be expected” (Beirness et al., 2008, p. 3). Humane Values refers to the belief that individuals with substance abuse problems deserve respect and dignity (i.e., no moral judgment is made) (Beirness et al., 2008). Focus on Harms refers to the belief that “The first priority is to reduce the risk of negative consequences of drug use to the individual and others” (Beirness et al., 2008, p. 3). Balancing Costs and Benefits refers to the need to assess for the importance of problems related to drug use and potential interventions so that resources can be aimed at specific issues (Beirness et al., 2008). Finally, Priority of Immediate Goals is described as “Achieving the most pressing and realistic goals is usually viewed as first steps towards risk-free drug use or discontinued use” (Beirness et al., 2008, p. 4). Harm Reduction programs typically manifest in Needle Exchange Programs, Supervised Injection Sites, Methadone Maintenance, Drug Substitution, Peer-administered Naloxone, Street Outreach Programs and Safer Crack pipe programs (Beirness et al., 2008). The following quote articulates how loaded the term has become:

The initial clarity and simplicity of the phrase “harm reduction” has evolved into an emotion-laden designation that has polarized groups with a common goal and is interfering with opportunities to engage high-risk populations and the
implementation of a range of substance abuse services and supports. (Beirness et al., 2008, p. 2)

Brian Danyliw, manager of Addiction Services, stated that it is important to consider how to discuss the concept of Harm Reduction. Brian advised that if he has time to explain the concept to people who are skeptical, he can generally convince them that there are useful aspects of it. He indicates that he will talk about designated driver programs or the staggering of licensed alcohol establishment’s closing times as examples of harm reduction at work. As I spoke with numerous professionals during my practicum I found that some of them were critical of Harm Reduction programs.

**Abstinence Model**

Bill Wilson is well known for his creation of Alcoholics Anonymous (AA) in 1935 which included the Twelve Steps (Lobdell, 2004). AA currently remains a significant aspect of programming at Addiction services. Lobdell (2004) is careful to point out that Wilson had the support of other “cofounders” which he reportedly was happy to acknowledge (Lobdell, 2004, p. 57). As indicated in the discussion of Harm Reduction, AA also carries strong opinions for and against largely due to its view of alcohol addiction as a disease (Schenker, 2009). Wilson tended to avoid the word “disease” because he did not want to create conflict with the medical community (Schenker, 2009). Wilson did use the terms “illness and malady” in describing alcoholism. The Disease Model is based on the view that addiction is a primary illness, a chronic illness, a progressive illness, a fatal illness, a treatable illness, an illness characterized by denial and one in which enabling behaviors allow the disease to continue (Johnson, 1980; White, & Wright, 1998).
Wilson reportedly wrote the initial AA book to “share a method that had worked for himself and 100 others” (Schenker, 2009, p. 205). While many have since taken AA to constitute the only way to recovery, Wilson is reported to have stated, ‘AA has no monopoly on recovery’ and he was well known for continuing to explore alternative approaches to recovery” (Schenker, 2009, p. 206). In this writer’s opinion, it is understandable that some individuals who recover using the Twelve Steps would in turn view it as something that should work for everyone.

Several staff at Addiction Services indicated the following resources as ones that they utilize in their work. One resource is Passages Through Recovery: An Action Plan for Preventing Relapse which is an abstinence model approach covering the recovery process, transition, stabilization, early recovery, middle recovery, late recovery and maintenance (Gorski, 1989). Gorski (1989) also includes the 12 Steps used in AA (Lobdell, 2004). Another resource called The Staying Sober Workbook: A Serious Solution for the Problem of Relapse is also a work of Terence Gorski (Gorski, 1992). Several groups are run out of the Addiction Treatment Centre in Regina that are based on this workbook.

**Solution-Focused Therapy**

Although Solution-Focused Therapy as described by Insoo Kim Berg (1994) is generally applied to work with entire families its principles are present in Addiction Services Programming. During my practicum one staff stated that she uses Miracle Questions with some of her clients (Berg, 1994). Solution-Focussed Therapy shares many of the same tenants as TTM (Prochaska et al., 1992), MI (Miller et al., 1998) and Client Centered Therapy (Rogers, 1965) in that there is a collaboration that occurs between the therapist and client. Collaborating with clients by using MI (Miller et al., 1998) to help them move through the Stages of Change in
TTM (Prochaska et al., 1992) is very similar to working with a client to develop solutions to their life challenges (Berg, 1994). Addictions Services Staff seem to seek the strengths in their clients which are definitely in line with principles of Solution-Focussed Therapy (Berg, 1994).

An Adult Therapy counsellor, at the new Addiction Treatment Centre, advised me of a book that she uses in her practice called *The Skilled Helper: A Problem Management and Opportunity Development Approach to Helping* (Egan, 2007). The book discusses Solution-Focused Therapy as being in common with the Skilled Helper Model (Egan, 2007). At its core, this model outlines three stages: help clients tell their stories, help clients set viable goals and help clients develop strategies and plans to accomplish their goals (Egan, 2007).

*Mental Health and Addiction Services*

Collaboration between the Regina Qu’Appelle Health Regions’ Mental Health and Addiction Services is very superficial in the daily provision of programs and services. In speaking with managers within both areas, it is clear that they are in support of more collaboration. The RQHR website refers to Mental Health and Addiction Services together which also seems to suggest an effort to have more collaboration between the two. It is my sense that Mental Health Services in the Health Region employs significantly more staff with university degrees while Addiction Services mainly employs people with Chemical Dependency Diplomas. Author Scott D. Miller was in Regina this past spring talking about the need for Mental Health and Addiction Services to be much more integrated (Miller, Duncan, & Hubble, 1997). My practicum experience demonstrated that there is little dialogue between front-line workers from these two areas.

Mental Health seems to have evolved from a history that is more professionally based, while Addiction Services has evolved out of peer led AA programming. Addiction Services is
becoming more professionalized as seen by increased hiring of social workers in the field generally (Van Wormer, 1995 p. 306). From a theoretical standpoint, the divide between Mental Health and Addiction Services will take time to evolve into a true partnership. “Practitioners who work at a mental health centre would do well to assess clients for a history of chemical abuse. And for practitioners of substance abuse clinics, knowledge of the major mental disorders is imperative” (Van Wormer, 1995). There is considerable literature about ways these services can be more integrated which is evidenced by Minkoff (2001).

The World Health Organizations Social Determinants of Health

I was advised by Addiction Services Staff that the Regina Qu’Appelle Health Region works to adhere to the World Health Organizations’ Social Determinants of Health (Commission on Social, 2008). The main themes are to 1) improve daily living conditions, 2) tackle the inequitable distribution of power, money and resources and 3) measure and understand the problems and assess the impact of action (Commission on Social, 2008). In my opinion, the Health Regions’ belief in the Determinants of Health recognizes that despite our overall high standard of living in Canada we have considerable work to do in all of these identified areas. Using core neighbourhoods in Regina as an example, I believe it is easy to see the need for these determinants to be addressed fully in our own community. As an example the living conditions of many residential buildings in Regina are in significant states of disrepair (i.e., mould, poor heat or mice).

The Transitional Outreach Program (TOP)

The TOP Model introduces additional theoretical perspectives relating to Cross-Sector Partnership (Selsky et al., 2005), Integrated Planning, Cognitive Disability, TOP Staff Role, Housing and Building Relationships with clients. It is argued that implementation of these
various themes within the TOP will strengthen existing addiction services and allow for the development of a more diverse service.

Cross-Sector Partnerships are said to occur across four main areas: “business-nonprofit, business-government, government-nonprofit and trisector” (Selsky et al., 2005, p. 849). In Saskatchewan this concept is referred to as Intersectoral Partnership as seen through the Human Services Integration Forum (HSIF) which works to strengthen interagency collaboration and integrate service delivery (Horsman, 2006). Connected to the HSIF are Regional Intersectoral Committee (RIC) Coordinators who work to move collaborative efforts forward. In my previous social work experience, I have worked with and seen the benefits that can come from Cross-Sector Partnerships (Selsky et al., 2005). In developing the TOP model this approach was included and it is argued that establishment of these partnerships will make the outreach program much more effective in its efforts to serve clients with addiction and housing challenges. I met with Danielle Pass who is the current RIC Coordinator in the RQHR and established a connection point for the TOP. Danielle has agreed to meet with TOP staff to discuss gaps in service that they are seeing that are not met by existing human services systems mandates. Danielle advised that she will take these identified gaps to the HSIF where Intersectoral discussions can focus on what could be done about the issues raised.

I observed very dedicated staff at Addiction Services who had well established connection with other professionals in the community. The main difference with TOP is that there is an expectation that the outreach staff meet these professionals, in person, in the community and work to establish relationships within other areas of the community that they are not familiar. It is argued that comprehensive integrated planning will make the work of TOP staff easier. If TOP staff can lead by engaging a clients’ support network in a meaningful
discussion, it is argued that they will be able to mobilize other community partners to participate with them in the development and follow through of effective client plans.

The TOP Model pays specific attention to the area of cognitive disability. In my professional experience, this topic area is often misunderstood by human service professionals and the community-at-large. The TOP outlines how individuals with cognitive disabilities often have expectations placed on them that they are not able to meet (Malbin, 2008 46). Malbin (2002) refers to an individual’s developmental age as being far more informative than chronological age. In my experience I have seen many individuals who did not have developmentally appropriate plans in place which required advocacy to address. Though integrated planning, I have been able to convince other partners that these clients needed plans based on their developmental age. I have seen some professionals expecting these clients be able to manage a monthly budget by paying rent, utilities and groceries because chronologically they are adults. The act of considering developmental age is simple; however, in my experience, professionals miss this too often.

Another theory that is part of the TOP model relates to the role outreach staff should play in it. In developing this model, it would have been easy to define the outreach staff’s role specifically in relation to their work with clients. I strongly believe that the success of the TOP Model depends on a percentage of the staff’s time being dedicated to capacity building in the community that is not specific to any given client. It is recommended that TOP staff participate on community networks and committees so that they are a part of the larger energy that is working to problem solve around housing, addiction and other social welfare issues in the community. I believe that energy focussed on community capacity building ultimately improves future outcomes for work with individual clients.
The TOP recommends using the Toronto Streets to Homes Model as one possible guide to addressing housing issues in Regina (Streets to Homes, 2009). This model clearly discourages treatment first or transitional housing first methods in favour of housing first (Streets to Homes, 2009). The basic premise of Streets to Homes is that everyone deserves a home regardless of the life challenges they are experiencing (Streets to Homes, 2009). A second major theme of the Model that the TOP supports relates to efforts made to engage local landlords and property management companies (Streets to Homes Model, 2009). It is believed that by working with those that supply housing, there will be opportunities to create unique and effective solutions for the housing needs of clients. In my experience, finding housing for clients with addiction issues can be very difficult. Typical searches in local newspapers often do not lead to the securing of homes for clients. During my practicum I met with individual landlords as well as property management companies to begin building relationships between them and Addiction Services. In the cases I worked with during my practicum, it was my relationship with the landlords that made finding and maintaining housing for clients easier.

It is argued that the building of strong relationships in the community will be critical for the TOP to be effective in providing quality outreach services. TOP staff may be motivated to work in the community; however, a specific set of skills is required to effectively communicate with others who have very different positions on what should be done. The TOP Model recommends Paul Born’s book Community Conversations: Mobilizing the Ideas, Skills, and Passion of Community Organizations, Governments, Business and People (Born, 2008a) and a second book edited by Born entitled Creating Vibrant Communities: How Individuals and Organizations from Diverse Sectors of Society are Coming Together to Reduce Poverty in Canada (Born, 2008b). Born (2008a) talks about needing to move away from right and wrong
thinking and instead seek common ground among differing perspectives. There is also excellent facilitator training from the Tamarack Institute for Community Engagement (Tamarack Institute, 2010) that I have recommended would be helpful to the TOP staff. These particular approaches are highlighted in the TOP, in part, to make the point that the successful community outreach depends on much more than simply meeting with clients in the community and networking with other agencies. In my experience, a qualified facilitator can keep various partners focused on common tasks and even convince estranged parties that something can be gained through their dialogue.
Values

The first two chapters in this report considered the wide range of programs and services offered by RQHR’s Addiction services in relation to ideology and theory. Although the TOP model has the potential to be accessed by any of these program areas, the majority of referrals are likely to come from within the Brief/Social Detox and Adult Therapy programming run out of the new Addiction Treatment Centre. As the TOP will be housed in this same centre, the remainder of this report will focus on the TOP in relation to these two program areas.

My Value Base and Social Location

I was raised in a family where my mother was a teacher and my father a social worker. The basic beliefs I was taught as a child related to the value of human services work, meaningful connections with family/friends and having varied interests outside of one’s profession. I am open with and accepting of the clients I serve. I believe they deserve compassion and sustained professional support as they strive to make more informed choices in their lives.

From September 2009 to September 2010, I was on an education leave from Ranch Ehrlo Society where I work as a consultant with the Saskatchewan Cognitive Disability Strategy (Saskatchewan Cognitive Disability, 2010). My career to date has involved work in disability-focused community based organizations such as the Regina Autism Resource Centre, Chip and Dale Housing, Help Homes of Regina and the Regina Residential Respite Centre. At the point of graduation with my Bachelor of Social Work in 1997, I began working for the Government of Saskatchewan in Child Welfare and Youth Justice capacities. My work has exposed me to a diverse range of programs and services that have taught me the value of comprehensive partnerships in the community to assist clients.
Value Base of Client Constituencies

The TOP will primarily work with clients who have more severe addiction issues. Although there may be some referrals that include gambling addiction issues, the majority of referrals will likely involve chemical dependency. In my practicum experience at Addiction Services, the clients I worked with directly and witnessed peripherally, that would be candidates for the TOP program, had health issues related to chemical dependency and were considerably isolated from positive influences as a result of their addictions. These clients were either unemployed or struggling to remain employed. As I was developing the TOP, I had the opportunity to work with some clients which helped to inform my program development considerations. These clients had varying challenges; however, they all had addiction and housing issues. I have found that people with addictions are often described as manipulative and self focused. On the surface it is easy to see the value base of these clients simply in these terms. Although as a professional it is critical to avoid the pitfalls of clients’ attempts to manipulate, it is far more useful to continue to remind clients of alternative views that could become part of their value base.

Potential Value Clashes between Self and Client

Within the TOP, the main focus is on addressing client’s addiction issues and securing and maintaining housing. A potential value clash could occur if outreach staff were to make assumptions about what a client needs to be successful. There is the potential for a human services professional to assume clients want the same things they want (i.e., stable employment or a nice home). A more effective approach is to ensure clients dreams and goals are heard and supported. A client’s view of success could be to stop consuming drugs but continue to drink alcohol. Another client may never be employed and be happy residing in a dorm at the Salvation
Army. In my practicum experience, I had connection with clients who had very different values than mine; however, clashes were avoided by my choice to present alternative ways at looking at issues without suggesting my values as superior to theirs. Instead of clashing on values, I simply make statements that suggest alternative view points and then leave the given issue alone. This has allowed me to express alternative values without engaging in conflict.

*Client and Society*

Saskatchewan has a strong economy that provides employment and business opportunities for those with required education and skills; however, I believe a message is continually sent that there are great jobs for anyone willing to work in the province. When a client with severe addiction and housing challenges meets this mindset, it has been my experience, that they are often viewed as lazy. This is a difficult issue to resolve considering that economic policy in this province is driven by Neo-Conservative/Neo-Liberal ideologies that tend not to support increases in spending on social welfare programming (Rice and Prince, 2000).

Many of the jobs available in Saskatchewan pay at minimum wage and are very difficult to make a living on. The following quote outlines a view that I believe offers much that could alter society’s perception of people with addiction issues (O’Hare, Newcombe, Matthews, Buning and Druker, 1992):

> The adverse consequences of this relationship between drug user and society is not one-directional. For as long as our society comprises individuals who discriminate against drug addicts, who stigmatize them, addicts will continue to be an ever-increasing body of people who exists outside society and their lack of ties to the social fabric increases the sense of alienation of those who use drugs, increases the likelihood that they will act in an anti-social manner to find their
drug use and decreases the likelihood that they will come forward for treatment or education, all of which contribute to a situation wherein drug use is a greater social problem than it need be and the adverse effects that it has on us as a society continue to increase. (p. 200)

The argument is made that in order to move away from this direction, “It is necessary to adopt a progressive policy towards drug users - a policy that is assimilative, rather than coercive that seeks to integrate drug users into society rather than marginalize them” (O’Hare et al., 1992, p. 200).

**Client and Agency**

For the most part, programming at Addiction Services is voluntary for clients; however, choosing not to participate has varying consequences. In my experience, clients of Addiction Services come to the agency with unique motivations. Some are there because they themselves chose to participate, some come because their employment is at risk if they do not, their marriages are in crisis and others come in to the Brief Detox as a result of public intoxication. For those clients who come with a genuine desire to seek help, I believe, the potential for value clashes is decreased. However, for those clients who are not as motivated to attend, there may be more likelihood for clashes in values. Some clients attend as a result of a driving while impaired charge and may only be there so they can get their driving privileges back. I would argue that a client who does not believe they have an addiction issue is much more likely to have a clash of values with Addiction Services despite the agencies client-centred approach (Rogers, 1951).

Addiction Services’ programs and services are voluntary but external realities directing clients to attend likely makes them feel obligated to engage. For a client who wants their driver’s license back, the voluntary choice to choose to say “no” to Addictions Services
programming denies the clients’ desire to attain his goal. As it is generally an outside agency, family or community that applies the consequences to client’s who do not complete addictions programming, it is my opinion that Addiction Services Staff can benefit from this reality by avoiding an adversarial position with the client. For example, if the court orders a client must attend Addiction Services, it is the client’s probation worker that likely bears the risk of clashing with the client because they submit the breech to court.

Agency and Worker

It has been my experience that some addiction professionals verbalize that they believe there are numerous paths for dealing with addiction; however, their actions suggest they really adhere to a specific ideology. During my practicum I observed that some professionals believe in abstinence-based methods as the only correct way to deal with addiction. Viewing addiction as a disease has been effective for a percentage of people; however, it is also my opinion that ruling out harm reduction based methods is really not client centred (Rogers, 1951). In my observation, some professionals’ beliefs are almost evangelical in nature when it comes to programming like Alcoholic Anonymous (AA) (Lobdell, 2004). In my experience, some professionals with their own history of addiction struggles have a belief that if AA worked for them it will also work for their clients.

I observed a consistent message from management within Addiction Services that was very accepting of abstinence based approaches, but was also very clear that these exist on a continuum that also includes Harm Reduction methods (Beirness et al., 2008). The message I received during my practicum was that clients should be connected with the most appropriate intervention for them. The agency’s position allows for a wide range of methods to be used to meet client needs. Despite this openness, I heard some very strong opinions that indicated that
the addiction field is going in the wrong direction by opening the door to other methods that do not expect abstinence.

To further complicate this issue, staff were advised that the Saskatchewan Ministry of Health is working on changing The Saskatchewan Model of Recovery Services to no longer allow any reference to addiction as a disease (Meeting The Challenges, 2001). The current version of The Saskatchewan Model of Recovery Services states “Chemical dependency is a disease” (Meeting The Challenges, 2001 p.4). In my opinion, news of this is not likely to encourage professionals with a belief in addiction as a disease to become more open to the entire addiction continuum. During my practicum, I spoke with an addiction consultant from the Ministry of Health who confirmed that this is the intended direction for the Saskatchewan Model of Recovery. In my opinion, the Saskatchewan Ministry of Health’s proposed new direction is likely to increase the divide between those who believe strongly in the abstinence model and other professionals who are open to a diverse spectrum of approaches.

The dynamics discussed above are an inevitable reality in an evolving addictions field. Van Wormer (1995) indicates that the addictions field has typically been dominated by recovering individuals. If reference to disease is no longer permitted, some staff advised that they will continue to use this language with clients ‘once their door is shut’. My experience suggests that support for the disease model is alive and well and I would assume that increasingly this method will exist outside of RQHR’s Addiction Services and retain a significant place on the addictions continuum. The major hurdle for the addiction field to overcome relates to finding the balance that acknowledges a place for traditions like AA while accepting the need for the field’s continued professionalization. The following is taken from the RQHR’s Addiction Services Policy and Procedures Manual “The mission of Addiction Services
is to reduce alcohol and other drug problems and to work in partnership to provide a continuum of holistic services to reduce the impact of addictions on individuals, families and communities” (Addiction Services Policy, p. 1 of 1, policy 203). I have found that abstinence based ideology is much more strongly stated in community-based addictions organizations, while within Addiction Services I found this message to be muted, because of expectations from management and policy to provide services on a continuum.

**Impacts of Values**

*Contracting/Goal Setting* - Transitional Outreach Program Staff, who are accustomed to traditional ways of working within the agency, may struggle initially in contracting and setting goals with clients, because it is argued that the scope of outreach work is much broader and requires additional skills. Staff will likely have a tendency to fall back on working in the office with clients. My experience in this practicum has demonstrated how much richer a case plan can be for an addictions client when you know more about their lives. The simple act of visiting a client’s home can positively inform a case plan. Through client consent, face-to-face contact with other professionals has the potential to provide better outcomes for the client by considering the holistic needs of a client are being addressed. The TOP model recommends a much broader view of what it means to provide services. Traditional Addiction Services assessments, counselling and other programming will remain important; however, concern surrounding the housing needs and larger community context represents a shift in values about how the agency could function in the future.

*Success of Interventions* - I believe that TOP staff through their outreach work will have the opportunity to better assist clients in reaching their goals. An example of success may mean staying in one home for more than a month when typically they have been evicted within a week.
For others, success can mean long term sobriety. I am confident TOP Staff will recognize big and small successes. From an existing Addiction Services perspective, success will continue to be based on assisting clients in moving through the Stages of Change outlined in TTM (Prochaska et al., 1992) through use of MI (Miller et al., 2002). It is argued that the TOP Model opens numerous opportunities for success in relation to Cross-Sector Partnerships (Selsky, 2005), integrated planning, cognitive disability and housing. It is my aim that TOP staff will immerse themselves in these new directions so that they will see success through community capacity building and the resolving of gaps in service.
Ethics

Tim South, an MSW graduate from the University of Regina, did a practicum at what was then called Alcohol and Drug Services during the winter semester of 2002. Tim’s Integrative Practicum Report (South, 2003) talks about how, at that time, there was only one Social Worker employed in the agency. In my practicum experience, there are still few social workers in the organization. Brian Danyliw, manager of Addiction Services for RQHR, states that he is the only employee with a Master of Social Work degree. I am aware of two staff with Bachelor of Social Work degrees in the agency. It is my understanding that Chemical Dependency Diplomas are the credentials held by the majority of staff within Addiction Services.

In the previous chapter, I discussed how the TOP model requires a broader view of the community in its delivery of addiction services. Further hiring of social workers could increase the agency’s capacity to provide services in the community. In other human services agencies like the Saskatchewan Ministry of Social Services, the majority of staff have social work degrees. I want to be clear that staff with chemical dependency diplomas bring tremendous skill and expertise to Addiction Services; however, it was interesting working in an agency where my social work profession was so underrepresented.

I worked directly with a limited number of clients during my practicum and I did not experience any ethical dilemmas within these cases. As a registered Social Worker through the Saskatchewan Association of Social Workers, I am obligated and guided by the Canadian Association of Social Workers’ Code of Ethics (2005). Although I am very familiar with the Code, I found myself considering its implications more during this practicum given the small social work presence in the agency. In working with clients in this practicum, I adhered to the six core values of the Code. I also believe the TOP Model is congruent with the Code as well.
Although this may change over time, having a social work degree is not a requirement for the TOP Program staff. In my practicum experience Addictions Services Staff are highly ethical in their practice with clients. There is considerable congruence between the ethical practice of staff at the Agency and the Canadian Association of Social Workers Code of Ethics; however, for example when it comes to the Code’s value “pursuit of social justice” (CASW, 2005), this may not be a concern for staff with Chemical Dependency Diplomas. This may pose a challenge in getting TOP staff to really buy into the need for integrated planning and Cross-Sector Partnerships (Selsky et al., 2005) to address complex social challenges. It may be difficult for staff with Chemical Dependency Diplomas to explore social justice issues to the same degree a Social Worker would. The TOP Model, although addictions focussed, considers implications beyond this one issue (i.e., housing and cognitive disability).

Addiction Services is guided by the Health Information Protection Act (HIPA) which has strict standards around confidentiality (Government of Saskatchewan, 2010). In my previous social work practice, I have seen how HIPA can make it more difficult to engage in comprehensive Cross-Sector Partnerships (Selsky et al., 2005). For example, my experience with the Saskatchewan Cognitive Disability Strategy (Saskatchewan Cognitive Disability, 2010) has highlighted the ethical considerations present in trying to balance one human service systems internal efforts to maintain confidentiality with the benefits the client may gain by several systems integrating and sharing information. Obviously, individual consent forms can be signed by each system for specific reasons; however, the problem arises when a client requires more open lines of communication to resolve complex challenges. The TOP will struggle with this same issue which centres on a debate about whether or not it is ethical to ask clients to consider signing a more generic consent form that allows numerous agencies to consult. My experience
has shown me that the ability to communicate with other systems quickly and easily can make interventions more effective. One challenge with a broad consent is that there is a risk that information not relevant to the issues at hand might be shared. The TOP will need to find some balance regarding limited and specific consent (i.e., a client consents to Addiction Services staff releasing their addiction treatment progress to another agency) and broader consent that allows for more open and detailed discussion about what a client’s true needs are. Another consideration relates to the degree clients understand the consent forms they are signing. If clients have cognitive challenges, staff will require significant disability experience to ensure consent is understood.
**Relationships**

Given the limited social work presence within Addiction Services, my commentary relates more to the development of Social Work practices to build future relationships in the TOP. The lack of Social Work presence is likely one of the reasons programs and services are internal and not out in the community. Relationships and how they are viewed are critical to the success of the recommended TOP Model. Through exploring existing Addiction Services programming, I witnessed a structure of working with clients in which contact with external professionals centred on referrals based on consent. Some phone discussions took place with these agencies; however, I did not see evidence of face-to-face comprehensive relationship building.

**Worker and Client**

Addiction Services counsellors are skilled at engaging new clients and maintaining strong relationships through the course of their involvement. Utilization of TTM (Prochaska et al., 1992) and MI (Miller et al., 2002) to move clients through stages allows staff to meet the client “where they are at”. Some staff advised that they are careful not to push clients into a new stage, but wait until they are ready to move forward. As a result, worker-client relationships are generally positive in nature. In the TOP model, an establishment of trust with the client is important to gain consent to do integrated planning with a wide range of potential partners. It is critical to be realistic in the goals so that clients feel success. I was able to build trusting relationships with the clients that I worked with throughout my practicum. I believe that the TOP will allow staff to continue their excellent work with clients in the community. I believe that many of the clients that will be served by the TOP find it challenging to navigate all of the
various systems that connect them. I would like to see TOP staff become a trusted support that clients can count on to assist them in maximizing the opportunities available to them.

**Worker and Agency**

I began my practicum at a major time of change within the agency. The majority of Addiction Services programming was located at 2110 Hamilton Street in Regina until the end of April 2010. In May 2010 the Addiction Treatment Centre opened at 1640 Victoria Avenue in Regina. The new facility incorporated some of the RQHR staff formerly at the old office with staff from the disbanded Regina Detox Centre run by Regina Recovery Homes (Regina Recovery Homes, 2010). The amalgamation of existing RQHR staff with staff from Regina Detox created a new environment to forge new relationships. I believe it was a good time to develop the TOP Model because the organization was already in the midst of change. The new directions recommended in the TOP may be easier for staff to incorporate given the overall large scale changes.

In recent years Addiction Services replaced the former agency, named Drug and Alcohol Services. Prior, it was known as the Saskatchewan Alcohol and Drug Abuse Commission. A gradual shift has been in the works for some time. On the Regina Qu’Appelle Health Region’s website Mental Health Services and Addiction Services appear together, suggesting that they are connected. In my practice experience, Mental Health and Addiction services remain much segmented and work very little together. Addiction staff talked about rarely connecting with Mental Health, despite years of working in the same building one floor apart.

**Worker/Worker**

Addiction Services staff are very respectful of each other despite the varying opinions they hold on the direction the agency is going. There is a great collective sense of humour that exists within the agency which I believe creates a healthy work environment. I found staff to be
up front about their views on the changes in the organization while remaining professional. Within the TOP, staff may initially find it difficult to find consensus on how to do outreach. The combination of one staff hired with a Bachelor of Social Work Degree, a second staff with a Chemical Dependency Diploma with a strong belief in the AA model (Lobdell, 2004) and a third Chemical Dependency Diploma staff who is very open minded about the entire addictions continuum has the potential to create a dynamic working environment.

Upon completion of my practicum, I noticed that despite a few months together pre-existing RQHR staff and former Regina Recovery Home Detox Staff rarely interacted. Although friendly to each other, it will take time to establish a common vision and for both to see each other as one. There may have been misconceptions about each other established over years that realistically cannot be resolved overnight. Although the transition may be difficult, it will benefit the long-term health of Addiction Services.

Worker and Profession

Addiction Services Staff understand that their work is governed by the Saskatchewan Ministry of Health. Despite this, I observed no contact between the Ministry and front-line staff. As indicated the social work profession does not have a strong presence in the agency and as such, most staff work within the chemical dependency profession. Social workers and professionals from other disciplines such as psychology will increasingly be hired within Addiction Services which will improve professional diversity.

The RQHR’s choice to hire Brian Danyliw as Manager of Addiction services was a very good one. In my experience Brian is a warm, compassionate and open leader who brings out the best in his staff. I believe that Brian’s possession of a MSW equips him well for gradually moving the agency towards the hiring of more social workers. I am aware of one Addictions
Services Staff who has a Chemical Dependency Diploma and is going back to school to get her Bachelor of Social Work Degree. Van Wormer (1995) states “Non-degreed alcoholism counsellors should be encouraged to pursue social work training” (p. 321). Van Wormer (1995) also indicates:

With a generalist’s understanding of the biological, psychological, and social components in human behaviour and a specialist knowledge of clinical interventions such as family systems therapy, social workers bring flexibility to the addiction field that is consistent with their holistic approach. (p. 321)

Brian is also a supporter of increased collaboration between Addiction and Mental Health Services. Throughout my practicum I observed Brian’s willingness to bridge communication with Mental Health. Brian advised that the new outreach staff will need to work with Mental Health Services to establish lines of service in connection to their outreach programming. Brian was open about the need not to form rigid boundaries between what constitutes Mental Health and what constitutes Addiction Services but to move in a collaborative direction realizing clients can be served by both programs.

Worker and Community

Of all the various relationships involved in the functioning of Addiction Services, the worker community connection is currently the most problematic. As indicated, the leadership at the agency understands the value in placing services in the community; however, it will take considerable effort and time to change the agency culture of working in the office largely secluded from the outside world. Community involvement would actually reduce their workload as far as their traditional work around assessments, Detox and day programming. Over time,
services offered by the agency could become more preventative in nature by being in the community.

With the recommended TOP model, worker connection to the community will represent a significant portion of the work. It is my hope that through the TOP staff engaging in work in the community, they will be an example that will encourage other Addiction Services employees to try it. The TOP Model indicates that staff should be connecting with various committees and networks in the community. It will take explicit direction from the leadership within Addiction Services to get the agency into the community. This will be the case for the TOP, because its design leaves no other option but to work in the community.

*Client and Community*

If we as professionals do not know our communities well and do not connect with them, we are unable to provide our clients with a road map for how they could best fit into the community. If professionals are motivated to form partnerships in the community that can increase supports to our clients, we can begin to form foundations for them to stand on once our involvement inevitably ends. By helping clients see the healthy possibilities in the community, they are given choices they may not have known about. This perspective may allow clients to see that unhealthy aspects of the community do not have to be their reality. The TOP model encourages clients to consent to inclusion of additional supports in the community. Forging relationships with other human services partners also can address gaps in service where clients’ needs are not being addressed.

*Client and Society*

Clients with addiction issues are not well understood by society. There are often myths about them that I believe inhibit their opportunities for success. There are stereotypes based on
racism that drive myths about certain cultural demographic groups being blamed for the majority of addiction related problems. In my opinion, the socio-economic status of clients has a great effect on how society perceives them. People who have money are generally less stigmatized than people who are intoxicated in public places on a regular basis. Our society is filled with marketing for alcohol, gambling and other products that we reportedly need. Based on my experience working with clients who have very severe addiction issues, I can well imagine that they might view society as a confusing place.
Strategies

Individual and group counselling are the primary strategies used within the new RQHR Addictions Treatment Centre. Staff base their interventions on TTM (Prochaska et al., 1992) and MI (Miller et al., 2002) as the foundation for their work; however, staff advised that they also draw upon other approaches across the addiction continuum in their attempts to meet individual client needs. The diversity in the client base within Addiction Services requires staff to draw from numerous strategies. The introduction of outreach programming within the agency signals a direction that is healthy. Although existing programs and services offered by the agency help move people forward, more could be done through agency engagement in the community.

Individual Counselling

Adult Therapy Counsellors at the Addiction Treatment Centre provide initial intake services and where appropriate follow-up counselling. These counsellors determine the extent of a client’s addiction issues. Staff advised that they look to determine if a client is chemically dependent or if they are not dependent but abusing drugs, alcohol or gambling. For example, many college students abuse alcohol during their schooling (Neighbors, Walters, Lee, Vader, Vehige, Szigethy & Dejong, 2007) but become healthy social drinkers for the remainder of their adult lives. This reality is obviously different for other college students who are chemically dependent on alcohol or drugs. Counsellor’s determination of the nature of challenges dictates how they will work with the client and for how long.

Due to a high number of clients frequenting the agency, Adult Therapy Counsellors normally see their clients approximately once a month. Although many clients would benefit from more frequent contact, time does not allow for it. Clients often fail to appear for scheduled appointments which means that the time between actual counselling sessions can be two or more
months before subsequent appointments can be set. The nature of addictions clients makes it likely that they will not follow through with many of their scheduled appointments. During my practicum experience, reminding clients of upcoming appointments by phone or email was not a common practice among the counsellors. The existing structure of counselling at the agency seems more in line with the philosophy of A.A. (Lobdell, 2004) than Harm Reduction (Beirness et al, 2008). It is my hope that outreach programming within the agency will begin to change this mindset, and staff will visit clients’ homes and encourage them to participate in programming.

Staff at RQHR’s Addiction Services stated that they do not do family interventions to address client addiction issues. Some staff advised that the ability to maintain relationships with their clients would be compromised by assisting in a family intervention. Other staff argued that TTM (Prochaska et al., 1992) is not as effective if clients are pushed towards a new stage before they are ready. Outside of discussing family issues in the confines of individual counselling, I am not aware of any addiction programming that involves family at the agency.

Some counsellors talked about the difficulty that can arise between counsellors based on individual ideologies. For example a client may initially be seen by an intake counsellor who is strongly influenced by the A.A. Model. This client may then begin seeing a follow-up counsellor who utilizes numerous strategies for addressing addiction issues. Some counsellors indicated that clients can become confused by these differing messages. I noticed that staff who are in the last 10 years of their careers were, for the most part, not happy with the direction Addiction Services is going. Younger staff seemed more open to further schooling in social work, human justice or psychology as they sensed that additional education will likely be needed in the future. Earlier in this report the relationship between the RQHR’s Mental Health Services and Addiction Services was briefly discussed and during my practicum I saw how Mental Health
staff had backgrounds in areas like psychology, social work, nursing and psychiatry while Addiction Services staff are employed mainly with Chemical Dependency diplomas. I have heard some professionals state that Addiction Services counsellors do not have the same counselling expertise as social work or psychology trained professionals. I believe strongly that Addiction Services counsellors are skilled individuals that offer a quality service to their clients.

*Group Counselling*

Group counselling is a major component of programming at Addiction Services which is seen through the agency’s offering of various evening groups and group day programming. The Day Program offers non-residential addictions treatment over the course of several weeks. Through assessment, clients are referred to the Day Program. This program differs from typical 28 day inpatient addictions treatment. The Day Program runs during business hours from Monday to Friday. There are additional groups that run in the evenings at the agency and serve a diverse range of clients. These groups were based on the work of Terrance Gorski (1989 & 1992) who believes in the disease model with abstinence as the way to recovery. Previously in this report, there has been discussion about the addiction continuum with Addiction Services; however, at RQHR’s Addiction Treatment Centre group programming does not utilize the entire continuum in any significant way. With the exception of RQHR’s Addiction Services Harm Reduction Methadone Program that has reportedly run harm reduction based groups, the abstinence model is the foundation of group work within the agency.

The Addiction Services staff who facilitated the various groups within the agency were client centred. The groups seemed to be a refuge for some client’s and for the next client an opportunity to be heard and learn from others’ experience. I had the privilege to sit in with one group and saw people in varying Stages of Change (Prochaska et al., 1992). Some reported that
they had maintained sobriety for a period of time, some talked about their recent use and others
denied their use despite being visibly intoxicated. Skilled staff challenged each individual to
consider next steps in a respectful manner. Despite the groups within the agency primarily being
run on the abstinence model, I am convinced that these groups meet a definite need for many
clients.

*Transitional Outreach Program*

The TOP recommends that many existing services within the agency can be taken into
the community and enhanced. It is argued that individual counselling can be done in the
community right in a client’s home. The TOP strongly suggests that existing assessments and
processes be conducted in the community if this is a better fit for a given client. The key is
moving away from a more rigid view of where services can be conducted and meeting people
where they actually live their daily lives. Being open to client’s needs in the community is not
only good for them; it also provides a healthier work place for staff.

The TOP introduces new directions for the outreach staff that relate to Integrated
Planning, Addressing Complex Gaps in Service, Cognitive Disability, and Housing. In my
practicum experience, Addiction Services does not engage in Integrated Planning with other
agencies, but rather is a broker of services for clients. I did not see any RQHR Addiction
Treatment Centre Staff leave the office to meet with other agencies involved with their client. I
did see referrals being made by fax and follow-up phone conversations with the agencies. The
TOP argues that client needs can be better met when, through their consent, staff from involved
agencies meet to consider the overall needs of their common client.

The TOP argues that through integrated planning, complex gaps in service are often
identified that often cannot be resolved without additional intervention. The TOP recommends
use of Cross-Sector Partnerships (Selsky et al., 2005) to resolve these complex problems. It is argued that as TOP staff begin to see trends with numerous clients that relate, for example, to a lack of appropriate housing that this can be addressed through Cross-Sector Partnerships. In Saskatchewan, the Human Services Integration Forum exists with a group of intersectoral partners working to address such concerns (Horsman, 2006). By TOP staff gaining the skills to work in these new ways, it is argued that they will be able to advocate for clients who have cognitive disabilities and who as a result are not receiving the services they are entitled to because the disability issues are not well understood. The TOP recommends that staff be trained in this area and learn how to advocate for clients, while maintaining relationships with other agencies. Another major theme within the TOP is housing. Many individuals with addiction issues struggle to maintain or find housing. The TOP requires staff to combine their addiction expertise with a new set of skills that focus on addressing housing issues. To do this effectively, TOP argues that staff will need to become connected to others in the community who are interested in housing issues. It is further argued that staff will need to build positive relationship with local property management companies and landlords to find solutions (Streets to Homes, 2009).
Skills

Within existing RQHR programming, staff are required to be adept in their working knowledge of TTM (Prochaska et al., 1992) and MI (Miller et al., 2002). Addiction Services Staff demonstrated a high skill level in their work with clients. As indicated, the TOP requires staff to become familiar with several new directions that are community based in nature. For the TOP recommendations to work, it is argued that formal training in the area of Integrated Planning, Intersectoral Collaboration, Cognitive Disability, and Housing are critical. During my practicum I became aware of the limited resources available for staff training. One staff advised that there is no internal Addiction Services core training for new staff. Reportedly staff are trained by other colleagues.

In talking about the TOP with staff, many summed up my work as a melding of current Addiction Services programming with community networking component. In the last five years of my career, I have engaged in intersectoral work to address complex gaps in service and it is a steep learning curve. I was advised that training would be limited for TOP staff. This is a concern. On the surface it may seem easy to attend meetings and build relationships in the community. The issues faced by the addictions population are complex and solutions to these challenges are likely to involve partners with different opinions on how to solve problems. The work of Paul Born (2008) provides an excellent example of the nuance required to be an effective facilitator and leader. My concern is that the TOP staff will simply continue on with typical addiction programming with a slightly more visible presence in the community. I have agreed to return to Addiction service in the fall of 2010 to work with the TOP staff so that they have the opportunity to gain a better understanding about what the program model recommendations are suggesting. Unfortunately I was not able to work directly with the TOP
staff as they were still required to work in their previous roles in the agency. It is my understanding that the staff will begin their outreach roles in the fall of 2010.

I had the opportunity to work with a small number of clients which allowed me to assess the TOP model recommendations I was working on. I believe this role requires a comprehensive understanding of people who have cognitive disabilities as many people with cognitive disabilities struggle with addiction issues (Malbin, 2002; Ylvisaker, & Feeney, 1998). Understanding this disability requires much more than a basic understanding of what it is. Staff will need to know and understand how to take this knowledge and apply it, which is not as easy as it sounds. Staff will need to be able to maintain relationships with other professionals even though at times advocating for client needs requires talking to their manager to resolve roadblocks.

The TOP Model defines specific Core Competencies that staff should have in order to do outreach work well in the community. I recommended that staff have significant human service experience as well as knowledge of the mandates of other service delivery systems in the community. Staff should have a well developed network of human services contacts and be able to collaborate with others despite differing views and competing mandates. Well developed presentation and group facilitation skills are required as well.
I would like to strengthen my social work practice in the area of community development in relation to housing. I see myself working with other stakeholders to determine best practice options that are likely to work in Saskatchewan. This province has a vibrant economy; however, I believe our cities, including Regina, can do a much better job of addressing the needs of vulnerable people. There are many myths about people on social assistance, people who have chemical dependency challenges, and people with disabilities. There is also considerable racism in our communities. I plan to be a voice that counters these myths and the racism with facts. I look forward to engaging community partners with different opinions about what should be done to address housing issues.

Born (2008a) discusses how it is easier to discuss challenges with people who agree with your position, but that it is more productive to work with those that have a differing view. Born (2008a) indicates that often there are common causes among opposing positions and that it is here that significant progress can be made. For example, bring landlords who have had their properties damaged by tenants with serious social challenges together with advocates for harsher penalties for landlords that do not take care of properties can help quell myths and allow both sides to learn and find common ground. The likely common factor is that both parties are seeking successful tenants.

Regina is a city that is still small enough to address inner city challenges more readily than much larger cities. Urban sprawl is increasingly becoming an issue in Regina, while there is also evidence of higher density developments in existing neighbourhoods which I believe is a much better route for healthy communities. Regina’s Cathedral area is a good example of a neighbourhood that has diverse businesses, socio-economic realities and types of housing. In my
future role as social worker, I plan to join others who are working to strengthen Regina’s core neighbourhoods. By focusing on the broader umbrella of housing, all of the other social challenges familiar to the social work profession can also be addressed. I am a firm believer that stable housing is the primary building block (Lutke and Antrobus, 2004) to addressing all the other challenges in a person’s life including cognitive disability. The Housing First strategies used in Toronto (Streets to Homes, 2009) also adheres to this philosophy.

People with cognitive disabilities often have significant struggles related to accessing and maintaining appropriate housing. My future work in this profession is likely to remain engaged in highlighting and working to address the numerous gaps in services that exist for the cognitively disabled. I plan to advocate for this population to have access to individualized programs and services that are congruent with their developmental ability (Malbin, 2008). One of the ways that I plan to advocate for this group is by providing best practice information about cognitive disability through training to families, human services agencies and the community-at-large.

The knowledge I have gained through my practicum at RQHR’s Addiction services will assist in my future goals in the area of housing. Addiction is, as argued in this report, is a significant factor for many clients’ housing circumstances. My social work career to date has exposed me to many varying roles within a number of human services agencies, programs and services. My recent practicum has provided another opportunity to network in the addictions area. I look forward to engaging with the community from an intersectoral approach where I believe more is gained by collaboration then individual systems only focusing on their own mandates.
I look forward to becoming more involved with the Saskatchewan Association of Social Workers (SASW) in the coming years. I believe in registration and I would like to work to convince professionals with social work degrees to register. I also believe that the SASW is not only important for us as social workers but also as an agency that can help portray the scope of the profession to the community-at-large.

My vision for the profession is for it to continue to become better understood by society. Social work stereotypes like we are all “bleeding hearts” or that we all have extreme “left leaning ideologies” are alive and well. Social workers generally support a role for government having a presence in social welfare programming and can be an irritant for Neo-Liberals/Neo-Conservatives (Rice et al., 2000). Born (2008a) indicates that getting caught in beliefs about one side believing they are right and the other wrong inevitably does not resolve much. On the other hand, approaching complex social issues with collaboration in mind could make the profession be viewed as one that is capable of mediating solutions to complex social challenges. Many polarized arguments will never convince the other side to change their view, but there is common ground in finding solutions to social issues and client needs.

The history of the profession grew out of social action (Sachs and Newdom, 1999) on social issues such as poverty. Today, many of us social workers would find ourselves in difficulty with our employers for engaging in social action that might help resolve some of the challenges. Despite this I believe the profession can find ways to make social action more prevalent. I believe that when a concerted effort has been made to address issues through collaboration there are times when social action can make further headway.
Conclusion

This practicum provided me with the opportunity to learn about every program area within the RQHR’s Addiction Services from an angle that I had never had the opportunity to see in my previous social work experience. I gained a stronger understanding of the client population served by the agency as well as the diversity in programming offered in it. This broad view provided a clear direction for where my energy needed to focus in the development of the TOP Model. Although the TOP was designed to be accessed by any program areas within the agency the model is much more likely to be used by the programs that serve the most chronic addiction clients. These clients typically have health challenges related to their addiction as well as numerous barriers to employment, housing and issues around positive community supports. This client population is mainly connected to the new Addiction Treatment Centre where Adult Therapies and Detox Programming exist.

It was interesting to see how existing programs and services in the agency are carried out with little connection to the community. I learned that staff connection with other agencies is most often through referrals. Phone and email communication with these agencies is generally the extent of the involvement with them. In my view this has more to do with the brokering of external services then it does with any meaningful integration. In my previous social work experience I have had open access to work in the community and as such I found it strange that staff only left the office to get coffee or to go home. Developing and outreach program within an agency in which staff rarely leave the office posed some unique challenges. I designed the TOP Model with clear community based strategies that fit with the agencies well developed addictions programming. I wanted staff in the TOP to have a strong guide for how they could connect with
the community to elicit the best results for their clients as it related to their addiction, housing
and numerous other social needs.

Since leaving the practicum, my main concern centres on the staff. Will outreach staff
engage the community to the degree that is recommended in the TOP? I was advised during my
practicum that there are limited training dollars available for staff. My concern is that staff may
believe that the TOP simply recommends some basic networking in the community to meet the
housing and addiction needs of clients. In reality it takes tremendous skill to be effective leaders
in the community. To be clear, I believe that the TOP staff are capable; however, the nature of
their previous internal style of work within the agency is different from being highly integrated
in the community.

As indicated in this report there are few social workers currently employed within
Addiction Services. In my view, it seems likely that the social work profession will increasingly
have a presence within the agency especially if the direction continues to focus towards the
community. A multi-disciplinary approach in the addiction field would serve it well.
Professionals with Chemical Dependency Diplomas bring tremendous skills and expertise to the
field and are an integral part of any multi-disciplinary considerations. Of the three TOP staff,
one has a Bachelor of Social Work degree which will be a definite asset in making the outreach
program a reality in our community. I like the mix of having a social work staff with two staff
with Chemical Dependency Diplomas. It will provide a solid footing of expertise for the
program.

Unlike agencies that have existed within a multi-disciplinary environment for some time,
the changes required for Addiction Services to get to this point will be difficult for some staff.
AA based or abstinence-based programming is no longer the dominant way for working with the
addictions population. It will be staff’s professionalism that will allow the agency to make this transition in a respectful manner despite charged emotions about the direction they should go.

Through this practicum I have gained a much better understanding of why it is important to consider the values of staff within an agency and how these intersect with the values of clients, the community and society at large. Although the basic philosophy that underlies services is the same for every client within Addiction Services, the values of each individual staff can affect each case differently. One staff may use the AA Model while another may focus on a Harm Reduction Approach. A client’s experience in the agency is uniquely shaped by the values of their worker.

In the TOP Model recommendations, I approached housing with both the present and the future in mind. Doing this supported my intention in making the Model address individual client needs today while also addressing community capacity building to address gaps in services. When I asked many Addiction Services professionals what they thought about an addiction outreach program that helped transition clients to housing, many stated that they did not believe there was any housing to connect them with. I discuss the Toronto “Streets To Homes Model” (Streets to Homes, 2009) within the TOP as one way of addressing the needs of clients. I argued that through relationship building with property management companies and individual landlords housing opportunities can be secured for clients (Streets to Homes, 2009). I also argued in the TOP that staff to have time away from specific client duties so that they can place their energy on helping to address gaps in the area of housing for sustainable solutions. This practicum experience has taught me that there are numerous opportunities for securing homes for people with addictions and many ways to support people in keeping their homes. I also believe that the TOP will provide a map for how gaps can be addressed.
I believe that the University of Regina’s Faculty of Social Work MSW Program has prepared me well to continue on in my Social Work Practice. My practicum experience at Addiction Services was one that I feel fortunate to have had. The opportunity to develop a program model has inspired me about the chance to develop future programs. I am thankful for the efforts of the Faculty of Social Work and Brian Danyliw, Manager of Addiction Services in making this learning experience possible.
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